

# **End of Term Evaluation Report**

## **Sundarbans Eye Health Service Strengthening Project**

**Project number 61812**

**Final submitted: 28 November 2018**

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**Submitted by Tropical Health**

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## Acknowledgements

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The Evaluation Team is grateful to the staff of Sightsavers in Haywards Heath, Delhi and Kolkata for their co-operation with the evaluation process, insightful contributions and assistance with planning at what was a particularly busy time for the Kolkata office.

The team is also grateful to the numerous project partner staff, community-based workers and volunteers who so generously contributed their time and thoughtful insights. Their motivation and commitment to the project's long term future is inspirational.

## List of abbreviations and acronyms

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ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BPHC	Block Primary Health Centre
DBCS	District Blindness Control Society
ETE	End of Term Evaluation
FGD	Focus Group Discussion
GIS	Geographical Information System
HMIS	Health Management Information System
IAPB	International Agency for the Prevention of Blindness
IEC	Information, Education and Communication
IKO	India Kolkata Office
KII	Key Informant Interview
MIS	Management Information System
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MTR	Mid Term Review
NGO	Non-Governmental Organisation
NHM	National Health Mission
NPCB	National Programme for the Control of Blindness
OECD/DAC	Organisation for Economic Co-operation and Development / Development Assistance Committee
OT	Operation Theatre
RAAB	Rapid Assessment of Avoidable Blindness
RAAVI	Rapid Assessment of Avoidable Visual Impairment
RMP	Rural Medical Practitioner
SCB	Standard Chartered Bank
SHS	State Health Society
SHIS	Southern Health Improvement Samity
SiB	Seeing is Believing
SSDC	Sundarbans Social Development Centre
ToR	Terms of Reference
UNICEF	United Nations International Children's Emergency Fund
VC	Vision Centre
VMA	Vivekananda Mission Ashram

# Executive Summary

## Background Information

The Sundarbans Eye Health Service Strengthening Project was a five-year project (2013-2018) covering 19 administrative blocks of West Bengal (collectively known as the Sundarbans) with a population of 4.7 million. Almost half of the population (47%) belong to marginalised groups such as Scheduled Castes and Tribes and over 40% of households live below the poverty line.

## Description of project

The project's goal was to “*contribute towards the elimination of avoidable blindness in the Sundarbans region of West Bengal by 2020*” by 1) Improving coverage and access to affordable, quality eye health services, 2) Increasing awareness and improving attitudes towards eye health in target communities and 3) Increasing the capacity of governmental and non-governmental institutions to deliver eye health services. The project worked with three established non-governmental organisation (NGO) partners and the State government to create 17 Vision Centres (VC) covering all 19 administrative blocks in the Sundarbans. It provided screening, referral and treatment services supported with awareness raising, outreach work and training for cadres of community level staff and volunteers in the government and informal health sectors.

## Purpose of Evaluation

The evaluation aimed to review the achievements of the project against objectives and outputs as detailed in the project documents, focusing specifically on understanding key successes and challenges in the implementation of the project, to help inform the future design of Sightsavers programmes and identify any further cross-cutting or organisational level lessons and recommendations.

## Evaluation approach

The evaluation used a combination of quantitative and qualitative assessment of project management data and insights from project personnel at regional and community level. Visits were made to three project sites and learning workshops were conducted with the project management team.

## Main findings

### Relevance

### Rating



The project was highly relevant, well aligned with government health policy and tailored to the local Sundarbans geographic and demographic profile. It selected partners strategically and engaged diverse, relevant cadres of community level personnel.

### Effectiveness

### Rating



The project achieved most of its service delivery and system strengthening targets, overcoming a series of operational challenges throughout the project's lifetime. Attention is required to the balance of effort devoted to quantitative targets and quality issues.

## Efficiency

## Rating



The project had several simultaneous areas of focus each with associated delivery pressures (large scale service provision in a challenging context, achieving full cost recovery and piloting Management Information System (MIS) and Geographical Information System (GIS) innovations). The number, scale and pacing of these elements in combination was problematic and clear prioritisation was needed. The project experienced problems in commissioning some major elements, which could have been foreseen with fuller scoping at an earlier stage.

## Impact

## Rating



The prevalence of blindness, severe and moderate visual impairment in Sundarbans has reduced from above the national average to below. The eye health care system has been strengthened with seventeen new VCs serving communities that had previously had poor access, and improved procedures and standards in the NGO and government facilities involved in the project. Attention is needed to embed the changes achieved.

## Sustainability

## Rating



The project model of tapering financial support to VCs combined with investment in business planning built in a strong focus on sustainability. Most VCs were transitioning to cost recovery status by the end of the project. Community level ownership of the programme was not formally established and project partners are concerned that the level of awareness-raising activity will reduce.

## Scalability/replication

## Rating



The project's model and approaches combined system strengthening in NGO and government sectors; a set of strategically located VCs staffed with specifically trained local personnel and engagement of large cadres of local health workers and volunteers. GIS and online MIS were piloted. All of these elements are replicable in similar contexts, subject to appropriate phasing. The paediatric element requires separate design.

## Coherence/coordination

## Rating



Co-ordination among the project partners worked well and the project elements (screening, training, awareness raising and service delivery) were coherent with each other. Coordination with government health services was mostly strong but challenges persisted in coordination with the education sector. The project's MIS remained a combination of offline and online, with compatibility and continuity problems.

## Conclusions

The project achieved most of its main objectives in a challenging context and the prevalence of blindness, severe and moderate visual impairment in Sundarbans has reduced significantly. NGO and government partners have worked together to improve service provision using standardised approaches. A financially sustainable VC model has been developed and tested, with promising early

indications. Innovative online MIS and GIS have been piloted and shown to be applicable, with substantial learning about the process.

## Recommendations

Main Recommendation	Operational detail	Responsible
<b>Project design</b>		
1. Allow sufficient time for holistic analysis of the operational context including local population demographics, attitudes and behaviours; market conditions; local government and other stakeholders' readiness to engage.	<ul style="list-style-type: none"> <li>- Ensure logframe addresses all elements</li> <li>- Include development of an advocacy strategy</li> </ul>	Sightsavers and partners – future projects
2. Consider children's projects separately, or at least as a dedicated stream within a larger project. Obtain specialist paediatric input throughout programme design, implementation and evaluation.	<ul style="list-style-type: none"> <li>- Maximise reach through using patient contact opportunities to explore potential further eye health care needs within families</li> </ul>	Sightsavers and Partners – future projects
3. Allow sufficient lead time before full implementation	<ul style="list-style-type: none"> <li>- Obtain any critical MoUs with relevant government departments</li> <li>- Pilot test new MIS and other technology early and phase performance targets to accommodate roll-out and consolidation</li> </ul>	Sightsavers and Partners – future projects
<b>Monitoring, evaluation and learning</b>		
4. Ensure future programmes develop a comprehensive monitoring and evaluation strategy with appropriate oversight, staff resource and budget, covering all elements of the project logframe	<ul style="list-style-type: none"> <li>- Develop indicators on quality aspects of the programme</li> <li>- Ensure output indicators are clearly defined, notably distinguishing between distinct individuals trained and numbers of trainings delivered</li> <li>- Phase output targets appropriately in line with business-critical milestones</li> <li>- Use VCMIS and GIS data to support VC management</li> </ul>	Sightsavers and Partners – future projects
5. Promote the timely sharing of learning and experience during project implementation	<ul style="list-style-type: none"> <li>- Promote communities of practice for informal peer support among VC staff and other trained personnel, to strengthen their increased capacity</li> <li>- Consider supporting VC staff to mentor new projects.</li> </ul>	IKO and Project partners - current
<b>Research</b>		
6. Ensure study populations and sampling for baseline/ endline	<ul style="list-style-type: none"> <li>- Introduce more sensitive age bands for GIS reports</li> </ul>	Sightsavers and Partners –



Main Recommendation	Operational detail	Responsible
surveys are matched to the project's target populations.		current and future projects Sightsavers evaluation team
7. Ensure maximum value is obtained from data collected for the project	<ul style="list-style-type: none"> <li>- Review the data collected for the child screening programme and consider whether it could be used for better prevalence estimation for child eye health.</li> <li>- Review and, if appropriate, complete the unfinished formal research reports commissioned during the project with due quality assurance</li> </ul>	Sightsavers IKO Sightsavers Research Managers
<b>Programme management and oversight</b>		
8. Formalise local stakeholder engagement through suitable existing or new committee structures (as recommended in MTR)	<ul style="list-style-type: none"> <li>- Support project partners to sustain local awareness-raising on key eye health messages</li> </ul>	IKO and project partners - current
9. Concentrate on leveraging and building a reputation for quality service provision throughout the care chain offered.	<ul style="list-style-type: none"> <li>- Review job descriptions for all project personnel to ensure management and clinical quality oversight roles are explicitly defined and appropriately allocated</li> <li>- Ensure attention to patient follow-up and associated documentation including treatment outcomes, post-operative complications and infections</li> <li>- Develop protocols for the provision of remote clinical and technical support through electronic media (email, skype or similar).</li> </ul>	IKO and project partners - current
<b>Sustainability</b>		
10. Ensure attention to sustainability is embedded in all elements of the project and included in the logframe, focusing on outcomes and impacts.	<ul style="list-style-type: none"> <li>- Introduce business planning support for VCs from the outset, ensuring it is tailored to a non-profit sector model</li> <li>- Develop a strategic approach to training that extends to training for trainers</li> <li>- Focus more of the government sector activity on embedding eye health awareness and relevant screening activity in the school and primary healthcare sectors.</li> </ul>	Sightsavers and Partners – future projects

# Introduction and background

## 1.1. Background

The Sundarbans Eye Health Service Strengthening Project was a five-year project (2013-2018)<sup>1</sup> covering 19 administrative blocks of West Bengal (collectively known as the Sundarbans) with a population of 4.7 million. Almost half of the population (47%) belong to marginalised groups such as Scheduled Castes and Tribes and over 40% of households live below the poverty line.

## 1.2. Purpose of evaluation

The Terms of Reference (ToR) for the end of term evaluation, reproduced in [Appendix 1](#), set out the aim of reviewing the achievements of the project against objectives and outputs as detailed in the project documents, focusing specifically on understanding key successes and challenges in the implementation of the project, to help inform the future design of Sightsavers programmes and identify any further cross-cutting or organisational level lessons and recommendations.

Target audiences for the report are funders, partners, programme staff and global programme support teams within Sightsavers.

## 1.3. Project description

With a total budget of \$1,714,797, the project was funded by *Seeing is Believing*, a collaboration between Standard Chartered Bank and the International Agency for the Prevention of Blindness (IAPB). The goal was to “*contribute towards the elimination of avoidable blindness in the Sundarbans region of West Bengal by 2020.*” Objectives include:

1. Improving coverage and access to affordable, quality eye health services
2. Increasing awareness and improving attitudes towards eye health in target communities
3. Increasing the capacity of governmental and non-governmental institutions to deliver eye health services

The project worked in collaboration with:

- Three partner NGOs: Southern Health Improvement Samity (SHIS), Sundarbans Social Development Centre (SSDC), and Vivekananda Mission Ashram (VMA).
- Local Community based organizations, Panchayat level eye care committees and District level steering committees
- The District Blindness Control Society (DBCS)
- The State Health Society and National Health Mission (NHM).

The project was managed by a project implementation team of Sightsavers staff based in the India East Area Office in Kolkata (IKO), with oversight from its Delhi-based technical lead. Directly employed or funded staff comprised a full-time Project Manager, three Project Co-ordinators (one in each partner organisation) and staff teams in 17 Vision Centres (VCs): one Vision Technician and three to four Community Health Workers (CHWs). The number of CHWs was determined by the

<sup>1</sup> A no cost extension, until 31 Dec 2018, was approved by AIPB in Oct 2018, to enable (1) completion of the final evaluation, (2) finalisation of GIS maps, (3) the completion of training of government doctors, and (4) final financial audits of project partners.

number of Primary Health Clinics (PHCs) covered by each VC – typically one per 100,000 population. One of the three partner organisations (VMA) carried out paediatric surgery in its own base hospital; all other surgeries were carried out by partners' operating hospitals within government premises. Two of the partners conducted surgery under the Government's DBCS scheme, with reimbursement. Each partner covered a distinct area's set of VCs, supported by an ophthalmologist, an optometrist and an Operating Theatre (OT) nurse. Organograms are provided in [Appendix 2](#). Most of the VCs served the single administrative block in which they were located; two of them additionally provided outreach services to a neighbouring block. The project thus covered all 19 administrative blocks in the Sundarbans.

In addition to directly employed staff the project made extensive use of community level personnel groups: teachers, Rural Medical Practitioners (RMPs), Accredited Social Health Activists (ASHAs) and Anganwadi Workers (AWWs). It also engaged a large group of volunteer supporters known as Health Ambassadors, who acted as champions for the project within their own communities and personal networks. All of these groups were provided with training for their roles.

The project included a pilot of a Geographical Information System (GIS) which was developed specifically for the Sundarbans as a tool to facilitate spatially informed programme management decision-making practice, in addition to a digital Management Information System (MIS).

## **1.4. Methodology and ethical considerations**

### **1.4.1. Evaluation Approach**

This independent evaluation covered seven OECD/DAC<sup>2</sup> evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability, scalability/ replicability, and coherence/ coordination, with 22 specific evaluation questions defined (see ToR, [Appendix 1](#)). These questions and associated data collection approaches are detailed in the Evaluation Matrix ([Appendix 3](#)). Sightsavers' rating guidance was in addition used to score the project performance against evaluation criteria ([Appendix 4](#)). The evaluation covered the project's full five years from September 2013 - August 2018, targeting informants from national, regional (West Bengal) and community level in the Sundarbans.

The evaluation was conducted by a team of two consultants, a Team Leader and National Consultant<sup>3</sup>, supported by the technical and management teams at Tropical Health<sup>4</sup>. The team roles are outlined in [Appendix 5](#).

### **1.4.2. Evaluation design**

The evaluation was retrospective, using mixed methods. There was an extremely short timeframe to plan the evaluation before the end of the project and the data collection phase was scheduled to begin immediately after the project ended. There was limited opportunity for participative approaches, limited time for iterative document review and limited availability of the IKO team to plan the field visit. The evaluation design therefore sought to maximise the opportunity for primary

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<sup>2</sup> Organisation for Economic Co-operation and Development / Development Assistance Committee.

<sup>3</sup> Lynne Elliott– Team Leader; Dr Patil – Team Member/National Consultant.

<sup>4</sup> Vikky le May and then Nicky Moran Prince – Evaluation Technical Coordinator; Caroline Vanderick – Quality Assurance.

qualitative data collection and make maximum use of the project's existing quantitative data. Quantitative output data were used to assess the overall performance against the project targets, triangulating project logframe output with baseline and endline survey data. Qualitative assessment provided in-depth exploration of the facilitators and barriers to implementing and sustaining eye health programmes in the Sundarbans context.

The evaluation was carried out in three phases (see [Appendix 6](#): Workplan):

**Phase 1: Inception.** The Evaluation Team reviewed background documents and data to inform the evaluation methodology and understand the project context. The Team Leader worked through skype and email with Sightsavers UK and Sightsavers India Delhi and Kolkata Offices to plan the field visit including selection of sites to visit and prioritising key informants. The Inception Report covered early insights from the document review, set out the agreed question framework, prioritised interviewee categories, described outline plans for the field visit ([Appendix 7](#)) and identified further preparatory steps and documentation required before the field visit (see [Appendix 8](#)).

**Phase 2: Data collection and preliminary analysis.** The evaluation team collected primary data from key informants at the regional and community levels and sought additional project documents during the field visit and afterwards. Participatory briefing and debriefing workshops were held with Sightsavers staff from Delhi and Kolkata at the beginning and end of the field visit. These sessions were facilitated by the Team Leader and National Consultant, with preparatory guidance supplied in advance to participants ([Appendix 9](#)). The output from these workshops was used in the development of this final report.

**Phase 3: Full data analysis and report writing phase** involved the collation and analysis of qualitative and quantitative data collected during the field visit and afterwards, and analysis of the further secondary data provided by the project (notably the draft baseline/ endline survey). A draft report was prepared for feedback from Sightsavers, revision and final editing.

#### 1.4.3. Ethical considerations

Government ethical approval was not required for the evaluation. Informed consent was obtained from all interviewees, guided by the Information Sheet and Consent Form. Information about the evaluation and consent form was provided in English and, where required, in Bengali ([Appendix 10](#)). No interviews were conducted with service users and all informants were adults. No identifiable patient information was viewed. Interview notes were made by the evaluation consultants and anonymised before analysis. Both evaluation consultants completed UNICEF's 'Ethics in Evidence Generation' course or equivalent, and signed/abided by Sightsavers' safeguarding code of conduct.

#### 1.4.4. Data collection methods

##### ***Secondary data sources***

The document review drew mainly on project documents provided to the Evaluation Team by Sightsavers in the UK and India. Some further documentation and additional information was requested by the Evaluation Team, and some external sources were identified by the Evaluation Team. A total of 47 documents were reviewed by the Evaluation Team (see [Appendix 11](#)).

## Primary data sources

All primary data collection was scheduled to take place during the field visit, covering Key Informant Interviews (KIIs) at national, regional and community level. Data from the project's GIS maps were examined in combination with progress reports for preliminary identification of potential sites of interest. Selection criteria were:

- One VC from each project partner
- A combination of High and low performing VCs
- A combination of single and two-block VCs
- Variety of North and South Parganas sites
- VCs that showed atypical service user profiles (one was noted to be attracting a larger proportion of women and younger service users).

The logistics of travel within Sundarbans from the Kolkata base allowed for visits to three VCs in the time available. The sites selected were: Canning II (2-block centre with atypical service user profile in one block), Hasnabad (higher performing VC) and Patharpratima (lower performing VC).

Key informants were selected through purposive sampling from a longlist of potential subjects provided by Sightsavers during the inception phase (see [Appendix 12](#)). This was supplemented using further purposive sampling during the field visit to achieve insights from each of the target categories. The only target category not achieved was teachers, at community level. While direct data collection from service users would have been optimal, it was recognised that this would not be feasible within the time and resource constraints of this ETE<sup>5</sup>. The evaluation identified and reviewed existing documentary evidence capturing end users perspective (notably a patient satisfaction survey) made available by the IKO team. In addition, insights from relevant community level informants were sought to help assess the quality of processes used to obtain service users' perspectives documented for the programme.

Table 1 - Key informants targeted and achieved

Data collection level	KIIs		FGDs		Total participants	
	Target	Actual	Target	Actual	Target	Actual
National level*	4	7	0	0	4	7
Sub-Regional level	10	11	0	0	10	11
Community level	6	10	30	19**	36	29
<b>TOTAL</b>	<b>20</b>	<b>28</b>	<b>30</b>	<b>19</b>	<b>50</b>	<b>47</b>

\* Includes two staff from Sightsavers headquarters office

\*\* The targeted teacher FGDs (nine participants) were not arranged, and some community level informants responded through individual interviews instead of groups.

Qualitative data collection mainly took place through face-to-face KIIs and FGDs during the field visit. Two KIIs took place after the field visit, remotely via Skype. The Team Leader and National Consultant shared the data collection roles, working jointly and/ or separately to make best use of the limited time available. As no provision was made for interpreters, the National Consultant conducted interviews and FGDs where Bengali language was required. Where concurrent interviews

<sup>5</sup> The process would involve selecting an appropriate and diverse sample and recruiting appropriately trained independent interpreters.

were scheduled which required Bengali language, IKO staff were used as translators. All interviews with senior staff were conducted in English.

Interviews and FGDs were based on semi-structured guides ([Appendices 13](#), [14](#) and [15](#)) which drew on the main evaluation questions, with language adapted as appropriate to the context. Contemporaneous written notes were made of all KII and FGD data, aligned with the evaluation questions. Interviews and FGDs were not recorded. Photographs were taken where appropriate, with consent.

#### 1.4.5. Analysis and production of evaluation report

Data from all sources were triangulated and reviewed jointly by the Team Leader and National Consultant during the field visit. Preliminary observations and ratings for the seven evaluation criteria were shared and discussed in a workshop with Sightsavers Delhi and Kolkata staff and their views on ratings were included as part of triangulation of data. Outstanding key information was requested in order to complete the analysis and revise the ratings after the field visit. Some key information remained unavailable or in draft form only and analysis and final ratings were completed on that basis.

#### 1.4.6. Limitations of the evaluation

The use of IKO staff to assist with visit site and key informant selection risked some conflict of interest and potential skewing of data.

The endline survey was not available until after the completion of the field visit, which meant insights from it could not be used in the main data collection phase. The version supplied was an early draft, which the evaluation team was able to discuss with one of the authors, and findings are used in this report on that basis.

Some key project management documents, notably the final completed logframe report, remained unavailable throughout the evaluation, which limited the robustness of conclusions drawn from quantitative analysis.<sup>6</sup>

### 1.5. Report structure

The Evaluation Report has three main sections:

1. This **Introduction and Background** section provides an overview of the project and the evaluation process.
2. The **Results** section details the findings for each of the 22 evaluation questions and provides the ratings for the seven main evaluation criteria.

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<sup>6</sup> The Y5H2 report spreadsheet was supplied in November 2018, after the completion of the evaluation, and was not included in the analysis. The headline final output figures used in this report (Table 5) were provided by the IKO during the field visit - these are broadly consistent with the Y5H2 report spreadsheet.



3. The **Conclusions and Recommendations** section identifies key observations on the findings, captures and learning points from the project team, and provides recommendations for enhancing the sustainability of this project as well as guiding future projects.

**Appendices** provide supplementary detail where required and copies of all tools used in the data collection.

## Results

### 2.1. Relevance

Rating



#### 2.1.1. To what extent did the project design align with the eye health priorities and policies of national and local government?

