Final Evaluation and Impact Assessment of the Programme

Reducing Poverty through Improved Eye Health in the "Post Health for Peace Initiative" in The Gambia, Senegal and Guinea Bissau 2009-13

Funded by the European Union and Sightsavers

Guinea Bissau Country Report

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Acronyms

CHW	Community Health Worker	OIC	Officer In Charge
CSR	Cataract Surgical Rate	PEC	Primary Eye Care
DPO	Disabled Persons Organisation	PHC	Primary Health Care
EU	European Union	PHFPI	Post Health For Peace Initiative
FGD	Focus Group Discussion	PMU	Programme Management Unit
HFPI	Health For Peace Initiative	PO	Programme Officer
HMIS	Health Management Information System	RAAB	Rapid Assessment of Avoidable Blindness
HRD	Human Resource Development	ROM	Results Oriented Monitoring
HReH	Human Resources for Eye Health	RHT	Regional Health Team
IAPB	International Agency for Prevention of Blindness	ROTP	Regional Ophthalmic Training Programme
IEC	Information, Education, Communication	SSI	Semi Structured Interview
IEWs	Integrated Eye Workers	SZRECC	Sheikh Zayed Regional Eye Care Centre
INASA	National Institute of Public Health		
IOL	Intraocular Lens	TP	Traditional practitioner
KAP	Knowledge, Attitude, Practise	VHWs	Village Health Workers
LPED	Local Production of Eye Drops	V2020	Vision 2020
MOU	Memorandum of Understanding	WAHO	West African Health Organisation
MOH	Ministry of Health	WHO	World Health Organisation
PNSV	Programa Nacional da Saude da Visao		

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Sightsavers

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EXECUTIVE SUMMARY

Programme Description: The Post Health for Peace Initiative (PHFPI) 2009-2013 is a three country project implemented in Senegal, Guinea Bissau and the Gambia with a funded budget of EUR 6,041,392; it followed on from the successful Health for Peace Initiative (HFPI) 2001-2006 initiated by the Heads of State of Guinea Bissau, the Gambia and Guinea Bissau. The specific objective of the PHFPI is to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions and thus contribute to the overall objective of contributing to poverty alleviation through the prevention of avoidable blindness. In Guinea Bissau it has been implemented in 4 of the 11 regions of the country. The total budget was EUR 922,298.

Purpose of evaluation: The primary aim of this evaluation is to assess progress and impact of the project in Guinea Bissau. Specifically, the evaluation sought to assess the implementation of project activities against final results with the aim of assessing the achievements, the processes affecting them, their sustainability, key lessons, the contribution to expected impact and the contribution of multi-country collaboration.

Methodology and Analytic Strategy: The evaluation methodology comprised: agreement of the approach outlined in the inception report, document review and analysis, field visits to each of the three countries by members of the five person evaluation team, and analysis of the findings using a common framework reflected also in the three reports. The field visits each included a technical review of a sample of eye units, interviews with national and regional health actors and partners, and focus groups with beneficiaries and community level stakeholders; this was complemented by a quantified survey of 250 service users exploring their experiences, attitudes and the impact on their lives.

Limitations: The time allocated to fieldwork was insufficient, resulting in 2 of 4 project regions being visited by the evaluation team. Much eye health data was not collated or analysed, requiring a considerable time investment by the evaluators to obtain and cross check basic data with PNSV and Sightsavers. Outcome indicators did not have baselines and had not been monitored.

Relevance: There were clear unmet needs for eye care services in the Guinea Bissau intervention areas before the project began with a high level of blindness in adults aged 50+ and a much higher proportion suffering from avoidable causes than WHO estimates. All stakeholders agreed the project was highly relevant to eye care needs in the intervention areas.

The project design was appropriate for addressing eye care needs in the project areas and it remains relevant to ongoing needs. However, there were some weaknesses in the generic project design that did not take account of the specificities of the Guinea Bissau context. In particular, the phased approach, starting in one region each year, combined with the longer lead time for staff training, meant that the human resources necessary for

delivering the eye care service delivery targets were not in place in time to introduce service delivery until much later on in the project.

Effectiveness: Given its low starting point, human resource training needs and political context good progress was achieved by the end of the project period in achieving training and infrastructure targets. In meeting some of its service delivery targets however the project was required to adopt strategies unsuitable to establishing sustainable health seeking behaviour patterns amongst the population.

Outreach campaigns have made eye care accessible to remote rural regions: awareness and acceptance of eye care services increased considerably. At national level, there is greater recognition of the importance of eye care within the Ministry of Health. However, there has been little evolution in the planning and coordination of eye care; it remains centrally controlled with limited involvement by regional health teams. Although eye care services have been established in the four regions, they are new and fragile; comprehensive eye care service provision, including refractive error and low vision services, are not yet available in response to need. Clinical targets of the project, excepting Vitamin A distribution were not achieved.

The Guinea Bissau training targets however for eye health and non-eye health cadres were met and/or exceeded and those trained are capable of meeting most common eye care needs and promoting community eye health. A system of routine supervision and refresher training to consolidate and further develop skills is being taken forward.

Infrastructure targets for refurbishing and constructing 6 eye units were met. Some design issues were addressed after the MTR but shortcomings to design and construction quality remain. Targets for equipping the eye units were met; eye care equipment is aligned to IAPB guidelines and found to be adequate in type/quantity, in working order and good condition.

The referrals of patients between different levels of the health service are not routinely tracked and the numbers of 'walk-in' patients presenting at eye units not recorded systematically by the HMIS or by eye unit staff. However, it is evident that the outreach strategy has raised awareness of eye health services and community attitudes are beginning to change: there is less fear of eye treatment and more willingness to seek treatment.

The project has been less successful in building organisational capacity. Regional health teams (RHTs) were involved in initial project design and welcomed the project but were not included by PNSV in routine planning and management of project activities. The PNSV focused its coordination efforts on eye health staff with little direct contact with the RHTs, who do not have a sense of ownership. The only capacity-building support for RHTs took the form of transport logistics.

Efficiency: Effective programme management is essential for making best use of project resources, mitigating risks and ensuring that opportunities and challenges are closely monitored and acted on. Overall, there was a good

level of oversight of project activities but less attention was paid to the volume of service delivery outputs, the nature and volume of the outcome indicators and to addressing strategic issues in Guinea Bissau, such as that of integration of eye care within the overall health system.

The project's level of financial transparency and accountability was a considerable achievement. The procurement of capital items and consumables was relatively efficient, but was not integrated into national systems. This creates a challenge in terms of sustainability, particularly in respect of medicines and consumables. The financial management system ensured centralised control and minimised potential risks to Sightsavers but created some inefficiencies and missed opportunities in project implementation. There was insufficient data to calculate unit costs and evidence on cost effectiveness is anecdotal. A senior Ministry of Health (M0H) source said that this is considered among the ministry's most cost-effective projects but without good data, it is difficult to demonstrate that the project is cost effective.

