# Advancing Healthy Communities – Affordable, Accessible and Quality Eye Health Services in Mozambique, Malawi and Zimbabwe
# **Executive Summary**

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### 1.1 Description of programme

The *Advancing Healthy Communities (AHC) programme* aimed to develop a mid-level eye care workforce to increase access to eye health services and to reduce the cataract surgical backlog in Malawi, Mozambique and Zimbabwe.

### 1.2 Evaluation objective and purpose

The end of programme evaluation addressed the following:

- Establishing to what extent the programme has contributed to improved eye health and prevention of avoidable blindness through the development of mid-level eye health professionals, and improved quality and quantity of cataract and other eye care services
- Measuring to what extent the programme has fully delivered outputs and attained outcomes
- Measuring cross-country learning and initiatives that have contributed to the programme and have provided added value to the regional structure.

### 1.3 Methodology

The evaluation approach was structured in line with the widely acknowledged evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. The further criteria of scalability and coherence were also added, as well as an emphasis on eliciting the lessons learnt throughout the programme. Data collection for the evaluation targeted programme staff and key stakeholders for in-depth interviews, as well as programme beneficiaries for a combination of interviews and focus groups.

### 1.4 Main findings

The AHC programme generally performed successfully after evaluations mid-way highlighted weaknesses in project design and implementation. A stronger focus on targets adapted for each country context, deliberate capacity building of lead partner institutions to manage towards targets, and flexibility in the use and management of resources resulted in most goals being met by the project's end.

Malawi, initially selected to coordinate the project in the other two countries, began work on the AHC programme with the most experience and existing infrastructure in eye health. Having run a mid-level cadre training programme in the past, Malawi generally performed strongly on the AHC project, particularly with regards to PEC integration into PHC, development of a robust curriculum, and regular support and supervision of deployed mid-level cadres by ophthalmologists.

Mozambique started with a high cataract surgical backlog – especially in Nampula Province – and very low human resource capacity. In addition, role definition and clarification of responsibilities regarding project management during the first two years of the programme slowed implementation. However, performance on mid-level cadre training and deployment, monitoring of surgical outcomes and understanding of eye health within government recovered once a management structure between the two provinces of operation was established. PEC worker training and integration into PHC proved less successful than in other country locations. One of the main factors affecting this was the lack of monitoring and support to recently-trained ophthalmic technicians by MoH Provincial Eye Health Coordinators, making the outcome of PEC worker training difficult to assess. Development of tools to effectively follow up on newly trained ophthalmic technicians would therefore be important in the future. As in Malawi, challenges with consumables and equipment supply frequently came up in the evaluation. However, the change in number of deployed eye care personnel and increasing government appreciation of eye health were key achievements of the programme.

Lastly, Zimbabwe had a challenging start to the programme because of the country's governance and economic environment and poor initial management arrangements for the country project. While there was limited success in the development of substantial additional capacity for cataract surgery, the training of ophthalmic nurses (OPNs) progressed well under the direction of the Parirenyatwa School of Nursing, growing this cadre significantly over the five years. Activities in Zimbabwe had a stronger focus than in other countries on integrating PEC into PHC. Zimbabwe was able to build capacity and a health care workforce at the primary level during the second half of the programme. Advocacy activities resulted in the production of a policy brief and position paper on PEC into PHC integration.

**1.5 Implications of findings**

The Advancing Healthy Communities Programme in Mozambique, Malawi and Zimbabwe began with very mixed results and slow performance, but over the course of its final two years achieved the majority of its goals. The project targeted the mid-level of the health system as the key to increasing the accessibility of eye health to rural communities and reducing the incidence of blindness in the region. Strengthened human resource capacity at this level, also enhanced the integration of PEC into PHC where the programme mobilised the village health worker cadre to support the role of mid-level eye health staff. Generally this was accomplished successfully, as shown by increased numbers of eye health staff deployed at the mid-level, and improved use and functionality of referral systems. The programme also had a positive effect on the technical capacity of training institutions, as all plan to continue to offer this training in future.