The project's proposal document<sup>7</sup> describes its policy context and overall strategy. There was good alignment with national policy & strategy:

- Equity, decentralisation and community participation are among key principles for the National Health Policy
- National policy incorporates eye care prevention through the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)
- The project reflects National Programme for the Control of Blindness (NCPB) strategies.

However, the project faced the widely-recognised challenge of addressing a low prevalence issue in the context of numerous high prevalence health issues and competing policy challenges.

*“The challenge for eye care globally has been the focus on mortality targets rather than morbidity - maternal, neonatal and child health, road accidents... indicators are often tied to economic productivity and eye care is presumed to be an elderly persons issue. This has meant eye care not been not given the same attention.”*

**Sightsavers staff member**

Senior project staff described opportunities for better framing of the eye health issue in relation to Non Communicable Disease (NCD) and or other relevant policies agendas, e.g. education and economic development. The project did engage the education sector, which was highly relevant, but found some persistent barriers there. These insights may help frame future projects' strategic approaches and ongoing advocacy work.

*“Going forward eye care needs to be considered as part of non communicable diseases, broaden the scope of people to talk to, ensure it's part of primary healthcare. Health programmes, finance... involve all of these players in discussions so that it widens the network involved in eye health.”*

**Sightsavers staff member**

<sup>7</sup> Agreement between IAPB and Sightsavers dated 27 August 2013: Sunderbans Eye Health Service Strengthening Project

## 2.1.2. To what extent does the project design and implementation respond to beneficiaries' eye health needs (including women), e.g. how far did the VC locations help in serving target populations, including in terms of equitable gender balance and accessibility?

The project was designed to meet the population-level profile of eye health need, concentrating on adults aged 40+ where prevalence of eye health problems is higher, increasing with age, and a higher burden of eye disease among women. VC location criteria were partially based on the practical needs of target service users, notably accessibility logistics for remote communities which were addressed through locating VCs in local transport hubs and gathering places such as market areas, and attempts at mobile clinics.

The engagement of cadres of established community health workers such as ASHAs enabled services to be highly sensitive to local dimensions of need: these workers have sustained relationships with community members and have contributed insights on how family dynamics, travel logistics, health beliefs and other individual factors affected service uptake. Similarly, the use of staff recruited from the local area ensured that services were designed with high levels of local insight and opportunities for informal feedback.

The target population's high rate of illiteracy (40%) was not explicitly assessed as a dimension of need although it was addressed in the awareness raising strategies, which made extensive use of non-written communication methods such as theatre and local events. Appropriate vision testing methods were used for people who could not read. Illiteracy can be associated with stigma and can exacerbate barriers to accessing services or compliance with treatment.

Data on service use by persons with non-visual disabilities were not routinely collected by the VCs or at baseline as it was not part of the original design although this issue was considered in the endline study. This found prevalence of non-visual disability in all adults over 40 to be 11.1%, prevalence increasing with age, as detailed in Table 2.

*Table 2: Prevalence of non-visual disability*

		Disability			Non-visual disability		
		N	%	95%CI*	N	%	95% CI*
Total		502	14.7	12.5-17.3%	377	11.1	8.9-13.6%
Sex	Male	212	12.9	10.8-15.2%	153	9.3	7.4-11.6%
	Female	290	16.5	13.6-19.8%	224	12.7	10.0-16.0%
Age	40-49	68	4.3	3.2-5.8%	47	3.0	2.0-4.4%
	50-59	104	12.0	9.3-15.3%	78	9.0	6.7-11.9%
	60-69	138	23.6	19.5-28.3%	997	16.6	12.7-21.5%
	70-79	112	40.9	33.6-48.5%	88	32.1	25.5-39.6%
	80+	80	70.8	61.0-78.9%	67	59.3	49.7-68.2%

Source 1: Sightsavers Draft baseline/ endline survey, 2018

The implications of disability profiles are relevant at the programme planning stage for an eye health programme serving an older adult population. The GIS maps for the project do not provide detailed enough age categories to detect whether the older age groups with higher disability rates are under-represented among service users.<sup>8</sup> Insights from FGDs suggest that some very elderly people have

<sup>8</sup> Age bands reported in GIS: under 15, 15-49 and 50+.



presented for treatment and considerable effort has been made to ensure it is provided, including home visits and discussions with wider family members.

The project also targeted child eye health. There was no baseline data on children's eye health and estimation of prevalence of eye health problems was based on national estimates. These overestimated prevalence for children, which led to problems with target setting (eventually revised downward for cataract surgery based on observations from screening). The main strategies used to address children's needs were the engagement of schools and the engagement of Angawadi workers. Children were not included in the endline survey.

Despite the target-setting challenges relating to children, the project performed well in screening large numbers, providing free spectacles to children who were found to need them and in raising awareness of vision issues among teachers and health workers.

The project was serving an extremely poor population and was designed to provide free or subsidised services where necessary. Attitudes to payment were not originally assessed for programme design but were later studied in the project's Spectacle Compliance Survey. Evidence from this and from payment patterns shown in the baseline and endline surveys<sup>9</sup> suggests most are willing to pay. This was also observed during the field visit to one of the VCs, during which a woman thought to have been a beggar insisted on paying a small amount for an eye check even when staff offered to provide it for free.

## 2.2. Effectiveness

Rating



### 2.2.1. Were the project objectives/ outcomes achieved or not, and what were the major factors influencing this?

Some provisional final headline figures relating to the project's overall goal and selected outputs were provided by the IKO during the field visit, and a draft baseline/endline survey was provided after the field visit. These documents suggest good to excellent performance, but final formal reporting documents would be required to verify this. An evidence gap may remain for some aspects of the project's stated objectives relating to the quality of service provision.

The project's logframe ([Appendix 16](#)) set out its three main objectives with 10 related outputs. Seven of the outputs included numerical targets. While some of the outputs covered quality issues, all 36 indicators were quantitative.<sup>10</sup> The logframe indicates MIS and other reports were prepared covering quality issues. Results of quality assessments are not recorded in the logframe indicator reports.

The most recent completed output table provided for the ETE was from February 2018 (first half of the final year.) These 6-monthly logframes report performance against cumulative output targets, showing some outputs with negative variance (mostly small) and some with positive variance (some extremely large). The logframe does not show overall numerical targets for some outputs, although interim targets for the period to date are given for them in the 6-monthly reports. There are some internal inconsistencies and anomalies within the logframe spreadsheets (e.g. some of the interim

<sup>9</sup> 80% of spectacle wearers had fully paid for them, paying a median 350 rupees. The median amounts people were willing to pay for eye checkups and spectacles were 100 and 200 rupees respectively.

<sup>10</sup> There was no separate Theory of Change (ToC) for the project; the proposal and logframe taken together cover the elements that would typically appear in a ToC.

targets shown were higher than the overall stated targets) and some inconsistencies between the logframe spreadsheets and other spreadsheets used in the project's MIS (e.g. the VC Reports spreadsheet used to analyse VC cost recovery performance indicated only three VCs had achieved 100% or more cost recovery by June 2018, whereas the last available logframe update and donor report indicated 10 were performing above 100% at March 2018). It is likely that these inconsistencies relate to the operational challenges of working with multiple local reporting systems and transitioning from offline to online MIS, rather than any underlying inaccuracy in the figures reported.

***Achievement on overall goal: To contribute towards the elimination of avoidable blindness in the Sunderbans region of West Bengal by 2020***

The draft baseline/ endline survey provides data on the Sunderbans population level prevalence of blindness, severe and moderate visual impairment among adults aged 40+, with age and gender disaggregation. There are no baseline or endline data for children or younger adults. The baseline data were collected in June 2014 (i.e. during year 2 of the project) and endline data collected in June-July 2018 (i.e. during year 5 of the project).

This survey suggests statistically significant reductions have been achieved in blindness and visual impairment in the Sunderbans between baseline and endline as shown in

*Table 3:*

*Table 3: Baseline/endline prevalence reductions, age-sex adjusted*

Condition	Baseline as reported in endline*	Endline
Blindness	2.0%	0.8%
SVI	4.8%	3.1%
MVI	12.7%	8.8%

\*the original baseline survey did not provide age-sex adjusted figures.

If verified this indicates the prevalence of blindness in Sunderbans has reduced from being above the national and regional levels (1% and 1.19% respectively)<sup>11</sup> at baseline to below at endline. However, caution is required as the national and regional baseline figures were assessed in 2007 and subsequent prevalence studies will be required to establish whether the reduction is sustained as the Sunderbans population ages, bringing new cases of cataracts and refractive error and the new challenge of retinal blindness from diabetes and age-related maculopathies.

*“The majority of blind people live in developing countries, and generally, their blindness could have been avoided or cured. Given the current predictions that the number of blind people worldwide will roughly “double by the year 2020, it is clear that there is no room for complacency.”<sup>12</sup>*

No conclusions are drawn in the endline survey about the project's contribution to these reductions.

<sup>11</sup> NPCB RAAB Survey 2007

<sup>12</sup> West S & Sommer A. Prevention of blindness and priorities for the future. Bulletin of the World Health Organization.

The endline survey shows a substantial and increased proportion of people reporting they used private sector hospitals for cataract surgery, from 38.5% to 57.7%<sup>13</sup>, detailed in *Table 4*. The major shift was from voluntary/charitable hospitals towards private sector providers rather than government hospitals, despite substantially increased awareness that government provides free cataract surgery (43.1% at baseline, 81% at endline), and a government policy change during the project which discontinued reimbursement for surgery at voluntary/ charitable hospitals.

*Table 4: Changing pattern of place of cataract operation*

Place of cataract operation	Baseline %	Endline %
Private hospital	38.5	57.7
Eye camp	11.5	17.0
Government hospital	15.5	16.1
Voluntary/charitable hospital	34.5	9.2

### ***Achievement on selected key output targets***

The project's 6-monthly logframe output reports cover screenings and treatment provision, training provision and awareness-raising activity up to the end of the first half of year five (February 2018).

Pending completion of the final logframe, final output figures were provided by IKO staff during the field visit as shown in *Table 5*.<sup>14</sup>

*Table 5: Outputs achieved*

Type of activity	Target	Achieved	Performance
Adult cataract surgery	33,120	31,783	95.9%
Paediatric cataract surgery	100*	102	102%
Vision Centres established	17	17	100%
Adults Screened	330,000	401,671	121%
Children Screened	457,000	451,395	98.7%
Trained Health Ambassadors	3,180	3,700	116%
Trained Rural Medical practitioners	2,520	2,521	100%
Awareness Events	2,262	2,700	119%
Trained Government Health workers on eye health**	930	1,493	160.5%
Trained Government ophthalmic human resource	98	70	77.7%

Source 2: Figures supplied by IKO during ETE field visit 2018

\* Target revised from 200 to 100 in April 2017

\*\* This figure amalgamates several groups of trainees, which are reported separately in the 6-monthly donor reports

<sup>13</sup> There is uncertainty over whether the difference in service use patterns may be related to how the term "private hospital" was understood by endline survey participants. This may require further clarification during finalisation of the draft endline survey report.

<sup>14</sup> The Y5H2 report spreadsheet was supplied in November 2018, after the completion of the evaluation, and was not included in the analysis. The headline final output figures used in Table 5 are broadly consistent with the Y5H2 report spreadsheet. Some of the figures provided during the field visit, e.g. "government health workers trained," cover groupings of the categories reported separately in the regular donor report spreadsheets.

Based on these figures the project has slightly underachieved on adult cataract surgery and training of government ophthalmic personnel, and either met or exceeded the other targets, subject to clarification of some training output definitions. The project collected data on surgery outcomes but these are not included in the logframe reports.

Quality issues observed in the field visit related to:

1. variable compliance with standards on hygiene and equipment maintenance, which had also been noted in project reporting. Some VCs still did not have adequate toilet and handwashing washing facilities and sterilising equipment was in poor condition.
2. patient record keeping systems which did not always document follow-up or synchronise between hospitals and VCs.

It was noted that quantitative data on training outputs does not clearly distinguish between numbers of distinct individuals trained and numbers of training events, as some individuals may have attended more than one event. Qualitative reports refer to follow up and refresher training events for some categories of trainee.

The baseline/ endline surveys provide population-level data for adults aged over 40 only. They report in narrow age bands that allow for relevant granular analysis, e.g. the detection of disability rates in upper age bands. The surveys were based on the standard tools available (RAAB and RAAVI, which focus on adults over 40 or over 50<sup>15</sup>), to provide comparability with other relevant data. The project served children and adults of all ages, and collected precise age data, but the GIS only reported service use data in very broad age bands that do not correlate to the baseline/ endline survey age bands. Data from the GIS could be further analysed in narrower age bands to align more closely with the baseline and endline surveys, but there remains a gap in baseline and endline data for children and younger adult populations covered by the project.

### **2.2.2. To what extent has the GIS location data been useful to the targeting and planning of outreach and school screening strategies and activities, and is there any corresponding evidence of decisions or changes in service delivery and treatment as a result?**

There were mixed reports on how the GIS location data were used. The system was introduced and developed during the first years of the project and rolled out through staff training in the second half of Year 3. The intention had been to provide reports to the VCs at 3-month intervals, to assist them with forward planning. In practice reports arrived less frequently and in some cases the latest reports in use at the end of the project were from June 2017. VC staff typically used the reports to review where their service users had come from in order to plan subsequent outreach work. VC Staff were interested in the potential of the system and willing to engage with it, e.g. some mentioned they were actively working on improving the quality of data entry.

The GIS data outputs have potential for project-level management overview, performance tracking and feedback, and for further analysis of project outcomes.

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<sup>15</sup> RAAB is a rapid, population-based survey methodology on blindness, visual impairment and eye care services among people aged 50 years and over. Full details available at <http://raabdata.info>

### 2.2.3. To what extent have the accepted mid-term review recommendations been actioned or fulfilled?

The Mid Term Review (MTR) took place in the second half of 2016 and the formal report was provided in April 2017 (Year 4 of the project). The formal Management Response indicated that all nineteen recommendations had been accepted. The response was updated in September 2017 to indicate progress on implementation of the recommendations: four of the recommendations had been implemented in full, seven partially implemented and three were not going to be implemented, notably recommendation 8 on the establishment of village level committees. The status of the remaining five was described as “ongoing” – it was not clear whether this referred to consideration of the recommendation or implementation. A final update requested for the ETE and provided after the field visit suggested that some of the recommendations may have been re-interpreted following the original management response, and in one case, recommendation 19, may have been misunderstood. The project’s self-ratings and ETE ratings for each recommendation are summarised in *Table 6*.

*Table 6: Final status of MTR recommendations*

	Self-rating	ETE rating
Completed	13	5
Partially completed	5	10
Not implemented	1	4

Three recommendations were self-rated as “complete” but considered “not implemented” by the evaluation team, i.e. recommendations 8, 18 and 19. The main difference between IKO team and evaluator ratings was between “completed” or “partially completed.” In most cases, the project’s self-rating as “complete” related to the action plan identified to address the recommendation, rather than the recommendation itself. In some cases, evaluators considered that the action plan had addressed only part of the accepted recommendation, and in some cases the activity described in the status update was different from the planned action. The full set of recommendations and status updates is provided in [Appendix 17](#).

Interviews with project staff in the VCs suggest that the MTR recommendations were not explicitly cascaded to VCs and few were aware of them.

### 2.2.4. How far has the project been able to incorporate a gender responsive approach in terms of reach and service uptake in Sundarbans? Are there any specific examples of initiatives which have worked which can inform gender targeting more widely in Sightsavers’ eye health projects?

The project performed well in providing services to women. Overall, as of March 2018, having reached 95% of its target to date, the project had screened more women than men, and performed more cataract surgery on women than on men. Among children, having reached 106% of the target to date, the project had screened more girls than boys but the resulting treatment patterns were

varied: twice as many boys as girls had cataract operations, but far more free spectacles were distributed to girls than to boys.<sup>16</sup>

Strategies employed to target women included using women's self-help groups, recruiting female staff for the VCs and engaging community based female health workers (ASHAs and AWWs) to improve outreach. Communication strategies used to target women included using imagery of women as well as men wearing spectacles in IEC materials.

Some VC's used price point strategies in recognition of women's lower purchasing power, pricing spectacle ranges affordably for each. This issue was reflected in the endline survey which showed men on average paid more for their spectacles than women: men 400 rupees, women 350 rupees.<sup>17</sup>

Some CHWs noticed that women tended to come to the VC in groups whereas men would attend alone. The service accommodated this preference: women were encouraged to come as groups as well as on their own for VC visits. Women attending in groups received individual tests and follow-up general eye health information was provided where appropriate to the group.

Project staff were aware that power balance within families could inhibit some women's uptake of services, especially for older women. They addressed this through family-level outreach in some cases, to assist with decision making about surgery.

During the inception phase the GIS maps had suggested that one VC (Canning 1) had a particularly high proportion of female users. This was one of the criteria used in selecting Canning for a site visit. During the evaluation field visit, VC staff were able to explain that this was because men in Canning 1 tended to travel for work, usually to Kolkata, leaving women and children remaining in the villages. This kind of underlying demographic insight would be useful commentary in programme planning and routine reporting.

## 2.3. Efficiency

Rating



### 2.3.1. Were there any timeline or resource allocation related challenges that needed significant alteration?

The emphasis on establishing operational VCs from an early stage meant that some VCs were found with hindsight to have had sub-optimal location and/ or operating hours, despite having used best efforts to locate them according to appropriate criteria (e.g. ground floor, near market areas). In one case (Patharpratima), the VC had to be relocated mid-project. Similarly, the investment in a mobile VC concept to serve remote communities had to be revisited when it was realised people adapted to the Sundarbans way of life were accustomed to moving between areas for services. The logistics of using mobile clinics also proved challenging: time consuming to load and unload with risk of damage to equipment and supplies, coupled with the government's discontinuation of a wider boat-based mobile health project which was meant to provide the platform for the eye care services. The mobile VCs were discontinued in favour of supporting remote service users to access land-based VCs.

<sup>16</sup> Further analysis of data collected for the project's Spectacle Compliance Report may offer insights into spectacle distribution issue. It may simply reflect a general adult pattern of higher spectacle uptake among women than men, which in turn would suggest a gender-sensitive approach to enhancing uptake by boys and men. Further research is required to investigate the difference between boys' and girls' surgery rates, as there would be no reason to anticipate differences in the prevalence rates for the eye health problems found.

<sup>17</sup> Further analysis of data collected for the project's Spectacle Compliance Report could provide more insight into this issue.



These are examples of an appropriate adaptive management approach adopted by the team for some aspects of the programme.

It would appear that insufficient lead time was allowed for concept testing when some of the proposed approaches, which were reasonable in the circumstances, could have been explored more fully before the pressure to deliver on outputs became the priority. The plan to employ a Sales Manager to support VCs in achieving spectacle sales targets had to be revised and budget reallocated to provide more extensive consultancy support. This set the sales support in the context of more comprehensive business planning for longer-term financial sustainability. The situation analysis conducted for the business planning support element provides a useful, comprehensive outline of considerations for the location of new VCs including the presence and strength of local competitor services<sup>18</sup>.

Working through schools was a major element of the programme but again the lead time did not account for the time required to achieve formal agreement with the Ministry of Education. This time issue could have been foreseen. A Memorandum of Understanding (MoU) with the State Government was secured in year 3, which project staff saw as a major achievement that will assist with long term sustainability for this element. Despite the challenges, teacher training targets were met but it took time to build effective engagement of teachers in the school screening work and teachers' unwillingness to undertake work meant other staff had to be deployed for schools' work.

*“Due to other demands, they may not take up an activity unless it’s a government directive.”*

**Project Coordinator**

*“Ministries take their own time and that may not be in line “with programme timelines”.*

**Sightsavers staff member**

GIS and MIS development and roll out took longer than anticipated, and the systems were found to have major compatibility challenges that had to be addressed including replacement software for the MIS. The scale of change involved in developing, introducing, refining and embedding these innovations was larger than anticipated, requiring additional human resource support and budget reallocation, and initial training was delivered too early<sup>19</sup> in relation to the planned roll-out of the systems. Transition to online MIS was incomplete by the end of the project. Lack of suitably skilled local contractors hampered the GIS and MIS software development and training elements. Similarly, plans for IEC work using radio had to be dropped when it became apparent there was no suitable local supplier. These issues could have been foreseen had more time been available for scoping and designing the project elements.

*“It (providing eye health care to remote communities) was an incredibly brave project to take on. It could have moved faster when decisions to change course were clearly needed.”*

**Donor**

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<sup>18</sup> Think Through Consulting: Sightsavers Vision Centre Final Report, July 2016

<sup>19</sup> There was a 6-month gap between the staff training and the implementation.

### 2.3.2. To what extent has routine and enhanced project monitoring in relation to school screening and outreach camps, as well as cataract surgical outcomes, been incorporated in project management during implementation, including in relation to MTR recommendations 1, 2, 4 and 7 on additional monitoring and analysis?

Implementation of recommendations 1 and 2 (school screening issues) 4 (outcomes and follow up of screening at eye camps) and 7 (surgery outcome data) was partially complete by the end of the project. Notably, in relation to recommendation 4, the MIS was only being used to capture patient data from the VCs, not the outreach screenings, and only eight or nine VCs were fully implementing the MIS. In relation to recommendation 7, the continuity gap remained between the patient record systems for surgery outcome recorded at hospital discharge and the separate system for 6-week follow up done by the VCs.

KIIs and FGDs with project staff and observations in the project's 6-monthly qualitative reports suggest that the increased focus on achieving and reporting on footfall targets was of value: while it did result in additional pressure, staff found this constructive and motivating. Concerns remain about the risk of compromising quality in the pursuit of solely numerical targets.