Coordination and Coherence: Eye health is aligned with the health systems in Guinea Bissau and the programme is consistent with the objectives of the guinea Bissau health strategy. In common with other vertical programmes in Guinea Bissau, eye health operates largely as a vertical service with centralised decision-making and resource flows and is not well integrated into general health management systems. Sightsavers does not appear to have pursued opportunities to collaborate with broader civil society on PHFPI, especially disabled persons organisations (DPOs). This could have added significant value to the programme, through more inclusive planning and review mechanisms and in forwarding influencing agendas.

Impact: Despite the lack of robust baseline and monitoring data, the programme achieved some significant gains. Cataract surgery rates (CSR) increased after a strategy of successive outreach campaigns was adopted. Key outcome indicators have not been tracked by the project however. Although a national CSR of 916 achieved in 2013 is up substantially from 111 in 2009, it remains below the WHO target of 2000. Cataract surgeons trained in The Gambia received training in the use of the monitoring tool but despite this the cataract outcome monitoring tool is not being used to monitor the quality of surgical outcomes. It was not therefore possible to assess whether the RAAB good outcome figure of 25.2% has improved.

There is some evidence that the programme is reducing cultural reticence to seeking eye health treatment. The sensitisation programmes, plus positive outcomes of surgical interventions, is making a difference to attitudes. Both survey results and focus group discussion (FGDs) evidence the significant impact of restoration of sight on the quality of life of eye health service users, confirming changes to quality of vision, confidence and self-esteem. Cataract patients in the FGDs spoke of greater independence and reduced sense of burden, ability to assist with domestic duties, look after children and care for themselves.

The programme has been less successful in developing influencing strategies aimed at integrating eye health care into overall health plans and budgets. Overall there is little evidence of a sustained influencing strategy being pursued at country level by Sightsavers acting alone or in conjunction with wider civil society. Progress was hampered by the fact that until 2012 there was no permanent presence in country to promote the Sightsavers brand or to strategically network.

Inter-country collaboration was not mentioned spontaneously by stakeholders in Guinea Bissau as a benefit or as a perceived weakness. When probed, it was evident that more opportunities to meet and visit might have been useful, but stakeholders were primarily concerned with their own programme. The working context, administrative culture and stage of development of eye health services in Guinea Bissau means that models and policies are not always transferable.

Sustainability: Although outreach to poor and hard-to-reach groups had a significant impact on surgery numbers in Guinea Bissau in 2013, it is not a sustainable approach and also prevented the establishment of continuous service provision from the eye units for walk-in patients.

An integrated supply system to regional eye units and pharmacies needs establishing. At national level, funders need to liaise with government on integrating eye health into health plans and budget lines. This work should be underpinned by improved information systems capable of providing evidence that the eye care approaches developed under PHFPI deliver sustainable gains as well as value for money.

Without further external finance, it is unclear how eye care services will be funded with little evidence that introducing cost recovery will generate sufficient funding to cover outreach or medical consumable costs. Sustainability therefore presents a major challenge. The view of the evaluation team is that the withdrawal of Sightsavers funding at this stage could significantly undermine progress made to date and that it should consider a financial contribution to support basic inputs for a further two-to-three year period.

Currently there is no overarching exit strategy in place for the sub regional programme although a Guinea Bissau disengagement strategy was developed in May 2013 and finalised in September 2013. It is unclear whether this has been widely shared or is being actioned.

Replication and Scalability: The model of using eye health system professionals in coordination with primary and community level health professionals and community-level actors and volunteers reflects similar approaches adopted by other vertical programmes in Guinea Bissau. The MoH would like to replicate this programme in other districts and ministry planners are hoping to find other potential partner or donor organisations.

While the general model is valid, the way in which it is replicated in Guinea Bissau will need to be informed by what happens after the withdrawal of

PHFPI. In particular, eye health services should be integrated into the RHTs by giving these teams some planning and management responsibilities for the eye units. Outreach activities and a new system of procurement needs establishing as the current system is not scalable given PNSV capacity.

Implication of Findings: PHFPI faced greater challenges in Guinea Bissau than in Senegal or The Gambia. At the outset, there were limited eye care services in only one part of the intervention area, a lack of suitable people to be trained, poor communications infrastructure and, during the project itself, periods of political insecurity. Given this context and the time taken to get trained eye health staff in place, excellent progress was achieved during the final year: five (soon to be six) eye units now exist in the four northern regions and the profile of eye health has been raised throughout the health system.

The challenge is to build on this investment and sustain gains achieved. Eye units have relied on intensive outreach campaigns to reach the population and, in so doing, have not established routine walk-in services. Without further external funding to consolidate eye care services there is a risk that they will cease to function. Given Guinea Bissau's challenging context and limited eye health resources compared with the other two countries, a longer funding period was clearly indicated from the outset.

Any further period of funding needs to address both structural and information deficits and consolidate the quantity and quality of progress achieved so far.

Assessment ratings by evaluators.

Relevance	Effective-ness	Efficiency	Coherence	Impact	Sustain-ability	Replication
						

1 INTRODUCTION

1.1 Background

The PHFPI 2009-2013 is a follow-on initiative to the high profile Health for Peace Initiative (HFPI) 2001-2006 established by the Heads of State of Senegal, Guinea Bissau, The Gambia and Guinea Conakry and covering 4 different disease areas; they had recognised that their populations were affected by common health problems and wished to foster peace in the politically volatile border areas. The programme of eye care activities involved multi-country collaboration on cross-border activities such as high-profile eye camps and the establishment of the Sheikh Zayed Regional Eye Care Centre (SZRECC) in the Gambia as a sub-regional training resource.

During HFPI, eye camps were conducted in Guinea Bissau and subsequently the South West Eye Care project was implemented in 2007-2011; these included Cacheu, also part of PHFPI.

Purpose of Evaluation

The aim of the PHFPI final evaluation is to assess the project's achievements and impact in The Gambia, Senegal and Guinea Bissau over the past 5 years. The specific objectives, using the Sightsavers framework of relevance, effectiveness, efficiency, coordination/coherence, sustainability, impact and replication/scalability are to evaluate:

- the implementation of project activities and outputs against final results, with the aim of measuring project sustainability and performance;
- the processes affecting achievement of project results
- the monitoring and evaluation system established and its outcomes
- key lessons learned during programme implementation including best practices
- the degree to which the programme contributed to expected impact and outcome including an exploration of the intervention logic
- the contribution and impact of multi-country collaboration to programme objectives

The study also seeks to assess long term change, outcomes and impact of the programme, in 2 areas:

- The degree to which the programme contributed to expected impact and outcome including an exploration of the intervention logic
- The contribution and impact of multi country collaboration to the objectives of the programme.

This report focuses on the implementation of PHFPI in Guinea Bissau and is one of three country-level reports forming the basis for the overall evaluation synthesis report, which contains the full Terms of Reference in Annexe 2 (see main report).

Programme Description

The European Union and Sightsavers fund the PHFPI with a total budget for Guinea Bissau of EUR 922,298. It is a five year programme designed to facilitate the implementation of good quality eye care services and also promote eye health in Guinea Bissau; The Gambia and Senegal. This holistic project is one of several components of the overall fight against poverty by improving the lives and social wellbeing of those who are visual impaired, particularly in the porous neighbouring border countries where long term conflicts still exist.