The project had some difficulty in establishing accurate baseline figures for cataract surgical rates (CSR). This matter was extensively addressed during the retrospective baseline and it was recommended that performance would be tracked against baseline figures. Recommended baseline figures as supplied by the retrospective baseline review were not used: instead the AHC Regional Programme Coordinator (RPC) reported that the project had calculated CSR for base

years in each country – being 2010 for Malawi and Mozambique and 2011 for Zimbabwe and the regional programme – and then calculated its target based on this figure[1]. Using this method of calculation, targets were shown to have been achieved across all levels of the programme.

The work of the advocacy component made a difference to understanding of eye health within the national and district/provincial government, however this has not yet translated into adequate allocation of resources to eye health. Therefore while the project was successful in demonstrating how a multi-country and multi-stakeholder approach to building health systems can work, there are still outstanding areas – as indicated earlier in this paragraph – to be addressed.

The continued success of the project will highly depend on each Ministry of Health's (MoH's) ability to secure the resources needed to follow through on key elements of the programme, and on the process through which Sightsavers hands the project over. It will be key that a clear strategy for continuing activities at national and regional level is devised in order for the project to maintain the benefits delivered.

Two repeated themes that fell outside the immediate scope of the AHC project's delivery but were consistently raised during the end of term evaluation by mid-level eye health professionals as critical, ongoing challenges were:

- Difficulties with procurement and maintenance of consumables and equipment for work at mid-level; and
- Mid-level cadres – while motivated by the impact of their work on beneficiaries – being unclear on their career paths.

These have been noted in this report as key areas for lessons learned that are likely to reoccur on future projects of a similar nature, and are detailed in Appendix F.

### 1.6 Recommendations

**Programme Conceptualisation and Planning**

1. Conduct detailed in-country situational analyses as part of proposal development and collect quality baseline data in the first year of new programmes.
2. Consult expertise at regional and country offices on feasibility and existing needs, and to develop any specific programme elements, such as monitoring and evaluation, and programme management approach. Planning for each country should include all members of relevant teams from the start, including both programme and finance staff, and ensure that highly skilled project staff are recruited for implementation.
3. Develop tools, systems (including meeting cycles) within the first six months of project and ensure targets are tailored to country specific contexts and are realistic given circumstances at project start-up, including a resource guide that provides definitions of the 'common and shared language' embedded within the project and associated with specific activities and targets.

**Overall Programme Management**

4. For any multi-location programmes involving multiple partners, embed management approach and activities within project design to actively cultivate successful elements of and relationships supporting partnership approach. Regional Programme Coordinators should embody this approach.

5. The complementary programming approach taken by Sightsavers Nampula – which allows for support for other eye conditions when screening and treating for trachoma (new TT+ programme) – should be adopted wherever possible by other projects addressing trachoma.

**Programme Learning**

6. Learning arising through use of project tools (e.g. quality of life tool; situational analyses of readiness for integration of eye health into district health plans) should be shared internally and with key regional eye health forums (such as IAPB Africa).
7. Provide for IT-based Continuing Professional Development (CPD) for mid-level eye health professionals in each of the three countries through structured programmes housed at training institutes that facilitate online discussion groups, case discussions/case studies, advice/problem solving, and regularly updated links to resources and best practices involving available ophthalmologists/cataract surgeons and other mid-level eye health professionals.

**Programme Evaluation**

For future project reviews employing FGDs:

8. Ensure that evaluation team is advised well before the time on the indigenous language requirements of groups so that appropriate arrangements can be made for interpreting of indigenous languages.
9. Request the evaluation team to develop a checklist outlining criteria for composition of groups to ensure that clinic staff involving in recruiting groups can use the checklist in their selection of a representative sample in line with evaluation requirements. Obtain collective verbal consent at the start of FGDs rather than formal written consent.