*“Having sharp targets has been good...helpful...these have brought focus”*

*“Normally this [targeting and planning] would be done annually... with weekly targets and this micro planning you know exactly what's happening”*

*“with the focus on numbers and financial systems change can become secondary... “it brings efficiency but the risk is you lose the larger picture.”*

**Sightsaver staff members**

Cataract surgery outcomes and patient satisfaction levels at population level were reported in the baseline/endline survey, shown in *Table 7*:

*Table 7: Cataract surgery outcome and patient satisfaction ratings*

Outcome rating	Baseline	Endline
Cataract surgery: good	75%	80%
Cataract surgery: poor	7%	8.7%
Satisfied	80.7%	88.7%
Indifferent	8.2%	<1%
Dissatisfied	11.2%%	10.4%

It should be noted that the average age at operation was 53.5 years in the endline survey compared with 64.2 years at baseline, which may be a factor in treatment outcome and satisfaction levels. The age profile of people treated in the project's hospitals is not reported in the logframe output tables, nor are patient satisfaction levels.<sup>20</sup>

<sup>20</sup> A patient satisfaction study report was supplied during the field visit. Data collection was done during 2015, involving 200 surgery patients from two of the partner hospitals. Patient age profiles are recorded in this report. There is insufficient methodological detail and results in the report to draw useful conclusions from it at this stage.



Surgery outcome data is not fully reported in donor reports although some data is collected at hospital level and in separate follow-up records at the VCs. Donor reports provide visual outcome data for cataract surgery, but no data on post-operative complications or infections. Observations made during the field visit suggest that there was less focus on managing service quality issues either at individual VC or project level, discussed further at point 2.4 below.

## 2.4. Impact

Rating



### **2.4.1. Has there been any impact on the service delivery capacity of government and NGO partner capacities as a result of the project? For example, the utilization of the infrastructure upgrading and the extent to which this has contributed to better eye care services to the patients at the 4 primary eye care centres and at the sub divisional level?**

The project successfully established 17 new VCs which are recognised at government level as filling a gap that government services could not meet and extending service provision in the NGO sector. The VCs serve as an important bridge between primary (including informal) and secondary care, with sufficient levels of clinical skill backed up with appropriate support to provide the required standard of service. The three NGO implementation partners have retained increased capacity to deliver services, and have made improvements to their own organisational capacity in terms of management systems, standards and protocols.

One partner organisation reported internal benefits from the focus on achieving targets, which has pushed performance and developed the organisation's capacity to deliver. This has to be balanced with concerns about quality, which to some extent is seen as a tension with the focus on numerical targets, both in terms of delivering and reporting on quality.

In the government health care setting, the project provided:

- Infrastructure upgradation in Kakdwip Sub divisional hospital
- Improvement of basic screening facilities in 18 Govt. Primary eye care facilities in Sundarbans
- State level training of 70 Paramedical Ophthalmic Assistants in association with State NPCB Cell and NRS Medical College.

In terms of system strengthening, standardised systems and processes were developed through the project but were not consistently implemented by VCs or partner hospitals and, in some cases, were missing:

- MIS was not fully functional
- No evidence of a system for documenting the routine follow up of surgery for adults or paediatrics
- Monitoring of visual outcomes was not clearly documented or tracked through the project's MIS
- No records of post-operative complications and subsequent follow up, or monitoring of post-operative infections.

The project had further unintended, positive, consequences for increased capacity within communities and at individual level. Community level informants – VC staff, health ambassadors,

other health worker groups trained for the project - widely reported that they felt increased employability, raised self-esteem, and enhanced status as contributors to their communities.

*“Before I had the training... I’d never have believed I’d be doing something like this.”*

**Health Ambassador**

*“Now I know where to refer, I’m now relieved and relaxed that it [eye health] can be taken care of.”*

**RMP**

*“If community member has a problem, we are beside them, when the person recovers it’s a point of happiness.”*

**ASHA**

The project was seen as an attractive job prospect and personnel (whether directly employed or in community cadres) expressed pride in being associated with it. During the field visit to one VC we observed a woman proactively enquiring about employment opportunities there.

#### **2.4.2. How far have the various trainings provided to the project staff and to different stakeholders been useful in terms of knowledge gained and strengthening the referral system in the project in a long term, sustainable way?**

Extensive training was provided to several critical groups including: clinical staff, management and outreach staff; key networks of other relevant health workers in the formal and informal health care systems, teachers and community level volunteers (Health Ambassadors).

The bespoke training developed for the project’s Vision Technicians was a major element in the project’s success, both during implementation and for the longer term. The VTs and CHWs employed in the project express high levels of commitment and job satisfaction, and strong desire to continue working in their communities.

One unintended consequence observed was increased engagement of the ophthalmologists in VC management activity in one case, allowing less time for clinical oversight. There is scope for clearer role definition to avoid duplication or gaps and ensure best deployment of the available skills, particularly in relation to quality oversight.

There was a clear rationale for targeting each of the external groups and training material was prepared for each. Sample curriculum material for teachers and RMPs were reviewed and participants’ views were sought in FGDs. There was a formal evaluation of RMP training but little documented evaluation or follow up of other groups of trainees.

Insights gained through FGDs with a range of training participants suggested that the training was highly valued. Trainees reported increased knowledge, confidence in referring appropriately, and enhanced professional credibility.

There are several references in project reports to challenges encountered in accessing groups for training, notably teachers, RMPs and ASHAs. With teachers, the issue was obtaining clearance from the Ministry of Education – this extended further to challenges in obtaining clearance for teachers to implement the screening activity for which they had been trained. For RMPs and ASHAs the issue

was clashes with other scheduled (government-led) training or meetings, which were compulsory and weekly in the case of ASHAs. There was limited evidence of attempts to integrate eye-health training with the government's training programme for these groups, and no evidence of plans to train cadres of trainers who could provide continuity after the end of the programme.

Training material included appropriately tailored manuals and handouts for each group.

Another highly valued aspect of the programme was the standardisation of materials and approaches developed for implementation in both government and NGO facilities. Treatment protocols and standards, procedural instructions and guidance documents were prepared and visible in VCs, and refresher training was provided for VC staff as required. Programme partners reported that these protocols and standards were being brought into use in their other VCs, not supported by this project, indicating a lasting impact. There was limited evidence of how implementation and compliance with these was being monitored and local responsibility for this management function varied.

There was widespread aspiration and commitment among people trained that they would continue to put their training into practice. There is opportunity for partners to develop a strategy for supporting this post-project and monitoring the extent to which training influences routine practice, e.g. in referral behaviour. This would help build evidence on the effectiveness, quality and impact of training provided.

#### **2.4.3. Is there any evidence of changes in community awareness and demand for eye care services in the project region? E.g. from the results of the population-based end line survey or other information sources**

The population-based draft endline survey suggests increases in awareness of key facts about eye health care and the services available, shown in *Table 8*. These issues were key messages in the project's IEC and training curricula at all levels. The scale of the project's IEC activity in the region during the period suggests it would be reasonable to conclude that the project contributed to this increased awareness.

*Table 8: Knowledge and perception on eye health among household heads at baseline and endline*

Statements	Correct response	Baseline (%)	Endline (%)	Change
Cataract is curable	True	80.6	88.6	+9.9%
Spectacles can improve your eye sight	True	71.9	93.0	+29.3%
You would visit an eye doctor if you were unable to see clearly	True	44.3	90.1	+103.4%
Some eye problems in adults and children require surgery	True	44.2	75.7	+71.3%
Government provides free cataract surgeries	True	43.1	81.0	+87.9%
Government has a health insurance scheme	True	38.8	85.4	+120.1%
Home remedies can treat most eye diseases	False	31.8	69.6	+118.9%
Infants can be born with cataract	True	33.3	44.2	+13.9%
Diabetes affects eye sight and can lead to gradual loss of vision	True	20.4	64.3	+215.2%
It is natural to lose your eyesight as you grow older and nothing can be done about it	False	7.3	0.6	-91.8%

Changes observed in eye health care-seeking behaviour include a finding that many more now report using private sector services and the vast majority now fully pay for their glasses.

Within the project, staff observed more and better-informed demand for eye health care. Communities were proactively asking the VCs to arrange camps, and service users understood more about the service when they attended a VC.

*“Community comes readily for refraction and buys spectacles”*

*Project Co-ordinator*

#### **2.4.4. Are there any aspects of the project which have been embedded in partner practice e.g. ongoing use of mapping based MIS etc., and has this influenced engagement with communities to sustain eye health service demand?**

Partners were enthusiastic about continuing the use of performance targets, suitably balanced with attention to quality. Mapping information was seen to be of particular value for monitoring in a region of this nature, characterised by target populations scattered over large remote areas with little data available about communities and how they access services. It was a useful complement to the local knowledge and insight that also guided local planning, and by presenting the data in map form, stimulated new ways of thinking about local coverage achieved. The use of modern technologies to enhance project management was being embraced. The project's online MIS is becoming established and some staff have spontaneously introduced social media network applications to enhance peer communication, sharing questions and experiences. One partner has adopted social media for internal communication including project and non-project staff. Subject to attention to ethical considerations regarding patient confidentiality and diagnosis/ prescription protocols, this kind of peer networking could be used to build a community of practice.. The project's GIS has offered staff at all levels a new way of looking at service use patterns within and across communities.

Continued attention to awareness raising through general publicity, local events, camps and seasonal themes, was seen to be important and project partners were keen to find ways to support ongoing IEC work.

## **2.5. Sustainability**

**Rating**



### **2.5.1. Does the project have a sustainability plan in place, and if so, to what extent has this been operationalised?**

Sustainability can be considered on several levels: sustainability of the individual services either in the form of the project's delivery centres or through other providers, and sustainability of the outcomes achieved (i.e. reduced prevalence of blindness and visual impairment in the population served). The project had a strong focus on long term financial sustainability for the VCs, discussed at 2.5.2 below. Project partners remain committed to sustaining the VCs.

The project invested in external consultancy in 2016<sup>21</sup> to support business planning and by the end of the project most of the VCs were approaching or achieving full cost recovery, eleven having reached full recovery. The consultancy provided a situation analysis which outlined the then relatively poor position of the VCs in competitive local marketplaces. The consultant developed a business model based on the marketing of spectacles and associated items relevant to local target customer segments (e.g. sunglasses for areas with large numbers of younger customers, solar torches in areas with large off-grid or student populations). The consultant was retained to provide training and ongoing support to the VCs to implement the business plan, with associated costs continuing till the end of the project.

VC staff responded well to the support, showing strong entrepreneurial ethos and commitment in taking ownership of their future sustainability planning. There was evidence of sustainability planning at VC level with both VC & partner base hospital staff confident services will continue. One partner had developed detailed sustainability plans and projections and there was evidence at VC level of staff taking ownership and implementing strategies they had identified for improving business performance, e.g. changed opening hours to be more responsive to local transport circumstances.

Risks to sustainability included: the anticipated reduction in future levels of outreach and awareness-raising work to generate footfall; lack of linkage with other government programmes; and the absence of a system to drive and monitor the services.

In terms of sustaining the project's outcomes, the focus on developing agreed common standards and protocols for government and non-government services and supporting their implementation within and beyond the project, has made an important contribution to sustainability.

Other potential indicators include the number of personnel engaged in the project who are likely to remain active in the area. The strategy of training local staff as VTs rather than trying to attract in staff with higher levels of clinical training was highly effective in this respect: there were high retention rates and the few who left have set up in local private practice, retaining the expertise in the community.

*“Some [VTs] left after one year, but they have opened their own shops. They are there in their communities contributing to eye health.”*

**Sightsavers staff member**

Working through RMPs was an important strategy with multiple benefits: the quality of RMPs' eye-health interventions improved (i.e. self-reported increased confidence in discussing eye health issues and referring appropriately); they are providing referrals to VCs and they are an important link into communities with poor access to health services. The project's formal evaluation of the RMP training, while acknowledging their limitations, identified a clear future role for RMPs in Sundarbans eye health care although it did not address the question of resourcing their future support needs.

The scale of training activity to engage cadres of existing community based health workers and volunteers, integrating eye health issues into their routine practice, was large enough to ensure a

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<sup>21</sup> Think Through Consulting: Sundarbans Vision Centre Final Report, July 2016



high level of coverage and penetration into remote areas. Data on the numbers of these trained personnel who remained active in their communities at the end of the project were not available.

### **2.5.2. What are the prospects for financial sustainability of the Vision Centres established under the project?**

The project was designed to achieve financial sustainability for the individual VCs by the end of the project period. The model gradually reduced grant funding for salaries while building up the VCs' cost recovery skills. This model was highly successful in focusing staff attention on the issue at all levels. Financial sustainability was an important factor for the funder, and SI had insights from previous similar projects including Kolkata where some VCs were still receiving support.

Based on the early signs that most VCs were achieving cost recovery and implementing the business plans they had developed, the IKO estimated that 12-13 of the 17 VCs would survive without further support and was committed to finding ways to support the others. Programme partners were equally committed to finding resources to sustain their services.

### **2.5.3. Is there any evidence of policy changes which have been stimulated by the project?**

There was no evidence of policy changes associated with the project although the MoU achieved between Sightsavers and the State Government in year 3 was seen as a major achievement that would have lasting effect in facilitating future collaborative work. Further engagement with the Ministry of Health and Education is required to sustain teachers' participation in screening work.

Within the health system, differing terms and conditions are in place for different types of health workers active at community level (ASHAs, AWWs, RMPs). This presents ongoing challenges for engaging the cadres of workers in a consistent manner, e.g. in referrals.

The project partners and IKO had clear insights into the main health policy agendas relevant to the project and some were active in related advocacy. For example, senior staff in the project partners were responding individually and strongly to the Government's change of policy on health insurance, under which reimbursement of NGO hospital surgery had been discontinued.

## **2.6. Scalability/replication**

**Rating**



### **2.6.1. What aspects of this project might be valuable and feasible to replicate in other Sightsavers eye health projects?**

Most interviewees agreed the project was replicable subject to some operational improvements:

- monitoring and record keeping, making better use of VC data.
- liaison with Ministry of Education to improve the School Eye Health programme elements.
- selection of VC sites should be appropriate to geographical characteristics, not necessarily simply aligned with administrative blocks. For example, larger areas should have 2 VCs.
- develop work with AWWs for paediatric cataract detection.

Elements of the project design that are highly valuable and replicable include:

- The VC model itself, based around the VT concept (discussed further at point 2.7.2 below).
- Choice of established, highly motivated and well regarded implementation partners.

- Investment in engaging large numbers of community level health workers in a range of formal and informal roles.
- Eye camps tailored to local community contexts.
- The tapering grant support model combined with business planning support for the VCs.

### **2.6.2. To what extent have the VCs provided a model for primary eye care delivery, in the context of a health systems approach in Sundarbans?**

The VC model proved appropriate and effective in the Sundarbans context, serving a population that the government was not reaching and which would be unattractive to private providers in a way that could, in time, achieve sustainability through cost recovery strategies.

The model has proved effective and flexible enough to adapt to the varied community contexts in Sundarbans, and bridges gaps in the health system. Integrating large existing cadres of community based health personnel in the formal and informal health care systems is a significant element in the model with two-way benefits to the project and to the health system. The volunteer health ambassador element offers an important communication and message amplification system.

### **2.6.3. How well has learning about successes and challenges been captured and documented, in order to allow for learning to translate to other projects?**

Most of the learning from operational insights from the project occur and are shared informally at community level, within the VCs and among associated peer groups of the community-based worker cadres. Successes and challenges were documented in detail in formal management reports. Aspects that were tracked and actively managed related to the project's numerical targets: where it was observed that challenges were being experienced on any of these, management intervention and support was deployed. Substantial experiential learning took place throughout the project. However,

- there was limited evidence of an analytic approach to management reporting, such as observation of output trends within or across the VCs. Substantial over-performance on targets, which occurred on several indicators in this project, requires management response in the same way as underperformance and risks the perception that quantity is prioritised over quality.
- while a wealth of monitoring information was captured offline and online, it was mainly used for upward performance reporting which focused on numerical targets and correcting any underperformance on them. The logframe was perceived primarily as an external reporting tool. Variations against output targets were recorded on the logframe and explained in accompanying management reports, but with little reference to implications for the project's overarching goals and objectives. There may have been opportunities to rebalance or refine programme elements during the project's lifetime to enhance quality and/or increase attention to longer term impact indicators.

There was evidence in management reports and in interviews of learning from other similar projects<sup>22</sup> including site visits.

<sup>22</sup> Examples available include Sightsavers' projects in Mumbai and Kolkata, which overlapped or immediately preceded the Sundarbans project.

Informal learning from community level personnel that would be relevant for other projects included observations about service use patterns, such as increase incidence of corneal injury at harvest times; observations on service users' preferences, such as women's tendency to attend in small groups; insights into practical issues such as synchronising opening hours with local public transport timetables.

Some formal research studies were commissioned during the project. The quality of two<sup>23</sup> of the externally commissioned reports reviewed as part of this evaluation was considered low. Budgets for these reports were considerably overspent and the reports remain in draft form.

Considerable learning has emerged in relation to the experience of introducing GIS and MIS, discussed further in Lessons Learned section 3.2 below. It would be useful to capture this systematically for wider dissemination.

## 2.7. Coherence/coordination

Rating



### 2.7.1. To what extent were the assumptions on which the various project components built, valid, and if there was any variance, how did this affect the project implementation?

The assumptions on prevalence of blindness and visual impairment in adults in the target population were broadly valid. The assumptions on paediatric conditions were not, although they were reasonable at the time having used the only available national and state prevalence estimates. As the project progressed and better insights into the prevalence of eye health problems in children emerged, targets were refined downwards.

Assumptions were made about VC staff ability to convert spectacle prescriptions to sales. This required more extensive sustained support than had been anticipated and investment was made in consultancy to assist the VCs with business planning and sales skills. Some VC staff were uncomfortable with this role. Achieving full cost recovery status took longer than anticipated in some VCs and had not yet been reached in others. The project ended before the transition could be confirmed as complete and consolidated. Most VCs were continuing to provide free or subsidised spectacles according to need, as envisioned in the project model, and anticipated that this need would persist. There was also a view that the VC service model had features other providers did not offer, notably the direct connection to the partners' base hospitals.

*"The VCs are connected with our hospitals, that's the unique thing of them."*

**Partner organisation representative**

One of the project's major assumptions was the continued reimbursement of cataract surgery provided by voluntary sector providers (all of the base hospitals were in this category). The government's policy change to only reimbursing surgery provided in government facilities has major implications for the project's model, especially given the reported preferences of service users for NGO facilities over government facilities and the observed population-level shift towards using private facilities. The change is under review and there is scope for advocacy on this issue.

<sup>23</sup> Patient satisfaction survey 2015; Spectacle compliance survey 2018.



*ASHA payment is based on 2,000 rupees<sup>24</sup> / month [£21.16] plus payments for referrals to government facilities only. If referral is made to a VC or an NGO partner hospital, there is no payment. Despite this ASHAs have referred patients direct to VC because this is easier for community members and often patients “don’t have faith in the government facility.”*

***Insight from FGD with ASHAs***

It had been assumed that schools could be assimilated into the child screening programme. The steps required to facilitate this proved more complex and lengthy than anticipated, requiring specific directives from the Ministry of Education for teachers to carry out screening work over and above the agreement for them to participate in training.

**2.7.2. Were any new factors identified later in the course of implementation that were more relevant to the problem statement? If yes, how did the project respond to these?**

The project acquired greater insight into the utility of mobile (i.e. waterborne) services for remote communities. Experience revealed practical challenges, combined with observations that travelling around the area for day to day necessities is part of communities’ long standing way of life. The project responded by discontinuing the mobile model and instead supporting travel to a replacement land-based VC. This was a major change with associated risks to the achievement of project targets. The decision was made carefully with due regard to the balance required between making major changes to address problems versus allowing sufficient time for new approaches to settle in. This thorough approach to weighing of risks was evident throughout the project.

**2.7.3. Given that this was a multi-partner project with complex inter agency dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall?**

Although the implementation partners operated relatively independently of each other, covering separate geographical areas from their own base hospitals, they worked well together on the programme-wide objectives, collaborating on standardization of approaches and management systems. The partners were well established NGOs with experience of eye health service provision and good reputations for quality, and there was a high level of mutual respect and shared values.

*“Partner selection is important. We needed partners who are prepared to work in difficult areas such as Sundarbans and partners with a development orientation/ ethos... partners who will push to meet targets and push for economic viability but still have a development ethos where they will treat patients who require treatment - it’s part of ‘leaving no one behind.’”*

***Sightsavers staff member***

Healthy competition and a spirit of friendly rivalry was encouraged in relation to target achievement, which was handled with a light touch and well received.

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<sup>24</sup> Oanda Currency converter. <https://www.oanda.com/currency/converter/>

Sustained effort was put into the relationship with the Ministry of Health, leading to the signing of a MoU that was crucial to the project to underpin sustained collaboration with the government health sector.

Systematic engagement of key networks such as RMPs who are often the first or only health service option for remote communities has led to better referrals from them to VCs.

#### **2.7.4. How well has the project been coordinated with any other partners' initiatives and programmes at local and national levels?**

The project partners were chosen partly because of their existing, complementary, programmes of work and areas of expertise (eye health specifically or broader health and development issues). The project capitalised on the partners' existing networks and activity programmes and services were integrated where appropriate. One partner described synchronising outreach visits to VCs for the project with other business visits to the area such as patient follow-up. Government sector health services were fully integrated as the treatment providers in the two areas where project partners did not run their own base hospitals.

The project aimed to co-ordinate with the government's school eye health programme but this proved more problematic. It took time to achieve the necessary formal government agreement; teachers could not easily be released for training. Challenges persisted with teachers perceiving that screening was not their core work and would require a Ministry of Education policy directive.

IKO staff observed that other NGOs active in eye health, e.g. Orbis, operate in the region, presenting an opportunity to explore the potential for increasing collaborative approaches to service provision and advocacy for ongoing government attention to eye health awareness and care.

# Conclusions and recommendations

## 3.1. Summary and conclusions

The project was highly relevant, well matched to the eye health needs of the target population in the challenging Sundarbans operating context and sensitive to gender issues.

Coordination with three main partner organisations worked well. Coordination with government worked less well: coordination with the school eye health programme and the process of securing MoUs was lengthy.