The overall impact level objective of the PHFPI was to contribute to poverty alleviation through the prevention of avoidable blindness in Guinea Bissau, The Gambia and Senegal by the end of 5 years. The specific objective was: to establish comprehensive good quality, accessible and affordable eye care services reaching at least 60% of the population in the intervention regions. In order to achieve this outcome, four main components were outlined: Capacity-building through training eye-care providers; Infrastructure development for delivering comprehensive eye services; Promoting community awareness; Partnership-building for adequate coordination.

These were composed of nine key result areas defined for the project activities[1]. Cross-border collaboration and learning featured as a cross-cutting theme and an enabler for increased impact. Key stakeholders include the Guinea Bissau national eye care programme within the MoH, Helen Keller International (HKI), and Sightsavers.

Context

PHFPI took place in 4 of 11 regions nationally, Cacheu, Farim, Bafata and Oio, against a background of political instability: implementation began six months after a coup in 2009 and was delayed by another coup in 2012. Since then, there have been disputed and delayed elections. Despite this instability, Sightsavers, the PNSV and regional teams have implemented the project and established an in-country presence, recruiting the Guinea Bissau programme manager after the 2012 coup.

2 Methodology

The overall evaluation team was composed of five members: three with social science and international development backgrounds and two West African ophthalmologists with extensive technical knowledge. After an initial phase of document review and analysis, the approach proposed in the inception report was agreed with Sightsavers and key implementing partners, field visits were then made to all three countries.

The field visit to Guinea Bissau involved three team members and included visits to two of the four project regions; one had started project activities in 2010 and the other in 2011. Information was gathered via:

- In-depth interviews with a wide range of stakeholders including:

- National level stakeholders in Bissau (MoH, PNSV, others) x 12
- Regional health teams, health personnel x 8
- Sightsavers regional and project staff x 4

- Focus group discussions with:
  - Women's Groups x 2
  - Community-level volunteers (CHWs) and traditional practitioners x 4
  - Beneficiaries x 3
- A small quantified survey with a random sample of 250 beneficiaries of cataract and trachomatous trichiasis (TT) surgery from Farim and Bafata regions, both visited by the evaluators. This explored levels of knowledge attitudes and practices towards eye health and the impact of surgery on beneficiaries' quality of life.

A debriefing of initial findings prior to detailed analysis was provided in-country. The itinerary and full list of the people consulted is contained in main report Annexe 7 (see main report).

2.1 Limitations

There were three main limitations: a/ the evaluation allowed for fourteen total days of fieldwork in Guinea Bissau by 3 consultants. This timeframe did not allow for full field visits to more than two of 4 regions; b/ data was often not available and it took considerable amounts of time and effort by evaluation team members to obtain and cross check relatively straightforward eye data, either not collected or collated by PNSV or Sightsavers. This difficulty suggests the need for more rigorous eye health information and monitoring systems; c/ the absence of baselines and monitoring systems against key qualitative indicators introduced challenges in assessing change over time – a *before and after* approach was taken to the formulation of some survey questions in order to overcome this limitation.

In spite of the limitations, the evaluators believe that the strategy for choosing the informants, as well as the combination of survey, focus group discussions and key informant interviews with clients, stakeholders and programme staff, and efforts to triangulate collected data, allowed for a thorough understanding of the programme's context, its strategies and activities and to formulate recommendations for ways forward.

3 RESULTS

3.1 Relevance

GA

This section considers the eye health needs in the project area, the appropriateness of PHFPI design for meeting these needs and for reaching the poorest and most marginalised people, and the alignment with national and international strategies.

Project design fit with eye care needs

There were clear unmet needs for eye care services in the project area before it began and all stakeholders interviewed for this evaluation agreed that the project was highly relevant to the eye care needs in the intervention areas.

A 2011 Rapid Assessment of Avoidable Blindness (RAAB) confirmed a high level of blindness (6.4%) in adults aged 50+and a much higher proportion suffering from avoidable causes (92.9%) than WHO estimates (85%). The RAAB also provided evidence of the poor quality of eye care services then available; only 28% of those requiring cataract surgery received operations and 60% of operations had poor outcomes. For many, traditional healers were the most accessible source of eye treatment with the RAAB revealing that couching had been used on 12% of operated eyes. A large unmet need for refractive corrections was also identified.

Of the four project regions, only Cacheu had previously received support for eye care provision. The Farim, Oio and Bafata regions had no eye care facilities. There was low awareness of eye health issues and, when sought, eye care treatment was obtained from traditional practitioners or was limited to locally obtaining eye drops for conjunctivitis. The only other options were to travel to Senegal, the Gambia or Bissau or to attend one of the occasional eye camps held by visiting foreign eye care teams.

Overall the generic project design was and remains relevant to the eye care needs in Guinea Bissau. There were however some important design issues that impacted on the project's overall effectiveness (see also 2.2):

- Initial service delivery targets and indicators were generic for all 3 countries and did not take the less developed and more challenging context into account.
- The phased approach, starting in one region each year, was imposed on the partners and meant that the human resources necessary for delivering the eye care service delivery targets were not in place in time: they needed two phases of training and those in the regions starting in 2010 and 2011 were only able to start delivering services in the last 12-18 months of the project.
- The initial budget submitted to the EU was deemed too high but the resulting cuts were not accompanied by a review of activities and targets. This gave partners the impression that the budget was not based on Guinea Bissau prices.
- Several activities were either not clearly articulated in the project document or proved insufficient to achieving intended results. These included plans for the empowerment of regional health teams and their involvement in planning and decision-making; improvements in planning and coordination and increases in government expenditure; and plans for sub-regional collaboration. A greater range or depth of activity would have been needed to achieve these outcomes as well as the more general inter-country collaboration.

The underlying theory of change for the project recognised that empowerment of regional health teams and improved planning, coordination and government

expenditure are key to establishing successful and sustainable services. However, these received little attention as the design reflected PNSV priorities for training of human resources and the provision of infrastructure, equipment and consumables.

Reaching the poorest and most marginalised populations

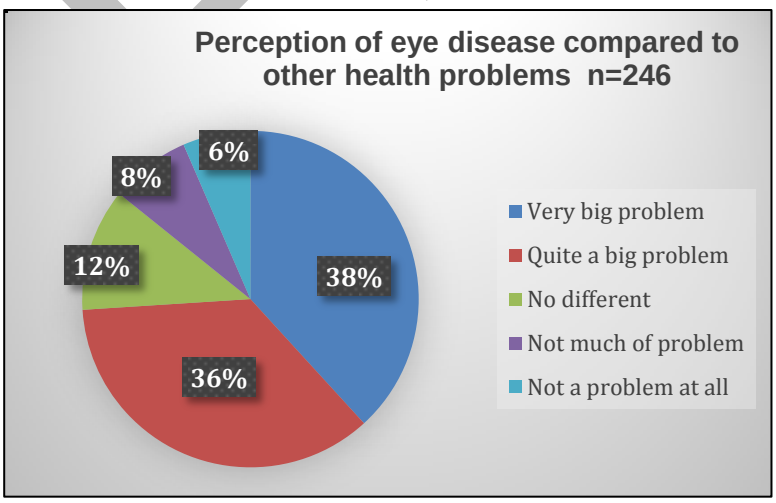
Several key implementation strategies were adopted, mainly in the final year, which extended the reach of the project to more remote and underserved communities:

- Outreach campaigns visited villages to screen for people with eye problems. This provided a service close to the population, many of whom are well over 10km from the nearest health centre.
- Surgery patients were given transport to and from the eye unit, thereby addressing the main cost and logistical barriers.
- Surgery, and related medicines and consumables, were provided free.
- Radio announcements on local and community radio stations were used to spread news of the eye care campaigns.
- Community health workers in some places provided village-level support.