**Advocacy**

Key opportunities that have emerged through this programme and can be implemented at a regional level:

10. Document and share evidence and approaches to key advocacy activities such as the development of policy and position papers, introduction of policy change and training curricula, lobbying for equipment and consumables at regional level; and understanding of community attitudes and traditional practices to cure blindness, and how to address these.
11. Support push for increased cataract surgery capacity through development of cadres that are recognised within the national health system and have a clear career path. Ensure that the cadres developed are aligned with possibilities within each country (e.g. Malawi to introduce training on OPNs for cataract surgery) and that this support is available and career paths mapped before training mid-level eye health professionals.
12. The Sightsavers Regional office should continue to engage with Southern African Development Community's (SADC's) Health and Pharmacy Division around the integration of eye health into primary health in order to ensure that the gains made thus far are not lost. Given efforts needed to achieve this commitment, it would be in Sightsavers' interest to develop a clear strategy on how this will be pursued.
13. At programme inception, develop sustainability strategy for advocacy group member organisations performing advocacy work on a voluntary basis.

**1.7 Evaluation ratings**

GreaterCapital has understood the evaluation ratings system provided by Sightsavers to refer both to end of term performance and achievements, as well as the project's performance across the entire five-year period of the project.

With regards actual ratings, it is acknowledged that performance across the project was overall very strong during the period mid-2012 to end-2014. If this period alone had been the focus of the review, ratings per country and at regional level would have been higher. However, poor performance at a number of levels across the programme during its first half cannot be discounted during a full term review such as this. As a result, we have adjusted our ratings to take stock of weaker performance during the first half of the project period, as well as strong recovery during the second half.

In addition, we have recorded some ratings as satisfactory but have noted in the narrative component of the report that there may still be some areas that require attention going forward in such cases. We thus request that the ratings are not simply interpreted in isolation from our narrative content detailing specific findings and recommendations.

**Relevance**

| | |
|---|---|
| **Regional** | **Highly satisfactory**  |
| **Malawi** | **Highly satisfactory**  |
| **Mozambique** | **Highly satisfactory**  |
| **Zimbabwe** | **Highly satisfactory**  |

**Effectiveness**

| | |
|---|---|
| **Regional *Rating*** | **Satisfactory**  |
| **Malawi *Rating*** | **Satisfactory**  |
| **Mozambique *Rating*** | **Satisfactory**  |
| **Zimbabwe *Rating*** | **Satisfactory**  |

**Efficiency**

| | |
|---|---|
| **Regional *Rating*** | **Satisfactory**  |
| **Malawi *Rating*** | **Satisfactory**  |
| **Mozambique *Rating*** | **Satisfactory**  |

| | |
|---|---|
| **Zimbabwe *Rating*** | **Satisfactory**  |

**Impact**

| | |
|---|---|
| **Regional *Rating*** | **Satisfactory**  |
| **Malawi *Rating*** | **Highly satisfactory**  |
| **Mozambique *Rating*** | **Highly satisfactory**  |
| **Zimbabwe *Rating*** | **Satisfactory**  |

**Sustainability**

| | |
|---|---|
| **Regional *Rating*** | **Satisfactory**  |
| **Malawi *Rating*** | **Satisfactory**  |
| **Mozambique *Rating*** | **Highly satisfactory**  |
| **Zimbabwe *Rating*** | **Caution**  |

**Coherence/Coordination**

| | |
|---|---|
| **Regional *Rating*** | **Highly satisfactory**  |
| **Malawi *Rating*** | **Satisfactory**  |
| **Mozambique *Rating*** | **Satisfactory**  |
| **Zimbabwe *Rating*** | **Highly satisfactory**  |

**Replicability/Scalability**

| | |
|---|---|
| **Regional *Rating*** | **Satisfactory**  |
| **Malawi *Rating*** | **Satisfactory**  |
| **Mozambique *Rating*** | **Satisfactory**  |
| **Zimbabwe *Rating*** | **Satisfactory**  |