The project had relevant and mainly realistic targets<sup>25</sup> and reached most of them despite implementation challenges. The project showed resilience in the face of these challenges and used a considered approach to introducing changes when they proved necessary. For example, the selection of sites for VCs was not always optimal to reach the greatest numbers, but the project flexed to relocate some centres. Home visit strategies were introduced in some VCs and seemed to work well in creating good rapport with the community and offer opportunities to extend reach, which should be explored.

In relation to specific target population subsets:

- The project performed well in reaching and delivering services to women.
- GIS data were not sensitive enough (owing to age bands being too large) to pick up any under-representation of disabled people.

The project now has a substantial dataset on children's eye health from the screening activity. Subject to assessment of the quality of the dataset, this may be of use at regional and national level in estimating the prevalence of eye health problems in this age group, addressing a health sector-level data gap. The project's particular strengths lay in:

- strategic selection of partners. Use of established local partners and VC staff from local communities meant the project was well connected to communities, VC staff had easy rapport with local clients and good local knowledge used for planning
- the VC model based around a VT, offering an effective bridge between communities and hospital-based health services. Quality perceptions are an important consideration in service users' choice of service provider, and in referral recommendations, even more than price in some cases. The VCs' direct connection to reputable base hospitals is an added value feature that enhances the quality of care offer.
- the tapering grant model supported by business training
- engagement of large, relevant cadres of community-based staff and volunteers
- developing and securing standardised approaches to MIS and service protocols
- effective use of local insight in combination with GIS data to plan and adapt activity.

Overarching challenges and issues for the project in the longer term include:

- The recent change in State Government policy on health insurance, focusing surgery reimbursement on government hospitals only, has implications throughout the project. Some

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<sup>25</sup> The child cataract surgery target was the only major revision necessary.

VCs are reporting reduced footfall, and one ophthalmologist reported having stopped visits to VCs because fewer special cases were being referred. Partner hospitals are now having to find alternative funding sources to continue providing free or subsidized surgery.

- The project's MIS and GIS are not streamlined and there are related technical capacity gaps within the project and regional contractor base
- Training has reached substantial numbers of key people in relevant settings and networks. This will need follow up and ongoing support to sustain its impact. Training strategy should include integration of content with existing training systems and provision for training of trainers.
- Management skill training was highly valued and has been embedded at partner and VC level. Some care is needed to ensure that highly trained senior clinical staff are not overly deployed on non-clinical management issues. Responsibilities for management and monitoring of quality could be more clearly defined in all personnel roles.
- The assumption was that voluntary/ charitable sector services focused on an extremely poor population can transition willingly and successfully to a private sector business model. Partner and individual staff motivation remain rooted in a non-profit ethos, and business modelling should be tailored accordingly. The VCs have evolved their strategies in this way. The extent of VCs' reliance on ongoing support to achieve or maintain full cost recovery has not been formally assessed although there is a high level of confidence that most will survive and the IKO is keen to continue supporting VCs through the transition period. Partners remain committed to providing their own core services and pursuing alternative funding support sources as required.
- Further engagement with the Ministry of Health is required to explore the potential for integrating eye health issues into mainstream primary health care training programmes and the potential for harmonising incentive systems for different types of workers in the referral system. Further advocacy is required to address ongoing accessibility challenges for people in remote communities, whether the strategy should be through location of services in remote areas or assistance with transport to service hubs.
- The project would have benefited from more technical support with commissioning formal research and with managing monitoring, evaluation and learning.
- There is scope to use VC and other personnel as peer supporters/ mentors for new projects, which would further build capacity for them as individuals and in the wider eye health care system.

### 3.2. Lessons learnt

Lessons emerging from the project cover insights about project design, management, implementation, monitoring and research. These included IKO staff's experiential lessons relevant to the design and operation of similar projects and lessons specific to the innovative GIS element. *Table 9* summarises the overall lessons learned, by theme.

*Table 9: Lessons learnt*

Lesson	Audience
<b>Project design</b>	
Project proposal development should include scoping of human resource requirements at all levels including availability of specialist contractors and any capacity gaps.	Sightsavers Project designers

Lesson	Audience
Sufficient lead time is required for an inception phase to ensure a coherent project MIS is developed and tested and formal agreements with partners are in place	Sightsavers Project designers Donors
Selection of major programme elements and approaches should have regard to human resource capacity to deliver and be balanced in a way that best serves the project's overall objectives	Sightsavers Project designers
Child health care initiatives require separate design or separate consideration and treatment when included as part of a wider programme, informed by child health data and child development insights.	Sightsavers Project Designers
VCs are important primary eye care provider providing good links between community & more formal health services	Government and other service planners
Good knowledge of local context was key as was the use of local staff which improved personal contact and rapport with patients	Sightsavers Project designers and other service planners
<b>Project management</b>	
Technical specialism on MIS and GIS is required in the project management team	Sightsavers
VC Management is key, using MIS for planning. Good technical and management support is required to embed standards and support planning	Project managers
Focus on targets was both positive and negative – overemphasis could lead to missed opportunities and impact on sustainability, or lead to unhealthy competition between partners	Project managers and funders
An established MHealth system would have been preferable to the bespoke MIS developed for the project, improving compatibility with GIS.	Sightsavers
Training on new procedures such as MIS and GIS should have been timed closer to roll-out of the systems	Project managers
<b>Project implementation</b>	
Transport for patients seemed to improve uptake of services	Project designers, government and other service planners
Camps and IEC materials were important in raising awareness of eye health and drawing communities to VCs	Project designers and managers
Ensure visual prognosis is explained to patient before surgery	Clinical staff and IEC content creators
<b>Monitoring and research</b>	
Baseline and endline surveys, thematic studies and routine MIS needed consistent approaches to data parameters and analysis	Project managers and evaluators
High levels of illiteracy may be a confounding variable and should be a consideration in project research including needs assessment for project design.	Project designers and evaluators

### 3.3. Recommendations

Drawing together the qualitative and quantitative data analysis, lessons learned and reflections by project participants, recommendations have been developed for future project designers and for the

partners in this project to enhance its sustainability prospects. The recommendations are grouped thematically in *Table 10*:

*Table 10: Recommendations*

Main Recommendation	Operational detail	Responsible
<b>Project design</b>		
1. Allow sufficient time for holistic analysis of the operational context including local population demographics, attitudes and behaviours; market conditions; local government and other stakeholders' readiness to engage.	<ul style="list-style-type: none"> <li>- Ensure logframe addresses all elements</li> <li>- Include development of an advocacy strategy</li> </ul>	Sightsavers and partners – future projects
2. Consider children's projects separately, or at least as a dedicated stream within a larger project. Obtain specialist paediatric input throughout programme design, implementation and evaluation.	<ul style="list-style-type: none"> <li>- Maximise reach through using patient contact opportunities to explore potential further eye health care needs within families</li> </ul>	Sightsavers and Partners – future projects
3. Allow sufficient lead time before full implementation	<ul style="list-style-type: none"> <li>- Obtain any critical MoUs with relevant government departments</li> <li>- Pilot test new MIS and other technology early and phase performance targets to accommodate roll-out and consolidation</li> </ul>	Sightsavers and Partners – future projects Donors
<b>Monitoring, evaluation and learning</b>		
4. Ensure future programmes develop a comprehensive monitoring and evaluation strategy with appropriate oversight, staff resource and budget, covering all elements of the project logframe	<ul style="list-style-type: none"> <li>- Develop indicators on quality aspects of the programme</li> <li>- Ensure output indicators are clearly defined, notably distinguishing between distinct individuals trained and numbers of trainings delivered</li> <li>- Phase output targets appropriately in line with business-critical milestones</li> <li>- Use VCMIS and GIS data to support VC management</li> </ul>	Sightsavers and Partners – future projects
5. Promote the timely sharing of learning and experience during project implementation	<ul style="list-style-type: none"> <li>- Promote communities of practice for informal peer support among VC staff and other trained personnel, to strengthen their increased capacity</li> <li>- Consider supporting VC staff to mentor new projects.</li> </ul>	IKO and Project partners - current
<b>Research</b>		
6. Ensure study populations and sampling for baseline/ endline	<ul style="list-style-type: none"> <li>- Introduce more sensitive age bands for GIS reports</li> </ul>	Sightsavers and Partners –



Main Recommendation	Operational detail	Responsible
surveys are matched to the project's target populations.		current and future projects Sightsavers evaluation team
7. Ensure maximum value is obtained from data collected for the project	<ul style="list-style-type: none"> <li>- Review the data collected for the child screening programme and consider whether it could be used for better prevalence estimation for child eye health problems.</li> <li>- Review and, if appropriate, complete the unfinished formal research reports commissioned during the project with due quality assurance</li> </ul>	Sightsavers IKO Sightsavers research team
<b>Programme management and oversight</b>		
8. Formalise local stakeholder engagement through suitable existing or new committee structures (as recommended in MTR)	<ul style="list-style-type: none"> <li>- Support project partners to sustain local awareness-raising on key eye health messages</li> </ul>	IKO and project partners - current
9. Concentrate on leveraging and building a reputation for quality service provision throughout the care chain offered.	<ul style="list-style-type: none"> <li>- Review job descriptions for all project personnel to ensure management and clinical quality oversight roles are explicitly defined and appropriately allocated</li> <li>- Ensure attention to patient follow-up and associated documentation including treatment outcomes, post-operative complications and infections</li> <li>- Develop protocols for the provision of remote clinical and technical support through electronic media (email, skype or similar).</li> </ul>	IKO and project partners - current
<b>Sustainability</b>		
10. Ensure attention to sustainability is embedded in all elements of the project and included in the logframe, focusing on outcomes and impacts.	<ul style="list-style-type: none"> <li>- Introduce business planning support for VCs from the outset, ensuring it is tailored to a non-profit sector model</li> <li>- Develop a strategic approach to training that extends to training for trainers</li> <li>- Focus more of the government sector activity on embedding eye health awareness and relevant screening activity in the school and primary healthcare sectors.</li> </ul>	Sightsavers and Partners – future projects

## Appendices

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### Appendix 1: Terms of Reference

## Sundarbans Eye Health Service Strengthening Project End of term evaluation

### Background

Project number: **61812**

Project duration: **01/09/2013 - 30/08/2018**

Project budget: **\$ 1,714,797**

Project partners: **Southern Health Improvement Samity (SHIS), Sundarbans Social Development Centre (SSDC), and Vivekananda Mission Ashram (VMA).**

#### GENERAL INFORMATION ON PROJECT AREA

The Sunderbans is a unique biosphere reserve of mangrove forests and one of the global heritage sites. It is located in the extreme south of West Bengal, spread over two districts, and comprised of an archipelago of 106 small remote islands. Of these, 52 are inhabited with a population of 4.7 million and the remaining districts are protected mangrove forest. The entire area is intersected by rivers flowing into the Bay of Bengal which make access to the area challenging due to the changing tides and wide estuaries. Many communities in the 19 administrative blocks remain cut off from other regions and this inaccessibility contributes to the high levels of abject poverty.

The region is also amongst the most affected and impacted by natural disaster. The last of the major disasters was cyclone Aila, which badly affected Sundarbans in 2009, however local flooding in most parts of the islands is an annual phenomenon. As per the recent Family Health Survey, the islanders struggle with both communicable and non-communicable diseases often leading to real dilemmas in deciding which problems to prioritize. It is estimated that the region needs three times more human and physical resources - doctors, primary health centres (PHC) and health sub-centres - to meet national Government guidelines.

The health care delivery system in the Sunderbans is comprised of a variety of public and private providers. The public services are delivered through a multi-tier infrastructure and private providers include private hospitals and nursing homes with the capacity to provide inpatient care. There are also a large number of unqualified private providers, RMPs (Rural Medical Practitioners) and not-for-profit organizations providing preventive and curative services through different programs and facilities. Eye health service provision in the region is wholly inadequate but it is available at the primary level through Block Primary Health Centres (BPHC) level where one ophthalmic assistant



for each BPHC is placed and provides screening services along with medicine prescription. At times, free medicine is also provided, however no spectacle is dispensed through the BPHCs.

With this at the background of socio economic and health scenario getting attention for eye health which is not a life-threatening condition is a challenge.

### **PROJECT DESIGN, GOAL, OBJECTIVES, AND OUTPUTS.**

The Sundarbans Eye Health Service Strengthening Project is a 5-year project covering 19 administrative blocks of North and South 24 Parganas Districts of West Bengal (popularly known as the Sundarbans) with a population of 4.7million. Almost half of the 4.7 million population (47%) belong to historically marginalised groups such as Scheduled Castes and Tribes. More than 40% of households live below the poverty line and 13% are officially declared as the “poorest of the poor”<sup>26</sup>.

The project is funded by *Seeing is Believing*, a collaboration between Standard Chartered Bank and the International Agency for the Prevention of Blindness (IAPB). It commenced in September 2013 and is expected to end in August 2018 (5 years).

The project goal is to “*contribute towards the elimination of avoidable blindness in the Sundarbans region of West Bengal by 2020*” and it has three objectives:

1. To improve coverage and access to affordable, quality eye health services
2. To increase awareness and improve attitudes towards eye health in target communities
3. To increase the capacity of governmental and non-governmental institutions to deliver eye health services

Towards this, the project aims to work in collaboration with;

- Three partner NGOS who have been providing eye health services in the region - Southern Health Improvement Samity (SHIS), Sundarbans Social Development Centre (SSDC), and Vivekananda Mission Ashram (VMA).
- Local Community based organizations with Panchayat level eye care committees and District level steering committees
- The District Blindness Control Society (DBCS)
- The State Health Society and National Health Mission (NHM)

The Sundarbans project contained an innovative element of a geographical information system (GIS) which was developed specifically for the Sundarbans as a tool to facilitate spatially informed programme management decision-making practice. This initiative was a pilot exercise for Sightsavers, and a first use of GIS to map baseline data, and for project routine monitoring<sup>27</sup>. Thus, GIS was incorporated into a baseline and endline population-based survey, with the baseline being conducted in late 2014 reaching >3000 people in 46 village clusters. This survey included an eye examination, and questions on health-seeking behaviours and socio-economic circumstances<sup>28</sup>.

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<sup>26</sup> As noted in the documentation on the government scheme Antadaya Anna Yojna launched in 2000 to ensure food security amongst the poor.

<sup>27</sup> Not the first use of GIS by Sightsavers though as it followed GTMP and health service mapping in Fako, Cameroon.

<sup>28</sup> It was based on an adapted Rapid Assessment of Avoidable Blindness (RAAB) methodology

Coordinate reference points were taken with a GPS device and the data was imported and analysed in a GIS. Routinely, data collected from vision centres was then imported into the GIS for ongoing geographic coverage tracking.

A short paper has been produced to summarise some of the key challenges and learning points from the Sundarbans GIS as Sightsavers moves to adapt and implement this technology in other programmatic contexts.

## Purpose of Evaluation

The end of term evaluation will review the achievements of the project against objectives and outputs as detailed in the project documents. Specifically, the evaluation will focus on understanding what have been the key successes and challenges in the implementation of the project, that can help inform the future design of our programmes.

The evaluation of the project will use the following 7 criteria which will be the basis for evaluation, analysis and reporting: relevance, effectiveness, efficiency, impact, sustainability, coherence/coordination and replicability/scalability.

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

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

### EVALUATION CRITERIA - QUESTIONS

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

- 2.1.1 To what extent did the project design align with the eye health priorities and policies of national and local government?
- 2.1.2 To what extent does the project design and implementation respond to beneficiaries' eye health needs (including women), e.g. how far did the Vision Centre (VC) locations help in serving target populations, including in terms of equitable gender balance and accessibility?

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

- 2.1.3 Were the project objectives/outcomes achieved or not, and what were the major factors influencing this?
- 2.1.4 To what extent has the GIS locational data been useful to the targeting and planning of outreach and school screening strategies and activities, and is there any corresponding evidence of decisions or changes in service delivery and treatment as a result?

- 2.1.5 To what extent have the accepted mid-term review recommendations been actioned or fulfilled?
- 2.1.6 How far has the project been able to incorporate a gender responsive approach in terms of reach and service uptake in Sundarbans?<sup>29</sup> Are there any specific examples of initiatives which have worked which can inform gender targeting more widely in Sightsavers' eye health projects?

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

- 2.1.7 Were there any timeline or resource allocation related challenges that needed significant alteration?
- 2.1.8 To what extent has routine and enhanced project monitoring in relation to school screening and outreach camps, as well as cataract surgical outcomes, been incorporated in project management during implementation, including in relation to MTR recommendations 1, 2, 4 and 7 on additional monitoring and analysis?

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

- 2.1.9 Has there been any impact on the service delivery capacity of government and NGO partner capacities as a result of the project? For example the utilisation of the infrastructure upgrading and the extent to which this has contributed to better eye care services to the patients at the 4 primary eye care centres and at the sub divisional level?
- 2.1.10 How far have the various trainings provided to the project staff and to different stakeholders been useful in terms of knowledge gained and strengthening the referral system in the project in a long term, sustainable way?
- 2.1.11 Is there any evidence of changes in community awareness and demand for eye care services in the project region? E.g. from the results of the population-based endline survey or other information sources.
- 2.1.12 Are there any aspects of the project which have been embedded in partner practice e.g. ongoing use of mapping based Management Information Systems (MIS) etc., and has this influenced engagement with communities to sustain eye health service demand?

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

- 2.1.13 Does the project have a sustainability plan in place, and if so, to what extent has this been operationalised?

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<sup>29</sup> WHO Gender assessment tool could be used:[http://www.who.int/gender/mainstreaming/GMH\\_Participant\\_GenderAssessmentTool.pdf](http://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentTool.pdf)

2.1.14 What are the prospects for financial sustainability of the Vision Centres established under the project?

2.1.15 Is there any evidence of policy changes which have been stimulated by the project?

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

2.1.16 To what extent were the assumptions<sup>30</sup> on which the various project components built, valid, and if there was any variance, how did this affect the project implementation?

2.1.17 Were any new factors identified later in the course of implementation that were more relevant to the problem statement? If yes, how did the project respond to these?

2.1.18 Given that this was a multi-partner project with complex inter agency dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall?

2.1.19 How well has the project been coordinated with any other partners' initiatives and programmes at local and national levels?

**Replicability/scalability** - *the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.*

2.1.20 What aspects of this project might be valuable and feasible to replicate in other Sightsavers eye health projects?

2.1.21 To what extent have the Vision Centres provided a model for primary eye care delivery, in the context of a health systems approach in Sundarbans?

2.1.22 How well has learning about successes and challenges been captured and documented, in order to allow for learning to translate to other projects?

## Review Team

This evaluation will be undertaken as part of the Framework Agreement, and the proposed evaluation consultant team will be discussed and agreed with Sightsavers global and project staff.

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<sup>30</sup> These may include population prevalence (e.g. child blindness, uncorrected refractive error), government health infrastructure and HR, etc.

# Methodology

The evaluators should detail the approach and methodologies to be used to indicate how they will fulfil the requirements of the ToR and address the evaluation objectives and evaluation questions. These may include qualitative and quantitative tools as appropriate to conduct this evaluation. The evaluation team will define an appropriate sample size, where relevant, and specify what mechanisms will be adopted to avoid selection bias.

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

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

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

# Reference Material

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

- Project proposal
- Logframe
- Project donor reports (Narrative and financial)
- MIS System Data
- Reports of meetings with partners, trip reports
- MOUs
- Relevant research reports
- MTR reports and any relevant Evaluation reports
- Management Response for MTR
- Letters of Variation
- SiB trip reports

## Timeframe

The timeframe for the evaluation will be between June 2018 and Dec 2018. It is expected that work on the inception phase will start in July and fieldwork is planned in September with a final report signed off by Sightsavers no later than 14<sup>th</sup> Dec 2018.

### INDICATIVE STRUCTURE AND PHASING OF EVALUATION

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

## Outputs/ Deliverables

### INCEPTION REPORT

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

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

### DRAFT REPORT

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



## **FINAL REPORT**

A Final Report will be submitted to Sightsavers within 15 working days after receiving the feedback from Sightsavers on the draft reports. The final report should be a detailed report of not more than 40 pages (excluding annexes), written in English.

## **DATA SETS**

The evaluation team will be expected to retain complete data sets (in Excel/Word) of all the quantitative data as well as any formally documented qualitative data gathered during the exercise. These data sets should be provided on request.

## **Reporting Format**

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

## **Administrative/Logistical support**

### **BUDGET**

The Framework Agreement Lead should submit to Sightsavers a proposal of the evaluation team, their roles and responsibilities and number of days' inputs, as well as a workplan and budget including team members' daily rates for the assignment and any other anticipated expenses not covered by Sightsavers.