These strategies reflect those used by many other vertical programmes in response to the poverty of the population. While they overcome many of the usual barriers to eye health treatment, they are not sustainable in this resource-poor environment: they do not establish patterns of health-seeking behaviour or service provision that can be sustained by the government without external support.

The relevance of the project intervention was confirmed by the perceptions of 74% of survey respondents indicating that eye disease is a very big or quite big problem compared to other health problems.

Chart 1 Perception of eye problems compared to other diseases



Alignment with national and international strategies and frameworks

The project design reflected the directions established in the (now outdated) Guinea Bissau National Eye Care Programme Strategic Plan. The PNSV

Coordinator and RHTs were involved in initial project planning consultation meetings and the relevant project objectives were then assimilated into the Ministry of Health annual plan and the national Human Resources for Health strategy. The MoH welcomes outside assistance and, although initially difficult, was happy to send candidates for eye health training.

Targets relating to the development of human resource, infrastructure and equipment were all aligned with the international targets established by the Vision 2020 (V2020) initiative, which provides a common framework agreed by the International Agency for the Prevention of Blindness (IAPB) and the World Health Organisation (WHO).

PHFPI design followed the pattern of other externally funded health programmes in the Guinea Bissau health system: these are run as vertical programmes coordinated by a key director at national and regional levels of the MoH. The aim implicit in the three country proposal was to reduce the verticality over the course of the project by increasing regional/community involvement in decision-making processes and by integrating eye care into the health system. This was not achieved for reasons outlined in the full report.

3.2 Effectiveness

A

This section explores the extent to which programme objectives in the main result areas have been achieved and how far this has contributed to the programme purpose and the strengthening of the health system in Guinea Bissau. It identifies the extent to which eye care has been integrated into primary health care (PHC) at district level, the priority given to eye care and some gaps for consideration in future programming.

Specific objective of PHFPI
To establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Guinea Bissau.

Given the low starting point in Guinea Bissau, very good progress was achieved by the end of the project period in the initial training of eye care workers and the setting up of secondary eye care units. Outreach campaigns made eye care accessible to remote and inaccessible rural regions: awareness of and demand for eye care services increased considerably. However, the eye units are not yet well-established with sustainable supplies and an adequate flow of eye patients presenting for treatment as there was a heavy emphasis on the outreach work.

At national level, there is greater recognition of the importance of eye care within the MoH. However, although one senior official expressed the desire for an eye care budget line, there is no specific budget allocation as all programme activities remain donor-funded. There has been little or no evolution in the planning and coordination of eye care; throughout the project

it was centrally controlled by the PNSV with very limited involvement of regional health teams.

The project log frame revisions after the 2012 Results Oriented Monitoring (ROM) were supported by Sightsavers UK and identified six common indicators for measuring progress towards the specific PHFPI objective across all three countries. Unfortunately, the review did not establish if/how these purpose level outcomes and indicators could be measured in practice: there was far greater ownership of the output level indicators.

Table 1 Issues with measuring project outcomes/indicators

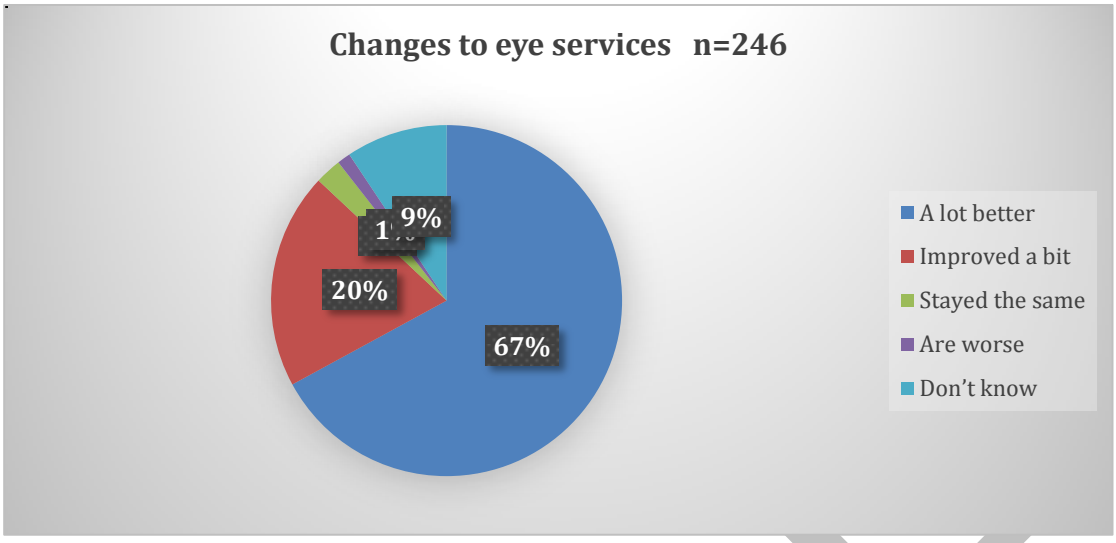
Outcome / indicator	Measurement issues encountered
Cataract surgical coverage rate	Requires a (costly) population-based clinical survey
Percentage of patients having positive surgical outcome	No use of cataract outcome monitoring tool
Number of cataract surgeries with IOL	Reportedly 100%
Percentage of facilities experiencing stock-outs of essential medicines and equipment	Not systematically gathered during project or defined.
Number of patients presenting at project facilities receiving eye health care services	Not clearly defined or measured: 'presenting' implies coming to the unit as 'walk-in' patients not those screened. This is not distinguished in Guinea
Percentage of committed expenditure on eye care met.	Not relevant to Guinea Bissau as no specific government allocation

This overall assessment is therefore based on the outcome indicator information available, results from the beneficiary survey and the evaluators' observations. More detailed findings are given in the discussion of specific result areas.

The eye services established in the intervention regions have been accessible and affordable owing to the strategy of running outreach campaigns offering free services. These took place in all health areas of each district and can thus be said to have reached 60% of the population in intervention regions. There was a noticeable improvement in the quality of surgery. In the beneficiary survey, 86% of patients recognised that services had improved a lot or a bit.