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

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

### **SCHEDULE OF PAYMENT**

The following payment schedule will be adhered to:

- On acceptance and approval of inception report: 40%

On acceptance and approval of final report: 60%

## Appendix 2: Project Organograms

Figure 1: Overall project structure. Source: project proposal

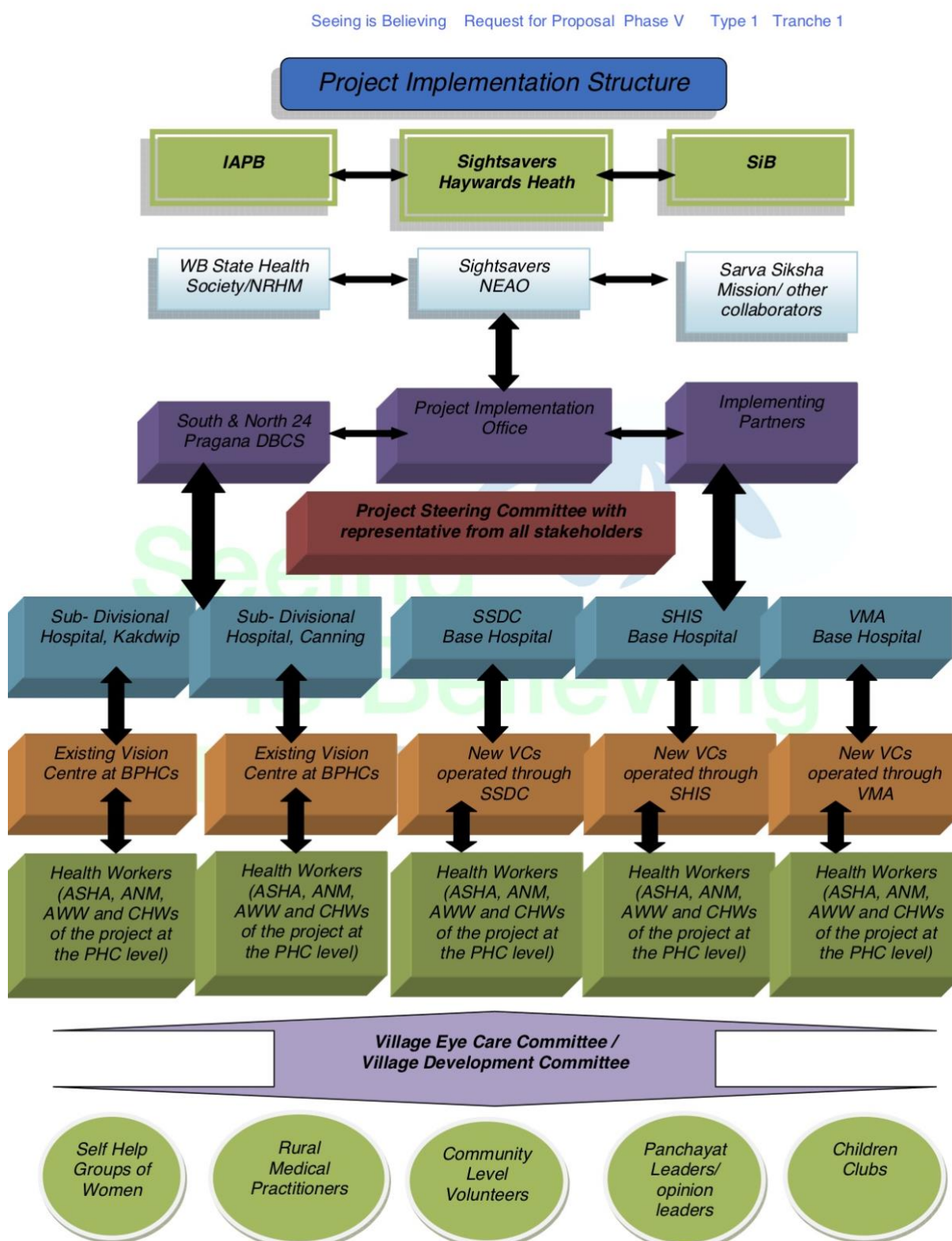


Figure 2: Project Implementation Structure. Source: IKO presentation

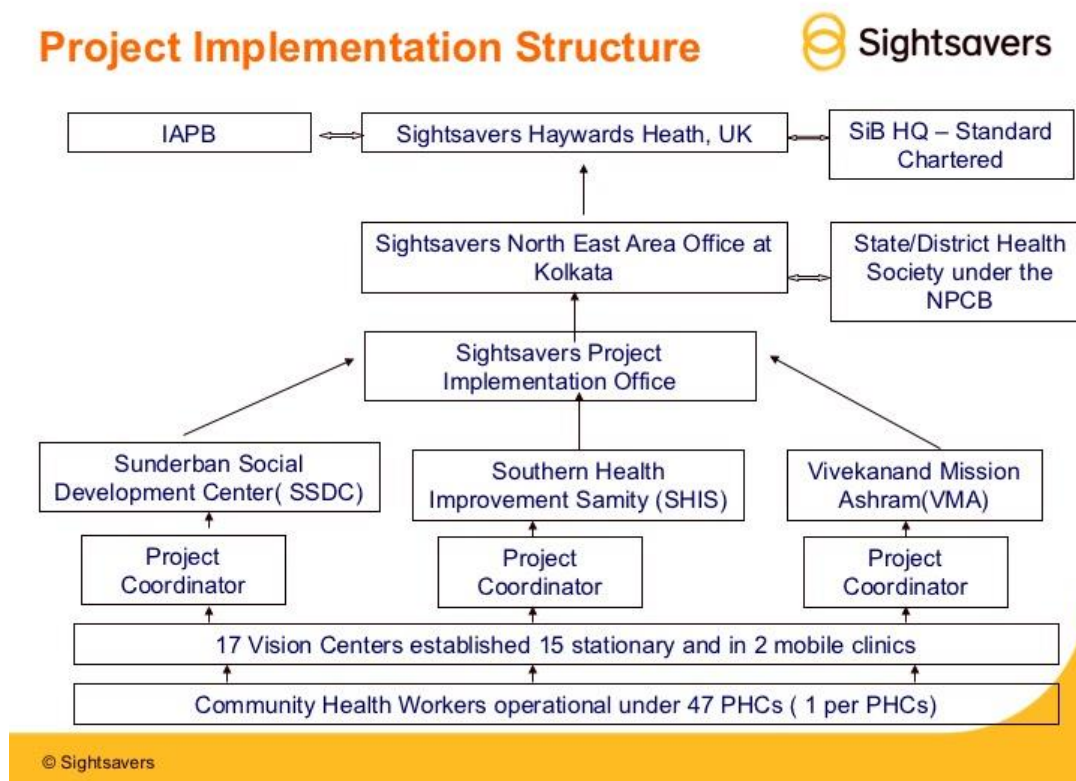
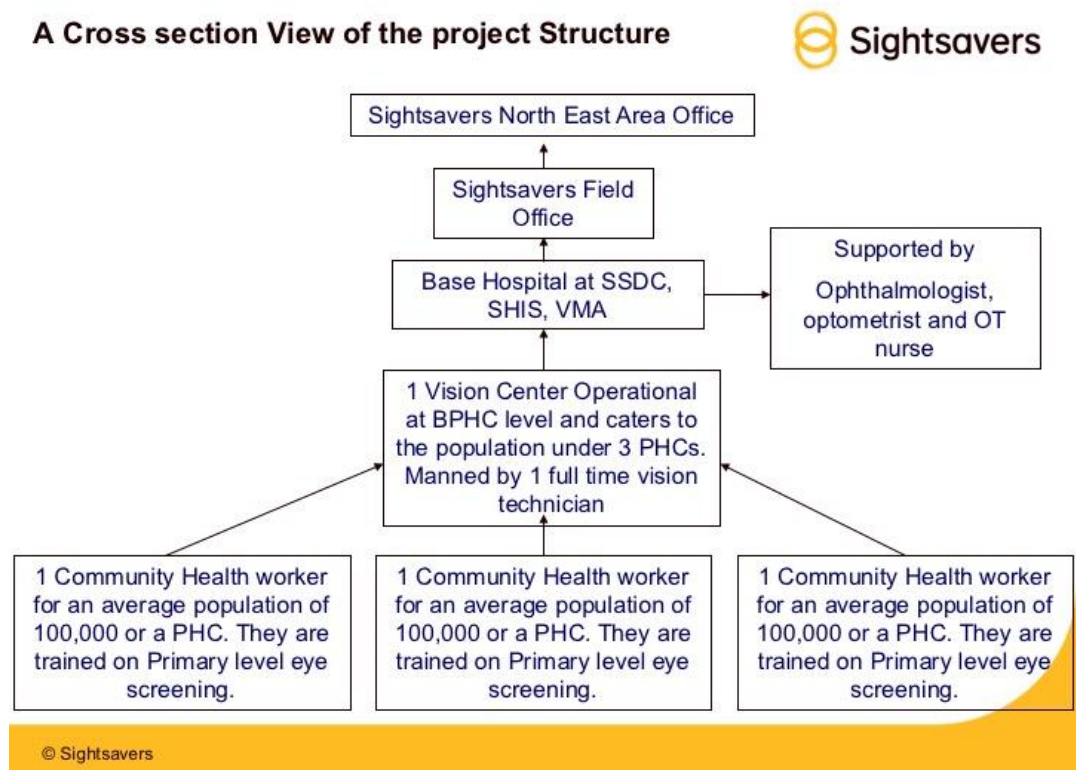


Figure 3: Cross section of project structure. Source: IKO presentation



## Appendix 3: Evaluation Matrix

	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
1.	<p><b>Relevance</b> – <i>the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.</i></p> <p>1.1 To what extent did the project design align with the eye health priorities and policies of national and local government?</p> <p>1.2 To what extent does the project design and implementation respond to beneficiaries' eye health needs (including women), e.g. how far did the Vision Centre (VC) locations help in serving target populations, including in terms of equitable gender balance and accessibility?</p>	<p><b>Briefing presentation</b></p> <p><b>Kills – senior stakeholders at national and local level</b></p> <p><b>Focus groups – community level personnel</b></p>	Document review	Log frame, Background documents; core project documents (SiB); MTR, Management response to MTR Donor reports, Sunderbans case studies and national and state strategies and policies and HMIS data
2.	<p><b>Effectiveness</b> – <i>the extent to which the objectives have been achieved and the anticipated results have been realized.</i></p> <p>2.1 Were the project objectives/outcomes achieved or not, and what were the major factors influencing this?</p> <p>2.2 To what extent has the GIS locational data been useful to the targeting and planning of outreach and school screening strategies and activities, and is there any corresponding evidence of decisions or changes in service delivery and treatment as a result?</p> <p>2.3 To what extent have the accepted mid-term review recommendations been actioned or fulfilled?</p>	<p><b>Briefing presentation</b></p> <p><b>Kills – programme implementation staff</b></p>	Document review	Background documents; core project documents (SiB), Annual reports, MTR, Case study reports, M&E data, achievements against logframe

	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	2.4 How far has the project been able to incorporate a gender responsive approach in terms of reach and service uptake in Sundarbans? <sup>31</sup> Are there any specific examples of initiatives which have worked which can inform gender targeting more widely in Sightsavers' eye health projects?			
3.	<p><b>Efficiency</b> – <i>the extent to which results have been delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.</i></p> <p>3.1 Were there any timeline or resource allocation related challenges that needed significant alteration?</p> <p>3.2 To what extent has routine and enhanced project monitoring in relation to school screening and outreach camps, as well as cataract surgical outcomes, been incorporated in project management during implementation, including in relation to MTR recommendations 1, 2, 4 and 7 on additional monitoring and analysis?</p>	<p><b>Briefing presentation</b></p> <p><b>Kills – Programme staff</b></p>	Document review and triangulation	Background documents; VC-level M&E documentation, Project-level amalgamated documentation; core project documents (SiB); MTR, Management response to MTR, Annual reports
4.	<p><b>Impact</b> – <i>the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme</i></p> <p>4.1 Has there been any impact on the service delivery capacity of government and NGO partner capacities as a result of the project? For example, the utilisation of the infrastructure upgrading and the extent to which this has contributed to better eye care services to the patients at the 4 primary eye care centres and at the sub divisional level?</p>	<p><b>Briefing presentation</b></p> <p><b>Kills –project partners, health sector staff</b></p>		Background documents; core project documents (SiB); MTR, Management response to MTR Donor reports, Sunderbans case

<sup>31</sup> WHO Gender assessment tool could be used: [http://www.who.int/gender/mainstreaming/GMH\\_Participant\\_GenderAssessmentTool.pdf](http://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentTool.pdf)



	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	<p>4.2 How far have the various trainings provided to the project staff and to different stakeholders been useful in terms of knowledge gained and strengthening the referral system in the project in a long term, sustainable way?</p> <p>4.3 Is there any evidence of changes in community awareness and demand for eye care services in the project region? E.g. from the results of the population-based endline survey (expected in September) or other information sources.</p> <p>4.4 Are there any aspects of the project which have been embedded in partner practice e.g. ongoing use of mapping based Management Information Systems (MIS) etc., and has this influenced engagement with communities to sustain eye health service demand?</p>	<p><b>KIIS – GIS users</b></p> <p><b>Focus Group Discussions – community level personnel</b></p>		<p>studies, endline survey if available</p>
<b>5.</b>	<p><b>Sustainability</b> – <i>whether benefits of the project or programme are likely to continue after donor funding has ceased</i></p> <p>5.1 Does the project have a sustainability plan in place, and if so, to what extent has this been operationalised?</p> <p>5.2 What are the prospects for financial sustainability of the Vision Centres established under the project?</p> <p>5.3 Is there any evidence of policy changes which have been stimulated by the project?</p>	<p><b>Briefing presentation</b></p> <p><b>KIIs – senior stakeholders and project staff</b></p>	<p>Document review</p>	<p>Background documents; core project documents (SiB); MTR, Management response to MTR Sunderbans case studies annual reports, project planning and strategy documents</p>
<b>6.</b>	<p><b>Coherence/coordination</b> – <i>the extent to which the project or programme has coordinated with other similar initiatives, interventions or actors, and</i></p>	<p><b>Briefing presentation</b></p>	<p>Document review</p>	<p>Background documents; core project documents</p>





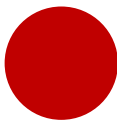



	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
	<p><i>the degree to which the project design and implementation is internally coherent.</i></p> <p>6.1 To what extent were the assumptions<sup>32</sup> on which the various project components built, valid, and if there was any variance, how did this affect the project implementation?</p> <p>6.2 Were any new factors identified later in the course of implementation that were more relevant to the problem statement? If yes, how did the project respond to these?</p> <p>6.3 Given that this was a multi-partner project with complex inter agency dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall?</p> <p>6.4 How well has the project been coordinated with any other partners' initiatives and programmes at local and national levels?</p>	<p><b>Kills – project partners</b></p> <p><b>Focus Group Discussions – community level personnel</b></p>		<p>(SiB); MTR, Management response to MTR Donor reports, Sunderbans case studies and</p>
7.	<p><b>Replicability/scalability</b> - <i>the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.</i></p> <p>7.1 What aspects of this project might be valuable and feasible to replicate in other Sightsavers eye health projects?</p> <p>7.2 To what extent have the Vision Centres provided a model for primary eye care delivery, in the context of a health systems approach in Sundarbans?</p> <p>7.3 How well has learning about successes and challenges been captured and documented, in order to allow for learning to translate to other projects?</p>	<p><b>Briefing presentation</b></p> <p><b>Kills</b></p> <p><b>Focus Group Discussions – community level personnel</b></p>	Document review	<p>Background documents; core project documents (SiB); MTR, Management response to MTR Donor reports, Sightsavers and partners' strategic plans, case studies, internal and external</p>

<sup>32</sup> These may include population prevalence (e.g. child blindness, uncorrected refractive error), government health infrastructure and HR, etc.

	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Tools	Secondary Data Tools	Secondary Data Source
				publications (e.g. newsletters, web)

## Appendix 4: Evaluation Criteria Rating

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

## Appendix 5: Evaluation Team roles

Position	Role
<b>Team Leader</b>	<ul style="list-style-type: none"> <li>• Attend and lead the team in the initial briefing with Sightsavers</li> <li>• Coordinate team members' inputs, facilitate internal evaluation planning meetings and provide first level quality assurance of team members' deliverables</li> <li>• Provide regular progress update to Tropical Health and Sightsavers</li> <li>• Lead the development and finalisation of the inception report, including data collection tools</li> <li>• Coordinate data collection</li> <li>• Lead overall health systems strengthening focus</li> <li>• Prepare and present preliminary findings at debriefing session in-country at the end of the field visit</li> <li>• Coordinate data analysis</li> <li>• Lead evaluation report writing and finalising</li> </ul>
<b>Team Member</b>	<ul style="list-style-type: none"> <li>• Provide overall support to the team lead in evaluation implementation</li> <li>• Contribute to all aspects of data collection in the field visit and in particular, lead community aspects of data collection and clinical service provision. During evaluation interviews focus in particular on contextual relevance of the project – addressing key evaluation theme – relevance and provide inputs and insights to other themes particularly efficiency, sustainability and assessing the applicability of recommendations within the Indian context.</li> <li>• Contribute to data analysis, leading on aspects of community and playing a co-lead role in terms of clinical service provision.</li> <li>• Contribute to the evaluation report writing, as agreed with the Team Leader. This may include developing short impact snapshots on the community or clinical service provision aspects of the evaluation.</li> </ul>
<b>Evaluation Technical Coordinator</b>	<ul style="list-style-type: none"> <li>• First point of contact between Sightsavers and Tropical Health for planning and coordinating evaluation</li> <li>• Day-to-day oversight and support to evaluation team to plan and deliver quality work on time</li> <li>• Coordinate and support quality assurance of the design, implementation, analysis and report writing for the evaluation</li> <li>• Approve consultants' days payment based on satisfactory delivery of evaluation outputs</li> </ul>
<b>Quality Assurance</b>	<ul style="list-style-type: none"> <li>• Technically quality assure the inception and evaluation reports</li> </ul>

## Appendix 6: Workplan

See excel file for better readability.

[illegible]

SI	Sightstavers Haywards Health	Tasks
ICD	Sightstavers India Country Office	Meeting
		Evaluation
TH	Tropical Health (when several TH personnel involved)	deliverable
		SI review
		deadline
		Team Leader not available

## Appendix 7: Visit schedule

Date/Time	Activity
<b>Sunday 16th September 2018</b>	
am	Arrival of Team Leader Lynne Elliott and National Consultant Dr Shaila Patil
pm	Evaluation team internal meeting
<b>Monday 17th September - both consultants with Sightsavers Kolkata staff</b>	
8.30am	Pick up from hotel
9.00am - 1.00pm	Welcome and Opening Briefing presentation followed by discussion and question and answer session on Sundarbans programme Review of programme, tasks and logistics Kills: Sightsavers staff
1.00pm - 2.00pm	<b>LUNCH</b>
2.30pm - 6.30pm	Kills: Sightsavers staff and project coordinators Team internal de-brief and review session
<b>Tuesday 18th September - both consultants</b>	
8.30am	Pick up from hotel
	Travel to Site Visit 1: Canning II VC ( Night stay at Diamond Harbour )
	Visit includes: Interviews with VC staff (Vision Technicians [VTs] & CHWs) and FGDs
12.30pm - 1.30pm	<b>LUNCH</b>
1.30pm - 4.30pm	Interviews and focus groups continue
4.30pm - 7.30pm	Return travel
7.30pm - 9.00pm	Team internal de-brief and review session
<b>Wednesday 19th September - both consultants</b>	
8.30am	Pick up from hotel
am	Travel to Site Visit 2: Patharpratima
am	Visit includes: interviews with VC staff (VT & CHWs) and FGD with Rural Medical Practitioners
am	
1.30pm - 2.30pm	<b>LUNCH</b>
2.30-4.30	Interviews and focus groups continue
4.30 - 5.00	Return travel
5.30 - 6.30	Team internal de-brief and review session
<b>Thursday 20th September - both consultants</b>	
8.30am	Pick up from hotel
	Travel to Site Visit 3: VMA Base Hospital
am	Interviews with Ophthalmologists (Dr Asim Sil & Dr Subhra Sil)
	<b>LUNCH</b>
pm	Travel to Site visit 4: Swastha Bhaban (Dept. of Health & Family Welfare)
<b>Friday 21st September - both consultants</b>	
am	Team internal de-brief and review session
	<b>LUNCH</b>
pm	Kill: Sightsavers staff
<b>Saturday 22nd - both consultants</b>	



Date/Time	Activity
8.30am	Pick up from hotel
am	Travel to Site Visit 5: Hasnabad
am	Interviews with VC staff (VT & CHWs) and FGD with Government Health Workers
pm	Travel back to Kolkata
4.30pm - 6.30pm	Final Team internal de-brief and review session
<b>Sunday 23rd - both consultants</b>	
all day	Consultants' working session - data review and analysis and prepare debrief presentation
<b>Monday 24th September</b>	
9.00am - 1.00pm	De-brief presentation session and discussion and final KIIs
1.00pm - 2.00pm	<b>LUNCH</b>
2.00pm - 4.00pm	Final KIIs, fact-checking and review of programme documents. Agree any follow-up steps
	Consultants depart Kolkata

## Appendix 8: ETE additional material requested

Item	Status
<b>Project documents</b>	
Y5H2 Logframe update	Not available
Endline survey report	Draft supplied
Previous trip reports for the 3 site visit locations	Not available (formal reports not prepared)
ThinkThrough Consulting Report	Complete
Full set of GIS maps for the 3 site visit blocks	Partial
<b>External documents</b>	
National Eye Health Strategy and other policy documents	Links supplied
<b>ETE preparatory work</b>	
MTR recommendations status update	Complete
Summary table: Overall service use by adults and children, disaggregated	Partial (children's data incomplete)
Summary table: Output achievement topline	Complete
Summary table: Access route topline	Not available
Summary table: Personnel in place at end of project	Partial (no data available on any personnel not directly employed by project)

## Appendix 9: Presentation Guidelines

### Sunderbans ETE 2018:

#### **Presentation Briefing Note for the Briefing Session on Day 1 of the India Data Collection Visit**

This briefing note is intended to explain how the initial briefing presentation session will be used to contribute to the Sunderbans ETE process. It explains the key themes to be covered in the presentation and offers guidance on content.

#### **Themes to be Covered in the Presentation**

The presentation should include high level results under each of the ETE key themes: relevance, effectiveness, efficiency, impact, sustainability, coherence/ coordination and replicability/ scalability as set out in the terms of reference.

#### **Presentation guidelines**

The presentation should last approx. 30 mins with 45 mins for questions and discussion. One or several team members could present.

The purpose of the presentation will be to convey the essence of the Sunderbans programme, painting the big picture that has emerged from all of the fine detail you routinely report.

Recommended elements to include:

- Overview on progress against logframe targets
- Headlines on what this progress has meant for Sunderbans programme partners and the end users of eye health services and wider impact e.g. government programmes other Sightsavers programmes
- Top-line view, identifying any key contributory factors to progress achieved
- Your honest assessment of prospects of proceeding to completion as originally planned
- Strategies for pursuing long term sustainability and again your honest assessment of prospects for this
- Lessons learned and any unintended consequences
- Any key challenges you have encountered along the way and the strategies you use to manage these
- Recommendations for other similar programmes.

The presentation itself need not contain a lot of detail but instead focus on the key messages.

Following the presentation, we can have group discussion with questions / points of clarification and answers.

The group discussion could last for up to 45 mins, combining questions/ points of clarification from the members of the Sightsavers team present and the ETE consultants.

Questions might include for example, the kinds of evidence you are drawing on to support your statements, ease/ challenges of demonstrating outcomes and impact for this type of programme, facilitators and barriers and more in-depth examples to illustrate the points you make.

You are welcome to involve all members of the team for fielding questions – the choice is yours.

The presentation briefing session is intended to provide an opportunity for the team to highlight programme successes and learning and provide your own in-depth reasons for any variations. It is designed to build on Sightsavers' commitment to learning and will be conducted in that spirit.

### **Some further detail on elements to consider covering in presentation and the discussion and question and answer session**

You may not wish or need to cover everything listed in the table below. Remember – choose your presentation content strategically. Detail can be included in the question and discussion session.

<b>Key Theme/ Element</b>	<b>Points to draw out as headlines in the presentation</b>	<b>Background detail to prepare for discussion and questions and answer session</b>
<b>Key Theme: Relevance</b>	Overview on project design and alignment with the eye health priorities and policies of national and local government?	The priority given to eye health by national and local government relative to other areas of health?
<b>Key themes of effectiveness and efficiency should be addressed here</b>  <b>Head-line progress against logframe targets and prospects for reaching final targets and key contributory factors (Programme management systems, operational context)</b>	Headlines on what has been achieved to date with comment on performance against targets. Significance of these results in the context of your programme? Significant milestones? Catalysts? Any important achievements that are not captured in existing reports. Any “Star performer” elements you would like to flag. Financial performance highlights. Financial recovery features of your programme and any highlights Any key or innovative partnership approaches that have been particularly important contributory factors to progress (or otherwise)	Year by year progress against targets, commenting on any, variations and adjustments - Key points on what changed and why, and the impact of the change on your trajectory of progress M&E processes and how well (or otherwise) these worked e.g. the GIS locational data and its usefulness in targeting and planning of outreach and school screening. Main cost drivers and highlight any performance issues Key factors affecting financial costs recovery aspects of the programme Indication of where your programme sits in a longer scale timeline – where it came from and where you want to go next.
<b>Key Theme: Impact</b>  <b>Main outcomes and impacts of what's</b>	Concentrate on showing outcomes and impacts that have <u>strategic</u> value to your programme and to eye health	Examples of outcomes and impacts e.g. aspects of the programme which have been embedded in partner practice - e.g. changes in health

Key Theme/ Element	Points to draw out as headlines in the presentation	Background detail to prepare for discussion and questions and answer session
<b>been achieved to date</b>	more broadly (for partners/ Sightsavers) – touch on issues such as equity of service provision and the challenges on reaching specific groups	practices/ organisation, ongoing use of mapping based Management Information Systems etc.  Examples of where the project could incorporate a gender responsive approach in terms of reach and service uptake  Influences of any of the above on community engagement and sustainability of eye health service demand?
<b>Lessons learned</b>  <b>Any of the key themes could be included here: effectiveness and efficiency, sustainability etc.</b>	Think from your perspective as leaders in eye health – your critical learning points; advice for other partners or others embarking on a similar programme; high level observations, what has been critical to success or things to avoid. Strategy for managing and sharing programme-level learning internally and more widely.	Practical examples of how you foster and support a learning culture. Any key actions taken as a result of learning points.
<b>Unintended consequences</b>  <b>Any of the key themes could be included here: effectiveness and efficiency, sustainability etc.</b>	Any major positive or negative unintended consequences of the programme and how you have/ are responding to them.	Specific examples of unintended consequences for Sightsavers, other partners, service users, programme staff and community level personnel or eye health more broadly.
<b>Key challenges and related strategies</b>  <b>Any of the key themes could be included here: effectiveness and efficiency, sustainability etc.</b>	Issues that may be relevant to others in this field of work and issues that may be unique to your context, which other similar programmes may need to be aware of.	Specific examples with detail of what happened, the impact on your programme (actual or potential), what you did to recover and how you are preventing recurrence. Risk management strategies and arrangements.
<b>Recommendations on replicability and scalability</b>	Top three recommendations for similar programmes Any major adjustments?	Detail of any suggested change, e.g. change in balance of resource allocation, change of emphasis,

Key Theme/ Element	Points to draw out as headlines in the presentation	Background detail to prepare for discussion and questions and answer session
	The intended impact of your recommendations – how would it benefit your own programme after programme closure and/or the wider eye health work – nationally or globally.	partnership approaches etc. for future programmed Broad resource implications - budget or staffing implications of any desired changes (no fine detail required) Feasibility considerations for your recommendations (again, top-line only - no fine detail required).

### **Next Steps:**

Please send your presentation to the ETE consultants by 10 Sep, in near-final draft if necessary. You could continue to fine-tune it after that date if you wish.

### **For further advice**

We are happy to answer any questions you have via email or separate SKYPE call about any of the items outlined above. Please contact: Lynne Elliott at [lynne@developmentsols.com](mailto:lynne@developmentsols.com)



# Appendix 10: Consent Form for use in English and for local translation

## Sundarbans Eye Health Service Strengthening Project: End of Term Evaluation

### Information and Consent to Participate in Evaluation

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

You are invited to participate in an end of term evaluation of the Sightsavers' Sundarbans Eye Health Service Strengthening Project, which is being conducted by two consultants on behalf of Sightsavers.

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

### Purpose of the evaluation

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

### Procedure

You will be asked a series of questions about your experience of the Sundarbans Eye Health Service Strengthening Project. We will take notes during our discussion to ensure we capture what you say accurately. We may also ask to take photographs, with your permission, to help add more context to the evaluation.

### Potential risks and discomforts

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

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

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

### Payment for participation

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

### Confidentiality

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

### **Participation and withdrawal**

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

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

Lynne Elliott, Tropical Health ([lynne@developmentsols.com](mailto:lynne@developmentsols.com))

Dr Shaila Patil, Tropical Health ([info@trophealth.com](mailto:info@trophealth.com))

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

---

Name and Signature of Respondent(s)

Date:

KII/FGD

## Appendix 11: List of Documents

Document	Sightsavers' prioritisation guidance (P)	Received (Yes ✓ / No X)	Reviewed (Yes ✓ / No X)	Notes
<b>Baseline survey</b>				
Baseline report July 2016	P	✓	✓	
<b>Budget, logframe and proposal</b>				
2013 63404- Logframe, proposal and budget	P	✓	✓	
2016 61812 Logframe	P	✓	✓	
<b>Case Studies</b>				
Coffee table book 21 <sup>st</sup> Nov 2017		✓	✓	
<b>Contract and LOVs</b>				
2013 - 63404 SiB Sunderbans Contract	P	✓	✓	
<b>Donor reports</b>				
2014 - 63404 Y2H1 Narrative report	P	✓	✓	
2014-61812 Y2H1 Finance and Programme Output Report	P	✓	✓	
2015 - 63404 Y2H2 Narrative	P	✓	✓	
2015 - 63404 Y2H2 Report Appendices	P	✓	✓	
2016 - 63404 Y3H1 Narrative	P	✓	✓	
2016 - 63404 Y3H1 Report Appendices	P	✓	✓	
2016 61812 Y3H2 Appendices REVISED	P	✓	✓	
2016 61812 Y3H2 Narrative	P	✓	✓	
2017 61812 Y4H1 Appendices Final	P	✓	✓	
2017 61812 Y4H1 Narrative	P	✓	✓	
Sundarbans Y4H2 Appendices FINAL	P	✓	✓	
Sunderbans Y4H2 Narrative FINAL revised Nov 2017 -2	P	✓	✓	
2018 Y5H1 Appendices	P	✓	✓	
2018 Y5H1 Narrative	P	✓	✓	
2018 Y5H2 Appendices		X	X	
2018 Y5H2 Narrative		X	X	
<b>Endline Survey</b>				
Endline survey	P	✓	✓	Draft supplied post field visit
<b>GIS</b>				
Sunderbans learning notes - V2		✓	✓	
JN_0313_Vancouver_MapPoster_V02		✓	✓	
Latest GIS output maps (to 2017)		✓	✓	
6 monthly maps – age, condition, patients, sex (to 2017)		✓	✓	
Block maps Basanti Canning I Canning II Gosaba Haroa		✓	✓	

Document	Sightsavers' prioritisation guidance (P)	Received (Yes ✓ / No X)	Reviewed (Yes ✓ / No X)	Notes
Hasnabad Hingalgunj Joynagar I Joynagar II Kakdwip Kultali Mathurapur I Mathurapur II Minakha Namkhana PatharPratima Sagar Sandeshkhali I Sandeshkhali II				
Cumulative data maps – age, condition, location, sex		✓	✓	
2018 output maps for 3 visit sites		✓	✓	Supplied post field visit
Sundarbans GIS Mapping Protocol Plan		✓	✓	
<b>Research</b>				
Other operational research: Spectacle compliance report		✓	✓	Supplied post-inception , draft status
Patient satisfaction survey		✓	✓	Supplied post-inception , draft status
RMP training report		✓	✓	Supplied post-inception
End Term Evaluation of the Mumbai Eye Care Campaign, 2015		✓	✓	Supplied post inception
Final Evaluation of the Kolkata Urban Comprehensive Eye Care Programme, Executive Summary, 2015		✓	✓	Supplied post inception
Narrative report: Focus Group Discussion with RMPs, 2014		✓	✓	Supplied post inception
Think Through Consulting Sundarbans Vision Centre Final Report, July 2016		✓	✓	Supplied post inception
<b>Implementation plan</b>				
2016 61812 Implementation Plan - SiB Sunderbans Project	P	✓	✓	
<b>M&amp;E Plan</b>				

Document	Sightsavers' prioritisation guidance (P)	Received (Yes ✓ / No X)	Reviewed (Yes ✓ / No X)	Notes
2016 61812 ME Framework	P	✓	✓	
<b>Monitoring data</b>				
VC Reports as of June 2018	P	✓	✓	
<b>MTR</b>				
Sunderbans Eye Health project MTR Evaluation Report Final	P	✓	✓	
Sunderbans MTR Management Response June 2017	P	✓	✓	
<b>Procurement</b>				
2015 61812 Sunderban SiB Project procurement plan		✓	✓	
<b>Project brochure</b>				
Final brochure 6X8		✓	✓	
<b>Additional documents supplied during or after fieldwork</b>				
National policy documents: Govt of India Ministry of Health and Family Welfare: National Health Policy 2017 Situation Analyses – backdrop to NHP 2017 Govt of India: National Program for Control of Blindness and Visual Impairment (NPCBVI)		✓  ✓	✓  ✓	
Training materials: School Eye Screening Manual Teacher Training Handouts Training Module for RMPs		✓	✓	
Baseline-endline summary (2 page pdf)		✓	✓	
Project management documents Minutes of Partners meetings (3) Job Descriptions and Reporting Structure of the Phase V Project Staff		✓	✓	

## Appendix 12: List of Key Informants

See excel file for better readability.

Stakeholder category	Specific stakeholder	Name	Role	Location	KII (estimated target)	Achieved	FGD (estimated target)*	Achieved	Purposive Sampling criteria	Suggested priority
<b>Sightsavers HQ level</b>										
		Andy Tate	Programme Systems Manager	UK	0	1	0	0		
		Emma Jolley	Global Technical Lead, Health and Disability Research	UK	0	1	0	0		
<b>National level</b>										
ICO staff (ICO)	Sightsavers India country office staff	Dr. Sandeep Buttan Mr. Prasannakumar PN	Global Technical Lead, Eye Health Director, Programme Operations	New Delhi	2	4**	0	0	Informants with most involvement/ responsibility with the programme	H
National govt partner (NGP)	Ministry of Health and Family welfare (MHFW)	Dr. Siddhartha Neogi	Assistant Director Health Services & State Programme Officer, National	Kolkata	1	1	0	0	Informants with most involvement/ responsibility with the programme	H
Donor (DON)	Standard Chartered Bank	Karuna Bhatia	Head -Sustainability	Mumbai	1	TBC	0	0	Informants with most involvement/ responsibility with the programme	H
<b>Sub-regional level</b>										
Sub-regional partner (SRP)	Sundarban Social Development Centre	Mr Raghunath Mandal	Project Coordinator	South 24 Parganas	1	1	0	0	Most senior, directly involved informant	H
Sub-regional partner (SRP)	Southern Health Improvement Samity	Ch. Srinivas Rao	Project Coordinator	North 24 Parganas	1	2***	0	0	Most senior, directly involved informant	H
Sub-regional partner (SRP)	Vivekananda Mission Asram	Dr. Subhra Sil Ultam Adak	Ophthalmologist & Project Director Project Coordinator	South 24 Parganas	2	3****	0	0	Most senior, directly involved informant	H
Health workers (H/C)	Optometrists				3	3	0	0	One from each partner	H
Health workers (H/C)	Government Health Workers				3	2	0	0	Selection at each block visited	H
<b>Community (Block)</b>										
Vision Technicians					3	3	9	4	Selection at each block visited	H
Community Health Workers (VC staff)					3	5	9	0		
Rural Medical Practitioners	Rural Medical Practitioners trained under the programme				0	2	3	9	One from each block visited	H
Teachers	Teachers trained under the programme				0	0	9	0	Selection at each block visited	H
Community Health Workers - other	ASHAs trained under the programme				0	0	0	2		
Community Health Workers - other	Angawadi workers trained under the programme				0	0	0	2		
Community volunteers	Health Ambassadors trained under the programme				0	0	0	2		
<b>TOTAL</b>					20	28	30	19		

\*If more than one key informant is present at the KII then it is still noted here as a KII given it will be guided by the KII guide.

\*\* We also interviewed Mr. Sudipta & Ms Arundhati

\*\*\* We also interviewed the Director. SHIS

\*\*\*\* We also interviewed the Pediatric Ophthalmologist, Dr. Asim Sil



## Appendix 13: Topic Guide - KIs for National and Sub-regional level

### Interview outline (time allowed: up to 1 hour)

1. Introductions according to local protocol (up to 5 mins)
2. Very brief recap on purpose of interview, scope of questions and how the response will be used. Invite clarification questions. (5 mins)
3. Main discussion (up to 45 mins)
4. Closing formalities (up to 5 mins)

### Interview schedule

Select questions from the main interview guide to shape interviews with key informants according to the following colour coding key:

- National level programme staff, partner staff, government representative and donor representative
- Sub-regional level partner staff, technical staff

Evaluation Questions	Sub Questions and Probes	Interviewees
<b>1. Relevance</b> – <i>the extent to which the project or programme is suited to the priorities and policies of the target beneficiaries, national partners, and donors, where applicable.</i>		
1.1 To what extent did the project design align with the eye health priorities and policies of national and local government?	1.1.1 What priority is given to eye health by national and local government relative to other areas of health?  1.1.2 How <i>(if at all)</i> have Sightsavers and MoH influenced each other's thinking?  1.1.3 What policies and other contextual factors <i>(if any)</i> have affect planning decisions?  1.1.4 Please provide specific examples of relevance	<b>Questions 1.1.1 to 1.1.5</b>  MoHFW representative  National Programme Staff  Donor: Standard Chartered Bank

Evaluation Questions	Sub Questions and Probes	Interviewees
	1.1.5 Please provide specific examples of where priorities have changed.	
1.2 To what extent does the project design and implementation respond to beneficiaries' eye health needs (including women), e.g. how far did the Vision Centre (VC) locations help in serving target populations, including in terms of equitable gender balance and accessibility	<p>1.2.1 What needs assessment processes are used?</p> <p>1.2.2 How (<i>if at all</i>) are end users involved in planning and review at any level? (<b>Prompt:</b> needs assessments or research, including specific attention to needs of women, the elderly or people with accessibility requirements? Please provide examples where this has happened.)</p> <p>1.2.3 How was this information used in project management?</p>	<p><b>Questions: 1.2.1 to 1.2.3</b></p> <p>MoHFW representative</p> <p>Sub-regional programme Staff</p>
<b>2. Effectiveness</b> – the extent to which the objectives have been achieved and the anticipated results have been realized.		
2.1 Were the project objectives/ outcomes achieved or not, and what were the major factors influencing this?	<p>2.1.1 What was the overall achievement against logframe targets? (<b>Probe:</b> paediatric targets and financial targets)</p> <p>2.1.2 What are the principal reasons for variation across the project sites (<b>Probe:</b> financial targets)</p> <p>2.1.3 Did anything make it easy to achieve the targets? Difficult? [<b>Prompt:</b> “champions” of the programme? Are the right people (organisations) involved and fully engaged? Is the current partner set sufficient?]</p>	<p><b>Questions 2.1.1 to 2.1.4</b></p> <p>National Programme staff</p> <p>Sub-regional programme staff</p>

Evaluation Questions	Sub Questions and Probes	Interviewees
	2.1.4 Can you think of anything which would have made achieving objectives and outcomes easier?	
2.2 To what extent has the GIS locational data been useful to the targeting and planning of outreach and school screening strategies and activities, and is there any corresponding evidence of decisions or changes in service delivery and treatment as a result?	<p>2.2.1 How (<i>if at all</i>) has GIS locational data been useful in targeting and planning of outreach and school screening strategies and activities? Can you give an example of this?</p> <p>2.2.2 What impact (<i>if any</i>) has this had on service delivery? On treatment? <b>[Probe:</b> any evidence of decisions or changes?) Can you give examples?</p>	<p><b>Questions 2.2.1 to 2.2.2</b></p> <p>National programme and partner staff</p> <p>Sub regional partner staff</p> <p>Sub-regional technical staff</p>
2.3 To what extent have the accepted mid-term review recommendations been actioned or fulfilled?	<p>2.3.1 What progress has been made against the recommendations of the mid-term review?</p> <p>2.3.2 What are the reasons for any recommendations which have not been actioned?</p>	<p><b>Questions 2.3.1 to 2.3.2</b></p> <p>National programme staff</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>
2.4 How far has the project been able to incorporate a gender responsive approach in terms of reach and service uptake in Sundarbans? <sup>33</sup> Are there any specific examples of	<p>2.4.1 How has the project incorporated gender responsive approaches into programming.</p> <p>2.4.2 What (<i>if anything</i>) has worked particularly well?</p> <p>2.4.3 How applicable are these approaches to gender targeting more widely in Sightsavers' eye health projects?</p>	<p><b>Questions 2.4.1 to 2.4.3</b> National programme staff</p> <p><b>Questions 2.4.1 to 2.4.2</b></p> <p>Sub regional partner staff</p> <p><i>Note: Canning II site visit special focus</i></p>

<sup>33</sup> WHO Gender assessment tool could be used: [http://www.who.int/gender/mainstreaming/GMH\\_Participant\\_GenderAssessmentTool.pdf](http://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentTool.pdf)

Evaluation Questions	Sub Questions and Probes	Interviewees
initiatives which have worked which can inform gender targeting more widely in Sightsavers' eye health projects?		
<b>3. Efficiency</b> – the extent to which results have been delivered with the least costly resources possible, and the manner in which resources have been efficiently managed and governed in order to produce results.		
3.1 Were there any timeline or resource allocation related challenges that needed significant alteration?	3.1.1 What made it easy to deliver the programme efficiently? What made it difficult? [ <b>Probe:</b> timeline, programme flexibility to respond to changes, resources?]	<b>Question 3.1.1</b> National programme staff National partner staff Sub-regional partner staff Note: Pathar Pratima site visit special focus
3.2 To what extent has routine and enhanced project monitoring in relation to school screening and outreach camps, as well as cataract surgical outcomes, been incorporated in project management during implementation, including in relation to MTR recommendations 1, 2, 4	3.2.1 In what way ( <i>if at all</i> ) has routine and enhanced monitoring in relation to: i) school screening and outreach camps, been incorporated in project management? ii) cataract surgical outcomes, been incorporated in project management?  3.2.2 Did all the planned improvements take place? [ <b>Probe:</b> specifically in relation to MTR recommendations 1, 2, 4 and 7 on additional monitoring and analysis].	<b>Question 3.2.1 to 3.2.2</b> Sub-regional partner staff and technical staff

Evaluation Questions	Sub Questions and Probes	Interviewees
and 7 on additional monitoring and analysis?		
<b>4. Impact</b> – the long-term change or effects (positive or negative) that have occurred, or will occur, as a result of the project or programme		
4.1 Has there been any impact on the service delivery capacity of government and NGO partner capacities as a result of the project? For example, the utilisation of the infrastructure upgrading and the extent to which this has contributed to better eye care services to the patients at the 4 primary eye care centres and at the sub divisional level?	<p>4.1.1 What (<i>if anything</i>) has been the impact on service delivery capacity for government and NGO staff as a result of the programme?</p> <p>For staff trained:</p> <p>What (<i>if anything</i>) has changed since being part of the programme? For You? Your team? Your clients? <i>Can you say more about this?</i></p> <ul style="list-style-type: none"> <li>○ How has involvement in the programme affected you?</li> <li>○ <i>What difference has it made to your work (if any)?</i></li> <li>○ <i>What difference has it made to your clients (if any)? (Probe: infrastructure improvements and the impact for eye care services.)</i></li> </ul> <p>4.1.2 Are there any downsides to being involved in the programme? (<b>Probe:</b> any change including: other work neglected, problems with clients served? Relations with other colleagues who have not been trained?)</p>	<p><b>Questions 4.1.1 to 4.1.2</b></p> <p>National government rep</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>
4.2 How far have the various trainings provided to the project staff and to different stakeholders been useful in terms of knowledge gained and	<p>4.2.1 What has been the impact of training on knowledge? And referral systems?</p> <p>For staff trained:</p>	<p><b>Question 4.2.1 to 4.2.2</b></p> <p>Sub-regional partner staff</p>