While the project has made good progress in setting up eye care services where little or none existed before, a comprehensive range of eye care service provision has not yet been achieved. Refractive error and low vision services are not available despite evidence of these unmet needs from the RAAB and discussions with beneficiaries.

Chart 2 Beneficiary response to changes to local/district eye services



More fundamentally, the eye care services that were put in place did not have time to become properly established and are not sustainable without continued donor support. Many elements – human resources training, medicines and consumables supply systems, health information and management systems, and planning and coordination processes – need further development and consolidation.

Human Resources for Eye Health (HReH)

Overall, the Guinea Bissau targets for the numbers of eye health and non-eye health cadres given initial training and deployed were met and/or exceeded.

Table 2 Training and deployment of specialist eye health and other health personnel

Five year target	Performance		Comments
	Trained	Deployed	
6 eye-health cadres trained and deployed	4 cataract surgeons 1 ophthalmologist 5 lid surgeons	3 cataract surgeons 5 lid surgeons (total of 8, all trained in lid surgery)	Cataract surgeons were also trained in lid surgery and refraction; 2 cataract surgeon are still in training The ophthalmologist is due to go to Farim after maternity leave
	1 LPED technician 1 Instrument maintenance technician		
140 non-eyehealth personnel trained in identification and referral of eye conditions	459 composed of a variety of different groups: nurses as IEWs, community health workers, teachers and traditional practitioners,		Training differed according to the target group; for teachers and traditional practitioners it was often focused on awareness raising rather than detection and referral

Stakeholders expressed satisfaction that in locations where there had been few or no eye health personnel, there are now trained people capable of meeting the most common eye care needs. Indeed, the project has trained two of the eight cataract surgeons in the country with another two still in training. Whilst this is a considerable achievement, all recognise that an absolute minimum number of eye health personnel have been trained and that each eye unit is understaffed.

Table 3 Trained eye care personnel present in relation to V2020 requirements

	Vision 2020 Recommendations	Bafata Region	Farim Region	Oio Region	Cacheu Region
Population	250,000	223,756	54,631	194,792	219,126
Ophthalmologist	1	0	1	*0*	*0*
Cataract Surgeon	1	1	1	*1*	*1*
Ophthalmic Nurse	2.5	0	0	*0*	*0*
Optometrist Technician	2.5				
CON	2.5	*3 cataract surgeons also trained as DONs*			
Lid surgeon		3	2	*2*	*2*
Integrated eye worker	100	457 for population of 722,245			

The table above shows the V2020 targets for a mature service and where the four regions currently stand. While the ratio of cataract surgeons to the population is satisfactory, they need support from an eye care technician so that the unit does not close if they are away. In line with WHO guidance, cataract surgeons should work under the supervision of an ophthalmologist. During the project, this was provided by the PNSV coordinator on an ad hoc "needs: basis .It is strongly advised that when the ophthalmologist returns, she is tasked with ensuring routine supervision and support for the cataract surgeons. Although the ratio of one ophthalmologist for all four regions is well below the Vision 2020 target, it will be a major improvement on the current situation.

The training of cataract surgeons was challenging and time consuming. Candidates first had to be trained as ophthalmic nurses and then as cataract surgeons. They were then also trained as lid surgeons and in basic refraction. This lengthy process should ideally have begun in all regions as close to the outset of the project as possible so that the trained personnel were deployed earlier in the project timeline. The regions that started in 2011, were thus only able to start addressing their service delivery targets in the final year. This training challenge was not recognised in the original project design and targets for all three countries.

The training provided in the Gambia was welcomed and considered appropriate to the needs of Guinea Bissau. However, it should be noted that

the cataract surgeons were not trained in either biometry or the use of the cataract outcome monitoring tool; the latter issue was identified and corrected during the later stages of the project but the tool has not yet been properly adopted as the PNSV put higher priority on other activities. Attempts to use an English version have been halted, and a Portuguese version is still awaiting approval and distribution.

Eye health training was given to a variety of non-eye health personnel: integrated eye workers (nurses, midwives and community health workers), traditional healers, and teachers by a cataract surgeon and/or by the PNSV Coordinator. The traditional healers and teachers had one day of training focussing on raising awareness of eye problems and the availability of eye care services in order to encourage patient referrals. The community health workers (CHWs) and integrated eye workers (IEWs) had two days training with more information on identifying eye diseases; they were encouraged to refer patients to the nearest cataract or lid surgeon and were particularly active in mobilising communities for the screening camps. Large numbers of village level volunteers including CHWs were trained specifically for assisting with azithromycin distribution.

This breadth of initial training for all groups – eye health and non-eye health cadres --- now needs supporting with refresher training and ongoing supervision. A promising initial move underway is the preparation of a primary eye care (PEC) component for submission and integration into the CHW core training course.

Infrastructure, equipment and procurement

The infrastructure targets were to construct three new eye units and refurbish three others: these were met. The three units visited by the evaluation team were all functioning in the final year of the project but the eye unit at Sao Domingos was only completed in late 2013 and had not been inaugurated at the time of the evaluation.

The design of the eye units followed MoH norms and its engineer was tasked with supervising the construction process. The constructors were selected using the specified European Union (EU) tender processes managed centrally by the PNSV. RHT involvement in the tendering and works monitoring processes varied: one RHT visited was involved in these but the other did not feel they were sufficiently involved.

The out-patient department (OPD) areas and room sizes are generally satisfactory. Some design issues were addressed after the mid-term review, but both the design of the eye units visited and the quality of construction have shortcomings that remain to be addressed:

- The changing rooms for the surgeons in the new units are across the corridor from the operating theatre, compromising sterility.
- The foundations and plumbing at Farim hospital eye unit are problematic.
- The plumbing fittings at Farim are inappropriate and are leaking at Contubuel.
- MoH mechanisms for signing off the work of contractors clearly did not function effectively.

The eye care equipment provided for OPD and surgical work was aligned with the IAPB standard guidelines and found to be adequate in type/quantity, in working order and good condition. No issues with insufficient equipment were reported by staff, although none of the units has been provided with biometry equipment. Biometry is essential for giving good cataract surgical outcomes, since without it only standard ranges of intraocular lenses (IOLs) are used.. The instrument technician is doing regular maintenance and keeping equipment functioning, but this may change due to a possible shortage of spare parts. Maintaining an adequate stock of spare parts is a key component of ensuring effective use of resources and of sustainability.

Although refractive kits were provided for the cataract surgeons trained in refraction, there was no provision in the project design for an optical shop and optometrist trained to be able to make glasses and supply low-cost spectacles.

Consumables for the eye unit were provided by the project. The Sightsavers project officer (PO) in the Gambia supported PNSV with stock management and procurement; this worked well for the screening camps but there were some stock-outs at the eye units during the project. At the time of the evaluation, all eye units were experiencing stock outs.