Evaluation Questions	Sub Questions and Probes	Interviewees
strengthening the referral system in the project in a long term, sustainable way?	<p>What impact has this training had for You? Your team? Your clients? <i>What has changed as a result of training? Can you say more about this?</i></p> <ul style="list-style-type: none"> <li>○ How has training affected you? [<b>Probe:</b> knowledge]</li> <li>○ <i>What difference has it made to your work (if any)?</i></li> <li>○ <i>What difference has it made to your clients (if any)?</i> (<b>Probe:</b> referral systems.)</li> </ul> <p>4.2.2. Has anything unexpected emerged as a result of training? (<b>Probe:</b> Are there any signs of health workers / volunteers transferring skills to and from the project? Has attention to this programme meant other issues are neglected?)</p>	
4.3 Is there any evidence of changes in community awareness and demand for eye care services in the project region? E.g. from the results of the population-based endline survey or other information sources	4.3.1 What has been the impact on community awareness and demand for eye care services? Can you provide specific examples of this?	<p><b>Question 4.3.1</b></p> <p>National programme staff</p> <p>Sub-regional partner staff</p>
4.4 Are there any aspects of the project which have been embedded in partner practice e.g. ongoing use of mapping based Management Information Systems (MIS) etc., and has	<p>4.4.1. What evidence is there of aspects of the project (in part or in full) being embedded in partner practice? (<b>Probe:</b> management based management information systems)</p> <p>4.4.2 How (<i>if at all</i>) has this influenced engagement with communities to sustain demand for eye health services? Can you say more about this? Are there any specific examples?</p>	<p><b>Question 4.4.1 to 4.4.2</b></p> <p>National Government</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>



Evaluation Questions	Sub Questions and Probes	Interviewees
this influenced engagement with communities to sustain eye health service demand?		
<b>5. Sustainability</b> – whether benefits of the project are likely to continue after donor funding has ceased.		
5.1 Does the project have a sustainability plan in place, and if so, to what extent has this been operationalised?	<p>5.1.1 What will happen to the work undertaken in this programme now the programme has closed?</p> <p><b>Probe:</b> Is there a sustainability plan? Is this being operationalised?</p> <p>5.1.2 What systems and structures needed to be established to ensure sustainability of service delivery? Are these in place?</p> <p>5.1.3 If the whole programme will not continue, is there anything which could/ will continue outside the whole programme format that could continue? Can you say more about this?</p> <p>5.1.4 What would you consider to be the most critical change required in helping partners to establish and maintain quality eye health services?</p>	<p><b>Questions 5.1.1 to 5.1.4</b></p> <p>National Government</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>
5.2 What are the prospects for financial sustainability of the Vision Centres established under the project?	<p>5.2.1 What is the likelihood that Vision Centres will be financially sustainable? Can you say more about this?</p> <p>5.2.2 If Vision Centres are not financially sustainable, what (if anything) could be done at this stage to enhance the prospects of financial sustainability?</p>	<p><b>Questions 5.2.1 to 5.2.2</b></p> <p>National government</p> <p>National Programme Staff</p>
5.3 Is there any evidence of policy changes which have	5.3.1 What ( <i>if any</i> ) policy changes have been stimulated by the project? Can you say a bit more about this?	<p><b>Questions 5.3.1 to 5.3.2</b></p> <p>National Government</p>

Evaluation Questions	Sub Questions and Probes	Interviewees
been stimulated by the project?	5.3.2 What is the reach of these policy changes – local, regional, national?	National partner staff Sub-regional partner staff
<b>6. Coherence/ coordination</b> – the extent to which the project or programme has coordinated with other similar initiatives, interventions or actors, and the degree to which the project design and implementation is internally coherent.		
6.1 To what extent were the assumptions <sup>34</sup> on which the various project components built, valid, and if there was any variance, how did this affect the project implementation?	6.1.1 Considering the assumptions around which project components were built, how valid were these assumptions? [ <b>Probe:</b> assumptions such as population prevalence, government health infrastructure and HR]  6.1.2. How ( <i>if at all</i> ) did any variance from these original assumptions affect project implementation?	<b>Question 6.1.1</b> National Government  <b>Questions 6.1.1 to 6.1.2</b> National partner staff Sub-regional partner staff
6.2 Were any new factors identified later in the course of implementation that were more relevant to the problem statement? If yes, how did the project respond to these?	6.2.1 Did any new factors emerge during implementation that were more relevant to the original problem statement? Can you tell us more about these?  6.2.2 How ( <i>if at all</i> ) did the project respond to these? i) What ( <i>if any</i> ) changes were made? ii) What were the reasons for no changes being made?	<b>Questions 6.2.1 to 6.2.2</b> National programme staff Sub-regional partner staff
6.3 Given that this was a multi-partner project with complex inter agency	6.3.1 How many programme partners were you working with for this eye health project?	<b>Questions 6.3.1 to 6.3.4</b> National programme staff

<sup>34</sup> These may include population prevalence (e.g. child blindness, uncorrected refractive error), government health infrastructure and HR, etc.

Evaluation Questions	Sub Questions and Probes	Interviewees
dynamics, how well have partner relations functioned, and has any necessary coordination been achieved overall?	<p>6.3.2. Can you describe what it's like having this number of partners?</p> <p>6.3.3 How have partner relations functioned? (<b>Probe:</b> has coordinated been achieved?) What made this easy? What made it difficult?</p> <p>6.3.4 What are the current gaps in partner relations? What are the prospects of filling them?</p>	Sub-regional partner staff
6.4 How well has the project been coordinated with any other partners' initiatives and programmes at local and national levels?	<p>6.4.1 Focusing more broadly, how (<i>if at all</i>) has the project been coordinated with other partner initiatives and programmes either locally or nationally? (<b>Probe:</b> What links exist to other major programmes that could be mutually reinforcing?)</p> <p>6.4.2 How (<i>if at all</i>) did coordination ensure the active participation and easy flow of information between all stakeholders? Can you provide examples?</p> <p>6.4.3 What made wider partner coordination easy? What made it difficult?</p>	<p><b>Questions 6.4.1 to 6.4.3</b></p> <p>National programme staff</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>
<b>7. Replicability/ scalability</b> – the scope and potential for the project, or elements of the project, to be suitable for replication or scale up in other settings, and whether the necessary conditions are in place for this to occur, if relevant.		
7.1 What aspects of this project might be valuable and feasible to replicate in other Sightsavers eye health projects?	7.1.1 Would you recommend the approach used in this programme to others? Who? <b>Or</b> What is it that makes you say you would not recommend it? ( <b>Probe:</b> in which context might this not be the best approach?)	<p><b>Questions 7.1.1 to 7.1.3</b></p> <p>National programme staff</p> <p>Donor</p>

Evaluation Questions	Sub Questions and Probes	Interviewees
	<p>7.1.2 Which components of the project are suitable for replication?  <b>Probe:</b> Can you give an example of this?</p> <p>7.1.3 What would you say to others who were thinking of implementing the approaches you have used?</p>	<p>Government rep</p> <p>National Partner staff</p>
7.2 To what extent have the Vision Centres provided a model for primary eye care delivery, in the context of a health systems approach in Sundarbans?	<p>7.2.1 Considering the Vision Centres, in what way <i>(if at all)</i> have these provided a model for primary eye care delivery? Can you say a bit more about that?</p> <p>7.2.2 What <i>(if anything)</i> would you change about the model? Can you say a more about that?</p> <p>7.2.3 Would you recommend this model to others?</p> <p>7.2.4 What would you say to others who were thinking about implementing this model?</p> <p>7.2.5. If you had to think of three top tips in relation to getting others involved in the vision centre model, what would they be?</p>	<p><b>Questions 7.2.1 to 7.2.5</b></p> <p>National programme staff</p> <p>Donor</p> <p>Government rep</p> <p>National Partner staff</p>
7.3 How well has learning about successes and challenges been captured and documented, in order to allow for learning to translate to other projects?	<p>7.3.1 What have been the top three learnings from the programme?  <b>(Probe:</b> successes and challenges)</p> <p>7.3.2 How <i>(if at all)</i> are learnings captured and documented?</p> <p>7.3.3 What evidence is there that learning has been translated to other projects?</p>	<p><b>Questions 7.3.1 to 7.3.3</b></p> <p>National programme staff</p> <p>National partner staff</p> <p>Sub-regional partner staff</p>

## Appendix 14: Topic Guide - KIs for Community Level

### Interview outline (time allowed: up to 1 hour)

1. Introductions according to local protocol (up to 5 mins)
2. Very brief recap on purpose of interview, scope of questions and how the response will be used. Invite clarification questions. (5 mins)
3. Main discussion (up to 45 mins)
4. Closing formalities (up to 5 mins)

### Interview schedule

This topic guide is designed for block level community health personnel including: rural medical practitioners, community health workers, teachers and vision technicians. **Note** these informants will mostly be involved in FGDs covered in Annex 15. However, where single individual community staff are met, this guide will apply.

The tool will be used to guide KIs.

#### Main Evaluation Areas and questions are shown below

##### 1. Relevance

1.1 Tell me a little about the eye health services available in this community?

1.2 Thinking about the programme supported by Sightsavers, how well did it support the needs of this community? **Probe:** How did it do that?

1.3 Can you tell me how (if at all) the programme identified local community's eye health needs? **Probe:** used local knowledge, formal assessments, paid attention to specific needs of women and people with accessibility requirements?

1.4 How is feedback gathered from people who use the services? (**Probe:** Any groups being missed?)

1.5 How is this information used?

##### 2. Effectiveness

## Main Evaluation Areas and questions are shown below

2.1 Turning to your programme targets – how did you get on with these overall? What’s working well? What’s not worked so well?

**Probe:** tailor this to known site-specific variances

2.2 What made it easy to achieve the targets? Difficult? [**Prompt:** “champions” of the programme? Are the right people (organisations) involved and fully engaged?

2.3 Can you think of the one thing which (is anything) which would have made achieving your targets easier

### Screening question:

Have you used GIS data in your work?

**If yes** – Q2.4 and 2.5

**If no**

Probe – what was the reason for this?

2.4 How (*if at all*) has GIS locational data been useful in targeting and planning of outreach and school screening strategies and activities? Can you give an example of this?

2.5 What impact (*if any*) has this had on service delivery? On treatment? [**Probe:** any evidence of decisions or changes?) Can you give examples?

**Screening Question:** did this programme receive any specific recommendations in the MTR? If yes - Q2.6 and Q2.7

if **No** move to question 2.8

2.6 What progress has been made against the recommendations of the mid-term review?

2.7 What are the reasons for any recommendations which have not been actioned?



## Main Evaluation Areas and questions are shown below

2.8 Can you please tell us about how you've gone about ensuring women and girls access the VC services? What has worked well? What else might you do?

**Probe in Canning II:** Canning I block seems to attract high numbers of women and young people. Can you say why that is?

2.9 Do you think your approaches would work elsewhere?

### 3. Efficiency

3.1. What made it easy to deliver the programme efficiently? What made it difficult? [**Probe:** timeline, programme flexibility to respond to changes, resources?]

3.2 The monitoring system changed after the MTR. How (*if at all*) has this changed the way you plan and manage your work? Has it made a difference? Can you give an example of that?

### 4. Impact

4.1 What (*if anything*) has changed since being part of the programme? For You? Your team? The community served? *Can you say more about this?*

- How has involvement in the programme affected you?
- What difference has it made to your work (if any)?
- What difference (if any) has it made to your community (**Probe:** infrastructure improvements and the impact for eye care services). What has been the impact on community awareness and demand for eye care services? Can you provide specific examples of this?

### 5. Sustainability

5.1. What will happen to the work undertaken in this programme now the programme has closed?

**Probe:** Is there a sustainability plan? Is this being implemented?

5.2. If the whole programme will not continue, is there anything which could/ will continue outside the whole programme that could continue?

## Main Evaluation Areas and questions are shown below

5.3. What would you consider to be the most critical change required in helping partners to establish and maintain quality eye health services?

### 6. Coherence/ coordination

6.1 Thinking back to how things were in this community when the project was started, have there been any major changes locally? Probe: any major changes in the population, government health services, other service providers?

6.2 Can you tell me how the programme dealt with any changes over the years? How well did it do this – what worked well? What didn't work so well?

I'd like to move to talk about working with other partners on the programme.

6.3 What has it been like working with other partners? How have you worked together? Tell me about that?

6.4 How (*if at all*) has the project been coordinated with other partner initiatives and programmes either locally or nationally?

### 7. Replicability/ scalability

7.1. Would you recommend the approach used in this programme to others? Who? **Or** What is it that makes you say you would not recommend it? (**Probe:** in which context might this not be the best approach?)

7.2. Which parts of the project are suitable for copying? **Probe:** Can you give an example of this?

7.3. What would you say to others who were thinking of implementing the approaches you have used?

## Appendix 15: Topic Guide - FGDs for Community Level

### Discussion outline (time allowed: up to 60 mins)

1. Introductions: (up to 10 mins): participants' roles and longevity in the project
2. Very brief recap on purpose of discussion, scope of questions and how the response will be used. Invite clarification questions. (5 mins)
3. Main discussion using selected prompts from discussion schedule (up to 45 mins)
4. Closing formalities (up to 5 mins)

### Discussion schedule

Has been designed for FGDs with:

Community level health personnel including: Rural medical practitioners, community health workers, teachers and vision technicians.

The tool will be used to guide focus group discussions.

### Main Evaluation Areas with FGD questions shown below

#### 1. Relevance

1.1 Tell me a little about the eye health services available in this community?

1.2 Thinking about the programme supported by Sightsavers, how well (*or otherwise*) did it support the needs of this community? **Probe:** How did it do that? How (*if at all*) did it respond to specific needs of women, the elderly or people with accessibility issues?

1.3 Can you tell me how (*if at all*) the programme identified local community's eye health needs? **Probe:** used local knowledge, formal assessments?

1.4 How is feedback gathered from people who use the services? (**Probe:** Any groups being missed?)

1.5 How is this information used?

#### 2. Effectiveness

## Main Evaluation Areas with FGD questions shown below

2.1 Turning to your programme targets (*if you have any*) how did you get on with these overall? What's working well? What's not worked so well?

**Probe:** tailor this to known site-specific variances

For those with no programme targets move to question 2.2. Note to interviewer use the alternative word – work in questions 2.3 and 2.4 for those with no programme targets.

2.2 Focusing on your work with this programme how has this gone? Tell us about that - What's working well? What's not worked so well?

2.3 What made it easy to achieve the targets (or your work with the programme)? Difficult? [**Prompt:** “champions” of the programme? Are the right people (organisations) involved and fully engaged?

2.4 Can you think of the one thing (*if anything*) which would have made achieving your targets (or work) easier?

### Screening question:

Have you used GIS data in your work?

**If yes** – Q2.5 and 2.6

**If no**

Probe – what was the reason for this?

2.5 How (*if at all*) has GIS locational data been useful in targeting and planning of outreach and school screening strategies and activities? Can you give an example of this?

2.6 What impact (*if any*) has this had on service delivery? On treatment? [**Probe:** any evidence of decisions or changes?) Can you give examples?

**Screening Question:** did this programme receive any specific recommendations in the MTR? If yes - Q2.7 and Q2.8

if **No** move to question 2.9

## Main Evaluation Areas with FGD questions shown below

2.7 What progress has been made against the recommendations of the mid-term review?

2.8 What are the reasons for any recommendations which have not been actioned?

2.9 Can you please tell us about how you've gone about ensuring women and girls access the VC services? What has worked well? What else might you do?

**Probe in Canning II:** Canning I block seems to attract high numbers of women and young people. Can you say why that is?

2.10 Do you think your approaches would work elsewhere? **Probe:** For other members of the community – the elderly or those with a disability?

### 3. Efficiency

3.1. What made it easy to deliver the programme efficiently? What made it difficult? [**Probe:** timeline, programme flexibility to respond to changes, resources?]

3.2 The monitoring system changed after the MTR. How (*if at all*) has this changed the way you plan and manage your work? Has it made a difference? Can you give an example of that?

### 4. Impact

4.1 What (*if anything*) has changed since being part of the programme? For You? Your team? The community served? *Can you say more about this?*

- How has involvement in the programme affected you?
- What difference has it made to your work (if any)?
- What difference (if any) has it made to your community (**Probe:** infrastructure improvements and the impact for eye care services). What has been the impact on community awareness and demand for eye care services? Can you provide specific examples of this?

### 5. Sustainability

5.1. What will happen to the work undertaken in this programme now the programme has closed?

## Main Evaluation Areas with FGD questions shown below

**Probe:** Is there a sustainability plan? Is this being implemented?

5.2. If the whole programme will not continue, is there anything which could/ will continue outside the whole programme that could continue?

5.3. What would you consider to be the most critical change required in helping partners to establish and maintain quality eye health services?

### 6. Coherence/ coordination

6.1 Thinking back to how things were in this community when the project was started, have there been any major changes locally? Probe: any major changes in the population, government health services, other service providers?

6.2 Can you tell me how you have dealt with any changes to the programme over the years? How well did it do this – what worked well? What didn't work so well?

I'd like to move to talk about working with other partners on the programme.

6.3 What has it been like working with other partners? How have you worked together? Tell me about that?

6.4 How (*if at all*) has the project been coordinated with other partner initiatives and programmes either locally or nationally?

### 7. Replicability/ scalability

7.1. Would you recommend the approach used in this programme to others? Who? **Or** What is it that makes you say you would not recommend it? (**Probe:** in which context might this not be the best approach?)

7.2. Which parts of the project are suitable for copying? **Probe:** Can you give an example of this?

7.3. What would you say to others who were thinking of implementing the approaches you have used?

## Appendix 16: Project logframe

### Title of the Project: Sunderban Eye Health Service Strengthening Project 2013-18

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
<b>Goal</b>	<b>To contribute towards the elimination of avoidable blindness in the Sunderbans region of West Bengal by 2020</b>	Prevalence of blindness	<ul style="list-style-type: none"> <li>Baseline and Final Evaluation Government data (National Programme on Control of Blindness, State Health Society, National Rural Health Mission, National Family Health Survey etc).</li> </ul>	National and State government authorities continues to support Blindness control programme beyond the project period.
		Cataract surgical coverage		
		Cataract Surgical Rate		
<b>Objective</b>	To improve coverage and access to affordable, quality eye health services	1.1: Number of individuals receiving eye health care services	<ul style="list-style-type: none"> <li>Baseline and end term surveys along with RAAB, KAP</li> <li>Mid-term evaluation report.</li> <li>Patient satisfaction survey report.</li> <li>Focus group Discussions</li> </ul>	No major political clashes, natural calamities, or public health epidemics affect the project area.
		1.2: Extent of coverage of eye health services within the project area		
		1.3: Percentage of patients receiving non-surgical services expressing satisfaction with services.		
		1.4: Number of referral hospitals and other institutions supporting the project		



Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
	To increase awareness and improve attitudes towards eye health in target communities	1.5: Number of individuals referred to other institutions	<ul style="list-style-type: none"> <li>Health facility survey</li> <li>GIS interface mapping data</li> </ul>	
		2.1: Number of individuals seeking eye health services		
		2.2 Percentage of surveyed individuals able to correctly identify eye care conditions		
	To increase the capacity of governmental and non-governmental institutions to deliver eye health services	3.1: Number of institutions providing eye health services		
		3.2: Percentage of facilities with the recommended staffing profile		
<b>Outputs</b>	<b>Output 1.1:</b> Increased geographical coverage of eye health services	1.1.1: Number of patients served per eye health care centre	<ul style="list-style-type: none"> <li>Health Management Information (HMIS) report</li> <li>Annual progress report</li> <li>Final evaluation</li> </ul>	<p>Greater commitment and support from key stakeholders</p> <p>No major changes in public policy</p>
		1.1.2: Number of outreach screening camps conducted		
	<b>Output 1.2:</b> 9156 free spectacles distributed to 457,800 screened children in schools	1.2.1: Number of schools screened		
		1.2.2: Number of children screened in school		
		1.2.3: Number of children provided with free spectacles		
	<b>Output 1.3:</b> 436,950 individuals reached with non-	1.3.1: Number of individuals screened		

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks	
	surgical eye health services (330,000 screenings, 106,950 refractions), prescribed 53,100 spectacles (3844 free)	1.3.2: Number of individuals receiving refractive error services			
		1.3.3: Number of individuals provided with spectacles			
	<b>Output 1.4:</b> 33,390 surgical procedures conducted (33,120 adult cataract surgeries, 200 paediatric cataract surgeries, 270 non-cataract surgeries (DR, LV, DCR, DCT etc.))	1.4.1: Number of adult cataract surgeries conducted			
		1.4.2: Number of paediatric cataract surgeries conducted			
		1.4.3: Number of other surgeries conducted (DR, LV, DCR, DCT etc.).			
		1.4.4: Percentage of patients classified as having positive surgical outcomes			
	<b>Output 1.5:</b> Sustainable referral network with government eye health service institutions established	1.5.1: Number of visibility events conducted	<ul style="list-style-type: none"><li>• Visibility event reports</li><li>• Referral agreements</li></ul>		
		1.5.2: Number of stakeholders supporting the project			
		1.5.3: Number of formal agreements within the referral network			
	<b>Output 2.1:</b> 2,262 awareness events (including 3 audio-visual events) conducted to	2.1.1: Number of awareness events conducted	<ul style="list-style-type: none"><li>• Project MIS</li><li>• Awareness event reports</li><li>• Focus group discussion with</li></ul>		
		2.1.2: Number of people reached through awareness events			

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
	reach approximately 2.35 million people	2.1.3: Number and type of IEC materials developed	the village development committee <ul style="list-style-type: none"><li>• Key informant interviews with community volunteers</li></ul>	
		2.1.4: Number of village development committees supporting awareness raising activities		
	<b>Output 3.1:</b> 17 functional vision centres and 3 optical dispensing units providing quality health services by year 2015	3.1.1: Number of vision centres established	<ul style="list-style-type: none"><li>• Project MIS</li><li>• HMIS report</li><li>• Quality assessment reports</li><li>• Training reports</li></ul>	
		3.1.2: Number of optical dispensing units established		
		3.1.3: Number of established facilities operating with a minimum agreed package of supplies and consumables for eye health service		
	<b>Output 3.2:</b> 2 government sub-divisional hospitals have improved infrastructure to deliver quality eye health services	3.2.1: Number of hospitals with required equipment to provide primary and secondary eye care services		
		3.2.2: Clinical protocol assessment score		
	<b>Output 3.3:</b> 7,382 eye health personnel trained to provide eye health services (2,520 RMPs, 98 ophthalmic paramedics and OAs, 3 optometrist prescription lab training, 17 vision technicians,	3.3.1: Number of eye health personnel trained		

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
	930 government health workers, 3,814 health ambassadors)	3.3.2: Number of village level health ambassadors trained		
	<b>Output 3.4:</b> 1,308 teachers trained to effectively screen children in schools	3.4.1: Number of teachers trained		
<b>Activities</b>				
<b>Output 1.1:</b> Increased geographical coverage of eye health services	1.1.1 Baseline survey( RAAB, RARE and KAP study)	Applicant organisation costs: US\$106,009 Support to local implementing partners: \$ 99,729 Service delivery costs: \$1,237,362 Communication - advocacy and community awareness: \$82,320 Training: \$67,474 Monitoring and evaluation: \$121,901		
	1.1.2: Establish vision centres (both stationary and boat) and optical dispensing units			
	1.1.3: Development and installation of map based MIS for access mapping			
	1.1.4: Conduct 2 outreach camps per VT per month for screening			
<b>Output 1.2:</b>	1.2.1: Conduct 1308 school screening events			

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
13000 free spectacles distributed to 457,800 screened children in schools and destitute adult	1.2.2 Conduct teachers training event			
	1.2.3: Establish system of centralized procurement of spectacles			
<b>Output 1.3:</b> 436,950 individuals reached with non-surgical eye health services (330,000 screenings, 106,950 refractions), prescribed 53,100 spectacles (3844 free)	1.3.1: Provision of non-surgical services through vision centres			
<b>Output 1.4:</b> 33,390 surgical procedures conducted (33,120 adult cataract	1.4.1: Provision of surgical services through the government and partner hospitals			

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
surgeries, 200 paediatric cataract surgeries, 270 non-cataract surgeries (DR, LV, DCR, DCT etc.)				
<b>Output 1.5:</b> Sustainable referral network with government eye health service institutions established	1.5.1: Establish formal systems for referral between primary, secondary and tertiary services			
	1.5.2: Conduct stakeholder meeting through bi-annual reviews			
	1.5.3: Develop business plans for the VCs along with the partner hospitals			
	1.5.4: Establish informal learning links between partners including technical quality issues			
	1.5.5: Conduct district / state level advocacy through celebration events			

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
	1.5.6: Convergence meeting/bi-annual review with NRHM and SSM, health department for programme support			
<b>Output 2.1:</b> 2,262 awareness events (including 3 audio-visual events) conducted to reach approximately 2.35 million people	2.1.1: Conduct community awareness events			
	2.1.2: Development and distribution of IEC materials			
	2.1.3: Conduct radio awareness programmes			
	2.1.4: Formation of village development committees			
	2.1.5: Sensitization of opinion leaders and health ambassadors to spread knowledge about safe eye health practices			
<b>Output 3.1:</b> 17 functional vision centres and 3 optical dispensing units	3.1.1: Establishment of vision centers in private places or in govt. BPHC/PHCs			
	3.1.2: Establishment of 3 no. of optical prescription lab at			



Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
providing quality health services by year 2015	non-government partner location			
<b>Output 3.2:</b> 2 government sub-divisional hospitals have improved infrastructure to deliver quality eye health services	3.2.1: Renovate 2 sub-divisional hospitals for delivering quality eye health services			
	3.2.2: Procurement and setting up of required equipment at sub-divisional hospitals			
	3.2.3 Clinical assessment and setting up quality standards in the hospitals			
<b>Output 3.3:</b> 7,382 eye health personnel trained to provide eye health services (2,520 RMPs, 98 ophthalmic paramedics and OAs, 3 optometrist	3.3.1 Training of project staff towards output deliverables			
	3.3.2: Training of 2,520 RMPs by the optometrist			

Headings	Statement	Indicators	Means of Verification	Assumptions / Risks
prescription lab training, 17 vision technicians, 930 government health workers, 3,814 health ambassadors)	3.3.3 Conduct training programme for 98 ophthalmic paramedics and OAs, 3 optometrist for prescription lab, 17 vision technicians, 930 government health workers.			
<b>Output 3.4:</b> 1,308 teachers trained to effectively screen children in schools	3.4.1: Orientation of School teachers			

## Appendix 17: MTR recommendations status update

### Management Response and Recommendations Action Plan

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**Evaluation Report Title:** Mid term Evaluation Report of Sundarbans Eye Health Service Strengthening Project

**Date of Response (dd/mm/yyyy):**

This management response was produced by Arundhati Bhattacharjee, Program Officer (Name) and recommendations action plan will be followed up by Sudipta Mohanty, Area Director (CD or Programme Manager).

### Recommendations Action Plan

Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators’ assessment of status
1	To better understand the actual prevalence of URE in school children, do a quality check on the school screening processes by conducting on-campus screening by optometrists, to check if the 1.4% RE presently being reported is accurate.	Accepted	High	A refresher training is planned for the Optometrists and Project Coordinators on minimum standards, process monitoring indicators, spectacle uses and its safety standards. The training will further percolated to the next level of cadres’ i.e. Vision Technicians and Community Health Workers.	Sightsavers	June 2017	The training has been conducted by a senior Optometrist of School Eye Health Project, Odisha.	<b>Completed</b> – Although a formal survey was not conducted, A senior Optometrist did review the school screening procedure from School eye health project. A second phase training was conducted with all 17 VTs and 42 community health workers. Optometrists are attending the school screening events to support and monitor the screening procedures done by VTs. The number of dispensed spectacles amongst school children have increased from earlier time.	<b>Completed</b>

Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If "Accepted", Action plan for Implementation or if "Rejected", Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators' assessment of status
2	Monitor process indicators related to the school screening process.	Accepted	High	A list of qualitative and quantitative indicators will be developed and shared with the project team to comply with the process and maintain the quality.	Sightsavers along with implementing partners	June 2017	<p>This has been done. A checklist</p> <p>And a standard procedure has been</p> <p>Shared with the team.</p>	<p><b>Completed-</b> A checklist and a standard procedure has been shared with the team. All children who were screened in the school screening and identified with refractive error were referred to the vision centre. Out of screened children, around 1.2 / 1.3% children have refractive error.</p> <p>However, any formal or structured tracking system is not available to verify the completion of referral. But follow up is being done by the community health workers through follow up with school teachers.</p>	<p><b>Partially completed</b></p> <p><b>The recommendation was to monitor process indicators. The response here indicates that while a checklist was created, there was no formal or structured tracking system.</b></p>
3	To improve uptake of spectacles by children in need of correction	Accepted	High	A spectacle compliance study has been planned to understand the	Sightsavers	December 2017	The study tool has been finalised	<b>Completed -</b> A study on spectacle compliance was conducted to understand how compliant people were with wearing spectacle and	<p><b>Partially completed</b></p> <p><b>The report remains in draft form.</b></p>

Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators’ assessment of status
	through a number of measures			usage of spectacles amongst children and also to analyse the perceived reasons and barriers for non-usage of spectacles			The study is now waiting for its ethical Clearance.	to understand some of the key drivers of patients’ behaviour. 424 adults and children were interviewed as part of this study. It was found that overall, spectacle use has been higher among women beneficiaries (93%) compared to men beneficiaries (90%) and higher among boys (95%) compared to the girls (92%). 46% of the respondents amongst adults reported that ‘good quality’ has been the main driver, followed by ‘safe glasses’ (30%). A small proportion of respondents also reported that ‘cheap/free glasses’ (8%), ‘accurate glasses’ (6%), ‘attractive style’ (5%) drive them to use their spectacles more.	

Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators’ assessment of status
								As regards the gender of the respondents, there was hardly any difference observed. Therefore, quality remains a top priority for adult patients according to the survey. As regards the gender of the respondents, higher proportion of boys (39%) mentioned ‘good quality’ has been the main driver, compared to the girls (27%). The survey provides a good body of knowledge and evidence to support learning and future project planning. We also observed that the spectacle conversion rates have increased in the vision centres where 11 out of 17 vision centres have spectacle conversion rate above 80% and the rest 4 centres are above 75% and 2 centres are above 70%	



Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators’ assessment of status
4	Establish robust record keeping process at screening camps to capture individuals’ screening outcomes, contact details and referral status. The referral uptake should be matched with these data.	Accepted	High	The MIS system at the vision centre level will be further streamlined so that individual patient data screening outcomes, contact details and referral status are recorded systematically and uniformity is there across the vision centres.	Sightsavers & Partners	December 2017	The trouble areas have been  Addressed with the service  Provider agency. A visit is planned  In October, along with the Project  Coordinators and IT Person from each  Partner NGOs  to resolve the issues.	Partially completed - A visit to the MIS service provider was done along with the project coordinators and IT person from each partner organisations. However, the MIS system does not have a mechanism to track patients attending camps or referred for cataract surgeries. Though CHWs are doing follow ups through home visits. The patients who are attending vision centres only they are captured through the MIS system. Out of 17 vision centres 8-9 vision centres are implementing the MIS system and others are not able to do it due to several issues like technical errors , new VTs do not have the training to do it etc.	Partially completed

Evaluation Recommendations (A)		Accepted/ Rejected (B)	Priority High/ Medium/ Low (C)	If “Accepted”, Action plan for Implementation or if “Rejected”, Reason for Rejection (D)	Responsibility (E)	Timeline (F)	Update Sep 2017	Update for ETE Oct 2018	Evaluators’ assessment of status
5	Work with SSA to screen all the children they have identified having any kind of disability, and document their eye status and those of their siblings and family	Accepted	Medium	One of the implementing partners authorised by SSA is already implementing this. A meeting with SSA is being planned to conduct a state level of training of teachers.	Partners	January 2018	A letter has been sent to the SSA Dept.  Seeking date for a meeting.	<b>Not addressed</b> - The Sarba Siksha Mission (Education for All) under School Education Dept. was approached for training of special educators to identify children having visual disability or any kind of disability. However, SSA already has a school eye health program where they have assigned specific NGOs for facilitating school eye health program. Since the number of special educators are very less in both the operational districts, so the proposal of conducting state level training for special educators and collaborating with SSA did not work out well. However, as we are training teachers in every schools where school	<b>Not addressed</b>

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							screening is conducted so the teachers are well aware of the visual disability and are able to identify the same and refer.	
6 Consider retargeting for paediatric cataract within this project period.	Accepted	High	All children attending anganwadi centres under ICDS Scheme in the project location will be screened during the rest of the project period. A proposal has been submitted to the Dept. of Child Development, Women Development and Social Welfare, Govt. of West Bengal. 200 anganwadi workers will be trained as master trainers so that they are capable	Sightsavers & Partners	ongoing process.	The project has already received Approval from the Dept. of Child Development regarding screening of all children in ICDS centres in the project location which is being implemented. So	<b>Completed-</b> The targets for the paediatric cataract was revised within the project period around April 2017. After that, an approval from the Dept. of Child Development was received to screen the children below 6 years who are attending the ICDS centres (Anganwadi centres) in the project location. Until 31 <sup>st</sup> August 2018, the project has been able to support 102- paediatric cataract surgery against a target of 100.	<b>Completed</b>

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				to identify children with eye ailments even after the project is over.			far the project has facilitated surgery of 84 children since beginning of the Project.		
7	Capture more accurate figures on positive surgical outcomes (the present data cannot be interpreted clearly)	Accepted	High	The discharge vision of the surgery patients are recorded at the base hospital. The community health workers will make sure and put extra efforts so that these surgery patients visit vision centre after 45 days for measuring the more accurate visual acuity and positive surgical outcomes.	Partners	Ongoing	Ongoing	<b>Partially completed-</b> The positive surgical outcomes are recorded at the base hospital during discharge. Though the 6 weeks follow up is being done at the vision centre. But patient wise streamline record keeping system is to be generated to keep the complete track of the patient.	<b>Partially completed</b>

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8	Towards building community ownership, the project should initiate village/panchayat level eye health committees, independent of the MoU with the State Government, and link that to the Health Ambassadors, the ASHAs, the RMPs and the teachers where appropriate.	Accepted	Low	There are existing village health, sanitation and nutrition committees comprising of Health Ambassadors, ASHAs, RMPs and teachers. Instead of creating new committee these committees may be oriented on eye health issues.	Partners	Ongoing	Ongoing	<b>Completed</b> - The project has trained all possible stakeholders in the community to ensure community ownership. All stakeholders including rural medical practitioners, health ambassadors, teachers, self-help group members, youth club members, government health workers were trained during the project period. There are many village and block level committees on development and other social issues where these people are part of that committee.	<b>Not addressed</b>  <b>The original recommendation was accepted but the implementation plan was an alternative course of action involving reliance on existing committees, to which some of the project’s trainees may belong. In the absence of any follow up of trainees to track their opportunities to influence, or evidence that the various committees did take up eye health issues, the evaluators consider that recommendation was not implemented.</b>

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9	Conduct an analysis of footfalls per VC working hour over the past 3 months to assess the interpretive value of this as alternative metric. In addition further explore and document the apparent variation in performance of the project VCs to identify key strengths and weaknesses in operational practice.	Accepted	High	The consultancy agency will be providing support to the vision centres which needs further improvement in operational practices. Capacity building of the staffs will be done in order to ensure the effectiveness.	Sightsavers	Ongoing	<p>The consultancy agency has been</p> <p>Engaged again based on focused</p> <p>Deliverables spread across 8 months.</p> <p>The major focus has been given on</p> <p>The strengthening of vision centres</p> <p>Which were weaker in terms of</p>	<b>Completed</b> – VC Analysis is being done every month in terms of key performance indicators like screening, refraction, spectacle conversion and cost recovery and shared with partners. Stronger and weaker VCs are being identified based on these indicators. The consultancy agency engaged in this project is providing special hand holding services to those VCs. The handholding support was focused towards achieving financial sustainability of the vision centres and capacity building of the staff. At the end of the project 11 out of 17 VC are able to recover its cost above 100%, 1 above 90%, 2 above 80% , 2 above 70% and 1 centre is above 55%	<p><b>Partially completed</b></p> <p><b>The recommendation was specifically about footfalls analysis, which does not seem to have been included in the support provided.</b></p>

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							Performance and capacity building Of the staffs.		
10	Conduct training for VC staff on spectacle conversion and set up	Accepted	High	The same consultancy agency will be hired for another 12 months to continue support. Major focus will be given to sustainability of VCs, following the business plans.	Sightsavers	Ongoing	Same as above.	<b>Completed</b> – Training of VC staff on spectacles product and sales were a continuous process in the project. Apart from the regular training, the VTs were sent to a reputed eye institute for special training on spectacles. All these training inputs have helped in achieving more than 80% conversion rate in vision centres. As a result 11 out of 17 vision centres have spectacle conversion rate above 80% and the rest 4 centres are above 75% and 2 centres are above 70%.	<b>Completed</b>



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11	Look for opportunities for expanding the viability and productivity of optical labs.	Accepted	High	Further discussions will be held with the management/ administration of the partner’s base hospitals where these Optical Labs are located. The project will make sure that other than grinding /compound power the plano powers are available with the Optical Lab to avoid of going to other vendors and make it economically viable.	Partners	December 2017	Not yet explored much .	<b>Completed</b> – The optical labs are centralised and located at the base hospital. But to minimise the spectacle delivery time the project has also upgraded 2 remote VCs with cutting and edging machine in each partner’s location.	<b>Completed</b>
12	Review strategies to maximise the ongoing effectiveness of the RMPs and Health Ambassadors.	Accepted	High	A study has been planned to assess the effectiveness of the training and linkages established with RMPs in terms of referring more	Sightsavers	November 2017	A study tool has been finalized  And waiting for its ethical clearance.	<b>Completed-</b> A study with RMPs was conducted where 324 RMPs were involved in the research studies. The findings revealed that 66% RMPs are referring patients to	<b>Partially completed</b>  <b>The recommendation covered both RMPs and HAs, and the focus was on strategies for maximising their</b>

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				patients to vision centres for treatment and surgery related services. The study will be conducted based on the sample size taken from the RMPs trained in Sundarbans since year to date of the project.				vision centres for cataract surgery and uptake of spectacle services. The RMPs are also organising outreach camps in their locality.	<b>effectiveness. The action taken was a study of RMP activity only. This produced useful insights. The HA role was not reviewed.</b>
13	Review the role of teachers in the school eye health component to ensure their role is appropriate and achievable for them, and is also effective in meeting the needs for identification, screening, and continued compliance of spectacle use among children	Accepted	Medium	One partner of SiB project is authorised by SSA to conduct school screening in Sundarbans. Advocacy with Government will be initiated so that screening of children by teachers may be mainstreamed in the school health program.	Partners	Ongoing	Ongoing	<b>Partially complete-</b> Motivation level of the teachers was found low due to heavy workload. In some schools, we found teachers are very proactive and helping the school screening process based on individual rapport and the interest of the teacher. But overall, the VTs and the CHWs are facilitating the process of screening.	<b>Partially completed</b>

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14									
	The management of VCs needs to be more business-like, using performance metrics selected from among those recommended by the business analysis by the Think Through consultancy report on supply chain management.	Accepted	High	An external agency will be providing support to vision centres for implementing the business plans.	Sightsavers & Partners	Ongoing	<p>An external agency has been engaged.</p> <p>This time the support will be focused</p> <p>More to business oriented. A major focus</p> <p>Has been given on setting sales targets of</p> <p>Spectacles and sunglasses for VC and</p> <p>Outreach camps. The staffs will be</p>	<b>Completed</b> - The sales consultancy agency has provided monthly hand holding support to the vision centres as per the business analysis. The vision centres have improved sales and footfalls in the VCs now. 11 out of 17 VCs are able to recover its cost beyond 100% and 11 vision centres have spectacle conversion rate above 80% and 6 above 70%.	<b>Completed</b>

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							Trained on how to track targets and new and Innovative sales techniques as per age, gender and location.		
15	Each of the VCs should be managed with targets, become part of the internal reporting system and analysis, and analytical reports should be presented as a distinct component of the project 6-monthly report. The capacity for this is needed in partner	Accepted	High	A meeting with the service provider will be held for restructuring the MIS system to generate reports on a monthly basis. The report will focus on patient location, services offered distribution of new and follow up patients and user fee raised. The VC staffs will be oriented to	Sightsavers along with implementing partners.	October 2017	A visit to Sadguru Seva Trust (MIS Service Provider) is planned in October 2017.	Partially complete - A visit was undertaken to the service provider with the partner staff and discussion held related to the VC software. The VC software is being implemented in 10 out of 17 VCs. In some of the VCs due to poor electricity and technical issues, the MIS could not run properly. The changes of VC staff also led to joining of new people who were not much acquainted with the software and that	Partially completed

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			leadership, VC staff and Sightsavers team.				affected continuous implementation of the VC MIS.	
16	Accepted	High	The MIS urgently needs to be operational at all centres and modified so as to ensure continuity of VC data capture/GIS transfer	Sightsavers along with partners	October 2017	A visit to Sadguru Seva Trust (MIS Service Provider) is planned in October 2017.	Same as above	Partially completed
17	Accepted	High	The external agreement for ongoing GIS analysis should be actioned and a clear timeline for transfer of data from VC to the external agency each quarter outlined and adhered to.	Sightsavers	Ongoing	An individual consultant has been Engaged and she is currently pursuing her work on GIS. 27 maps	Completed - The external consultant has prepared GIS analysis based on patient data who are accessing services from vision centre. The patient data was analysed as uptake of services, conditions diagnosed, sex and gender wise reach. The GIS maps were shared with the project team so	Partially completed  The recommendation and implementation plan refer to quarterly reporting and maps, not six-monthly.

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							Have been developed and will be  Disseminated amongst staffs. Staffs  Will be trained on analysing and using  The data for effective outreach planning.	that these GIS maps can be used as a monitoring tool.	
18	A distance-time coverage analysis needs to be undertaken so as to provide a basis for the comparing expected versus actual coverage.	Accepted	High	Better road info and ferry routes will be incorporated in the GIS. This will help to understand the geographical accessibility, model spatial coverage of the existing VC or primary health	Sightsavers	In process	This has been incorporated  While discussing the deliverables.	Completed - Same as above	Not addressed  GIS output maps did not provide the road and ferry route information, and distance-time analysis was not done.

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				facility network, estimate the number of primary health facilities working under capacity and the population underserved in the area.					
19	Sightsavers project staff to undertake review of the log frame with support from global staff, to determine indicators which will be used for the remainder of the project term, and clarify plans for their collection and reporting.	Accepted	High	Every six month the log frame is being reviewed and accordingly action plan is being developed and reported for the next reporting period.	Sightsavers and HH	In process	In progress	<b>Completed</b> – Some of the indicators were reviewed every quarter and on a six monthly basis. The log frame was reviewed before the project ended.	<b>Not addressed</b>  <b>The evaluators believe that this recommendation was misunderstood. It was interpreted as reviewing the project targets (which was done via the LoV) and reporting on the existing logframe indicators, whereas the recommendation has been to review the indicators themselves. This would involve potentially changing</b>



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									or prioritising them and revisiting the related data to be collected. An example would be service quality indicators, whose absence is discussed in the report.
Additional Actions (G):									