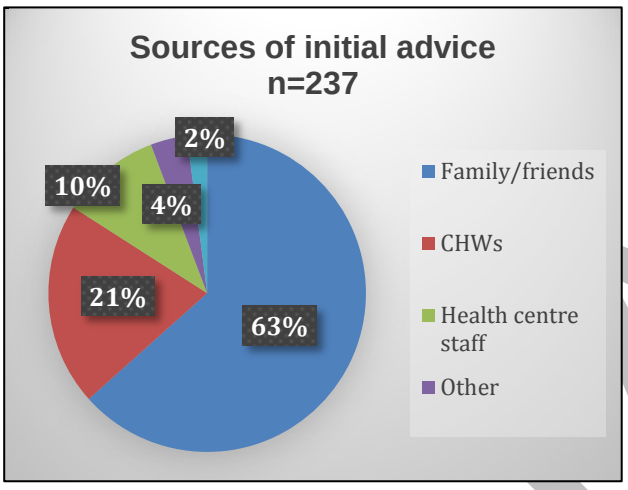
The unit for the local production of eye drops (LPED), situated at the National Hospital, was given equipment and the LPED technician is capable of producing a good range of the different eye drops needed for both OPD and surgical use. During the project eye drops were ordered by PNSV and provided free: no revolving fund was established for ensuring their continued production. Production levels are low as eye drops are made on request and the Regional Hospitals are not aware that they can order them. The parallel PNSV procurement process functions outside the standard health system and is completely un-integrated; this is unsatisfactory for health system strengthening as well as for sustainability and replicability. An integrated system for the supply of eye health consumables to regional eye units and pharmacies needs developing with the involvement of Ministry of Health planners, regional health teams, eye health staff, the LPED technician and pharmacy representatives as well as the PNSV staff.

Referral systems

The referrals of patients between different levels of the health service and the numbers of patients presenting for treatment at the health facilities (walk-ins rather than those reached during outreach screening) are a good indicator of health system functionality but neither of these are measured by the HMIS data collection in Guinea Bissau. Despite Sightsavers' requests, these data gaps remain and eye units provided only patchy data on these aspects. The PNSV administrative assistant has been working with INASA (the national statistics agency handling the HMIS) to develop eye care indicators and more data is becoming available but it does not yet permit a consistent or detailed picture of the evolution of eye care service delivery.

The strategy of training school teachers, traditional healers and CHWs was intended to increase the number of referrals to the eye units; however despite the enthusiasm shown by CHWs for their community work linking people with eye health services, it seems to have had limited success. The evaluation survey findings suggest that patients had often spoken first to a friend or family member and then had been screened by the cataract surgeon. It should be noted that the CHW network is still under development and many have not had eye care training.

Chart 3 Sources of initial advice



The radio announcements by outreach campaigns and facilities at the eye units were very effective. Service users in FGDs reported coming straight to the eye unit after hearing about it on the radio and without consulting anyone else. Radio is clearly a very effective medium for reaching remote areas with news of opportunities of free eye care treatment; an information booklet with key messages and information concerning eye health for media personnel was developed at the end of the project.

The use of other awareness-raising approaches was limited: CHWs had enough leaflets only to show and no eye health posters were seen at the eye units visited. No attempts to improve eye health education through school health clubs (integrating into a general health framework) were made. These would admittedly have required additional human and financial resources but strategies for partnering with local associations to help with this were not explored.

Service delivery

The progress of service delivery against targets shows the considerable progress of the programme, particularly during the last year of the project. This was partly enabled by the return of trained personnel and partly by the realisation of senior Sightsavers and MoH directors in 2012 of just how much Guinea Bissau needed to do if it was to reach the service delivery targets. Senior MoH planners worked with the PNSV and regional teams to ensure that progress was made.

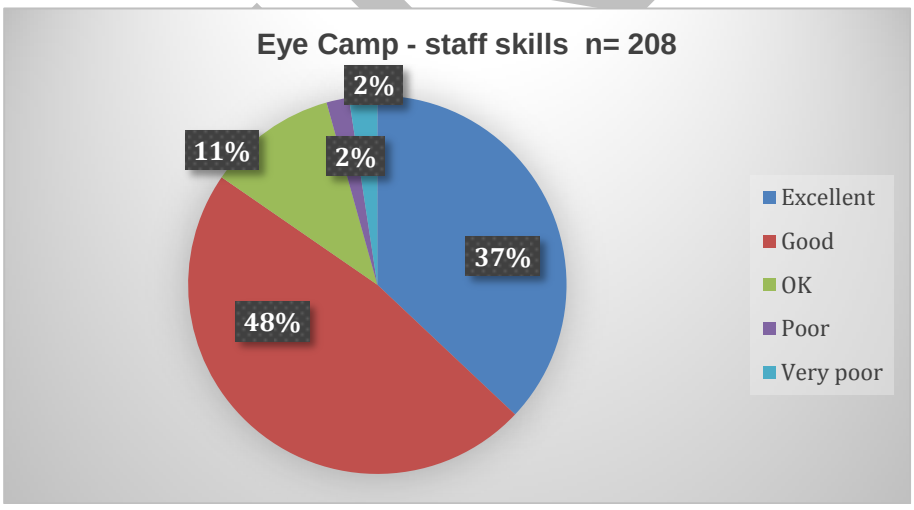
Table 4 Progress towards service delivery targets

Service type	Total 2009–2013	Five year target	Comments
Cataract surgeries	2,131	2,682	Achieved 79% of target
Trichiasis surgeries	2,158	4,230	Achieved 51% of target
Nos people screened	23,933	37,500	Achieved 64% of target
Nos treated Azithromycyn	493,157	n/a	-
Under 5s receiving Vit A	255,284	166,950	Achieved 153% of target

Numbers of cataract surgeries rose dramatically in the final year, contributing to a rise in the national cataract surgical rate from 111 in 2009 to 637 in 2013, a 474% increase. While this is still well below the Vision2020 CSR goal of 2000, it is a very noticeable improvement. The quality of surgery has not been systematically monitored using the cataract outcome monitoring tool, but IOLs were used for over 99% of cataract surgeries conducted. Medical records are not maintained and therefore a random examination of patient records by the evaluators was not possible, to assess any noticeable improvement against the 25% poor outcome indicated in the RAAB; The recurrence of trichiasis in operated cases is another indicator of the quality of the surgery: there was no information available on this and it should also be audited.

A large majority of cataract and trichiasis patients participating in the survey were happy with the staff skills and with their attitudes towards patients. See Chart 4.

Chart 4 Satisfaction with cataract surgeon skills and trichiasis skills



For maintaining their surgical skills, cataract surgeons need to operate a minimum of 150 cases annually while an eye unit needs at least 250 cataract cases a year to function effectively. This volume was achieved in each region during the final year of the project but is very unlikely to be maintained. The halt to free consumables and surgery will mean that recently trained cataract surgeons will not get the volume of cases they need to develop and maintain their skills unless further funding is found.

In April 2013, a trachoma impact study led by the London School of Hygiene and Tropical Medicine showed that the three rounds of azithromycin distribution had reduced trachoma prevalence to below the 5% threshold in the three regions surveyed (not Cacheu).This is a notable achievement, meaning that further distribution is not required. It also provided a minimum estimate of 840 people requiring TT surgery in the three regions, recognising there might be many more. This is well below the project target of 4,230 lid surgeries, which was, perhaps understandably, not met. The trichiasis surgery numbers were only realised by patients coming to PHFPI districts from outside the project region.

The Vitamin A supplementation was undertaken by the Ministry of Health's Nutrition Unit using a campaign strategy. This is supported by the HKI office in Southern Senegal who continued to do this for PHFPI. Vitamin A supplementation has not been integrated into the vaccination programme and so will also cease with the end of project funding as the Nutrition Unit has no sustainability strategy (see 2.5).

Eye health staff were frequently absent from the eye units during the last year of the project as they were working with the outreach teams. This prevented a continuous service being offered for walk-in patients at the eye units. This is reflected in the low numbers of patients (14%) reporting that they had attended the eye unit rather than a free eye camp (85%).

The outreach strategy was essential for reaching project targets and clearly very successful in raising awareness of eye health services and reaching poor and marginalised communities. Community attitudes are beginning to change: there is less fear of eye treatment and more willingness to be treated. However, it has not promoted health-seeking behaviours compatible with the resources available: the lack of government funding for outreach work means that this strategy is not sustainable. In tackling the main barrier to cataract surgery of cost, the project has reinforced pattern of waiting for the free treatment offered by campaigns. This was evident in exchanges with service users and all stakeholders recognised that patient numbers would drop off dramatically if people were asked to pay for surgery and did not have access to free transport.

Nonetheless, 70% of respondents indicated feeling more informed about eye health issues compared to 2009 although the majority also indicate a need for greater public information. The evaluators also observed a dearth of IEC materials in eye units, schools and health posts. Survey respondents identified media, family and community eye workers equally as main sources of eye information, suggesting that community volunteers are having an impact.

Charts 5 and 6: Level of eye knowledge and Sources of information

Chart 5 Level of community knowledge since 5 years

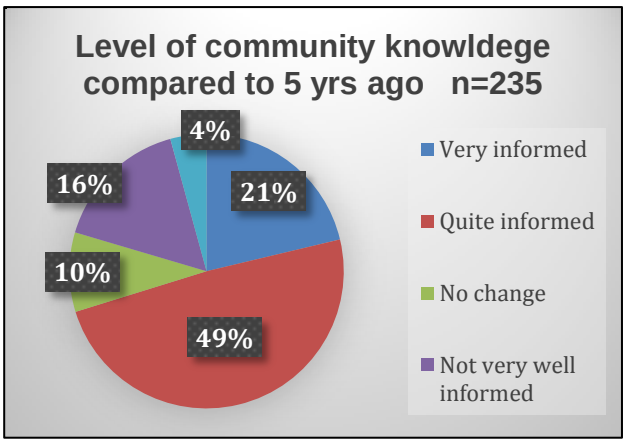
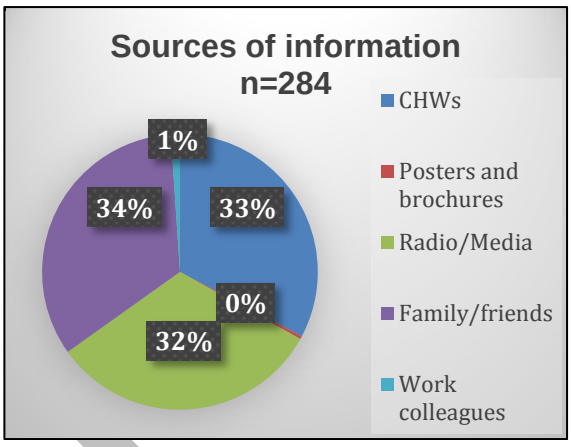


Chart 6 Sources of information



Empowerment of regional teams

Regional health teams (RHTs) participated in the initial project design and welcomed the project. However, apart from contact in the annual planning meeting, they were not involved by PNSV in the routine planning and management of project activities and their contact has been principally during project monitoring visits and at two experience sharing meetings meetings. At the outset, direct management by PNSV was partly a practical decision because of the absence of banking facilities in the regions. This situation has since improved and some vertical programmes now delegate activities to RHTs, who prepare quarterly accounts. This has not been the case with the eye programme; the PNSV focused its coordination efforts on the eye health staff and had little direct contact with the RHTs, who clearly appreciated the eye care services but did not have a sense of ownership. One RHT member was dissatisfied with this and had only realised at an experience sharing meeting that it was meant to be 'their project'. The only capacity-building support for the RHTs took the form of transport logistics. It was evident that RHTs would benefit from same training in project management and monitoring given at national level.

Both the RHTs visited and the Sightsavers programme manager in Guinea Bissau believe there is good potential for integrating eye care into RHT activities. This could be achieved by involving eye care staff to join regional teams making outreach trips; ordering medicines and consumables via the national procurement system, and giving regional or hospital staff line management responsibility for eye care staff while the PNSV or regional ophthalmologist provide technical supervision.

3.3 Efficiency

A

This section examines the efficiency of implementation and assesses the management of the project. It explores how well resource inputs were converted to desired outputs and the efficiency of the monitoring and evaluation systems.

Programme management and oversight

Overall, there was a good level of oversight of project activities and most outputs, but less attention was paid to the volume of service delivery outputs, to the nature and volume of the outcome indicators and to addressing strategic issues in Guinea Bissau, such as that of integration.

PNSV management was intended to establish local ownership of the project, with monitoring and support provided by the Sightsavers PHFPI Programme Management Unit principally through the Gambia-based PO. The three member PNSV team was also managing two other projects, while the ophthalmologist Coordinator also works at the National Hospital. An administrative assistant was hired in late 2010 to increase PNSV capacity and many tasks were then delegated. However, the lack of job descriptions (throughout the Ministry of Health) meant that the assistant's authority level was unclear and delays in obtaining final approvals often prevented timely implementation of tasks.

Prior to 2012 there were no Sightsavers staff based in Guinea Bissau. Sightsavers programme management unit (PMU) was composed of the PHFPI Program manager and Sightsavers RO staff in Dakar and the PHFPI Finance Manager and the Programme Officer, both based in the Gambia, who visited Guinea Bissau about once every three months. Annual oversight visits made by two senior Sightsavers RO staff and monitoring visits by the PHFPI Program manager from Dakar succeeded in addressing some capacity issues but did not result in any mitigating strategies for the highly centralised nature of PNSV planning and management, which was clearly a concern. While PMU leadership belatedly registered the gap between service delivery performance and its targets in 2012, it did not raise or resolve the outcome indicator issues with Sightsavers in UK.

With mixed accounts of how appropriately senior ministry officials were kept informed by PNSV of project progress, more effective inclusion of senior Ministry of Health planning officials in Sightsavers communication streams might have improved their participation in planning and management and have gained more proactive involvement prior to the 2013 experience sharing meeting. Despite the frequency of communications between PMU staff, there were evidently gaps that led to some issues being addressed late and others not being considered.

In a difficult working context such as Guinea Bissau – which is politically unstable, has its own working culture and where many demands are made on the few technical human resources available – opportunities and challenges need to be monitored as they arise for effective programme management. With no personnel in country, it was difficult for Sightsavers to develop a good knowledge of the local language, a thorough understanding of the political, economic, social and administrative context and familiarity with the Ministry of Health environment and its dynamics. Had the Guinea Bissau Programme Manager been in place at the outset, some of the implementation issues may have been addressed more efficiently.

Sightsavers has access to overseas technical expertise in many areas relevant to this project; those for EU procedures, finance, monitoring and evaluation were drawn on but those for ophthalmology and construction were not activated and instead local sources of expertise were relied on, e.g. for construction; this was not always efficient in terms of resource utilisation due to poor design and quality of work/fittings that now need correction. A senior Ministry of Health official commented that it would have been useful to have eye care expertise available from Sightsavers, reflecting the fact the lack of Sightsavers technical oversight in this key area.

Logistics and distribution

The procurement of capital items and consumables was relatively efficient but was not integrated into national systems. This creates a challenge for sustainability, particularly in respect of medicines and consumables.

The PNSV team ordered medicines centrally and delivered them direct to the eye units, effectively by-passing the health system pharmacies at hospital, regional and national levels. This approach was justified on grounds of the ease and efficiency of calculating the quantities needed for outreach campaigns by the eye units. Surplus consumables and stock remaining after campaigns tended to be brought back for storage at the National Hospital eye department facilities, although latterly they were left for ongoing use at the eye units. This system has persisted partly due to the poor relationship with the national pharmacy (owing to an earlier batch of poor IOLs) but it does not promote sustainability. Regional health actors are highly dependent on PNSV and unaware of how to access eye drops from the national LPED.

Although the PNSV administrative assistant has received procurement training, the focus should now be on integrating the procurement and storage of eye medicines and consumables into the national system and setting up appropriate cost-recovery mechanisms. There is now an excellent opportunity to do this as the central pharmacy is being supported to computerise and deliver medicines to facility level.

Ophthalmological equipment was procured by the Sightsavers PMU members in the Gambia office and supplied to Guinea Bissau. The regional health teams were happy with this system as they do not have the capacity for procuring this equipment efficiently, but the PNSV office would have liked to be more closely involved especially in receiving prompt reports of financial expenditure incurred on its behalf outside Guinea Bissau. There were some delays, e.g. the slit lamp for Bafata, which impacted on service delivery; these were attributed to changes in the Sightsavers procurement system

During the project Sightsavers changed to a centralised procurement system and introduced a “Ford or Tata” vehicle policy on global cost grounds. A Ford vehicle was supplied to Guinea Bissau, contrary to PNSV wishes as spare parts are unavailable in Guinea Bissau; the vehicle is already reported to be unserviceable. While these policies and systems may be more economical from an organisational accountability perspective, they are clearly not always efficient or cost effective at a local level.

Monitoring, evaluation and learning

Guinea Bissau has a limited and non-computerised health management information system (HMIS) system. Data is provided for a basic range of primary level indicators to the National Institute of Public Health (INASA) and work is currently underway to extend this to secondary level. PNSV plans to include the core WHO indicator list for eye diseases, and progress on this should be monitored by Sightsavers.

For this project, unanalysed eye care data was collected by eye health staff at district and regional levels and passed monthly to RHTs and PNSV. There was no clear system, format or allocation of responsibilities for data collection in country and, unsurprisingly, there were some information gaps in the quarterly reports that were submitted to the PMU and then completed by the Gambia PO using Sightsavers forms during quarterly visits. Late in 2013 an external consultant was hired to sort out and consolidate data prior to completion of final project reports and this evaluation.

Although impressive data sets exist against all output indicators, Sightsavers has been more challenged to demonstrate evidence of qualitative change and progress at overall and specific purpose level. Log frame indicators were revised in 2012, following the ROM recommendation, but key baselines were established for qualitative change indicators including quality of life. A reliance on quantitative objectives and indicators has thus guided activity with insufficient reference to outcomes or to the qualitative changes the project aimed to achieve. Health system changes resulting from the project's work have not been systematically captured.

Experience sharing and review was an important element of the PHFPI programme. However, given the emphasis placed on output monitoring together with challenges of obtaining robust baselines, the experience sharing sessions, whilst seen as very useful by those attending, could only provide limited lessons. Deeper analysis is required to learn lessons and to inform management decision making in a nascent eye care service. That analysis requires reliable and consistent data. Work is required to plug the current monitoring gaps on cataract surgical outcome rates; CSR; impact on users lives and satisfaction levels; latest prevalence rates; community eye health attitude and knowledge levels.

Finance and resource mobilisation

Overall, the evaluation suggests that the project had the necessary resources and could not have used them to achieve more. The project's high level of financial transparency and accountability is a considerable achievement given the difficulties of some other projects in Guinea Bissau. The finance management systems ensured centralised control and minimised potential risks to Sightsavers but were, at times, a limiting factor and led to some inefficiency and missed implementation opportunities.

Financial constraints were apparent at the outset owing to the budget cuts made on submission. It was reportedly further complicated by the need to accommodate funding for HKI involvement in Vitamin A distribution. This was not clearly understood by some Ministry of Health stakeholders within Guinea

Bissau and some felt they had been misinformed or not fully consulted. The budget cuts led to a phased approach being adopted and activities only began in the final region in year three. This meant that some eye staff only started working in the last year of the project and made it difficult to achieve the service delivery targets. As one ministry official said "You can't train and operate at the same time." A better solution might have been to phase the activities in all four regions and prioritise training from the outset.

The accounting system functioned efficiently overall, with the receipts and accounts for the previous month submitted by PNSV to Sightsavers with a request for the following month's financial transfer. Having the PNSV coordinator as one of the cheque signatories was reported to have reduced delays at Ministry of Health level. At the outset, the monthly financial transfers from Dakar were prone to protracted delays but a change in Sightsavers' central systems and direct transfers from UK improved transfer speeds. There remained some ongoing minor delays arising from delayed PNSV requests and from PMU communications and approvals processes.

Routine monitoring and mentoring visits by the PHFPI finance manager and the full-time involvement of the experienced PNSV accountant improved PNSV capacity for meeting Sightsavers' requirements. The financial monitoring tools are complex, reflecting EU requirements, and placed a high reliance on communications with the PHFPI finance manager.

Table 5 shows annual expenditure against budget for Guinea Bissau. It reflects some of the implementation difficulties, notably security issues in 2009 but is broadly satisfactory given the context. Detailed analysis confirms that some capital items were under-budgeted and also reveals some small but surprising oversights: the translation budget was hardly touched despite issues arising from the provision of most documents to partners in English.

Table 5 Annual expenditure against budget 2009-13

GUINEA BISSAU	2009	2010	2011	2012	2013
Budget in Euros	153,113	153,113	242,427	208,578	Not yet available
Expenditure in Euros	117,457	162,258	204,034	187,683	
% of budget spent	77%	106%	84%	90%	

NB. Evaluator calculations from summaries provided not finally adjusted or approved for EC reporting.

The financial management systems established at the outset did not evolve to reflect the greater PNSV capacity during the project nor the fact that banks had opened at regional level. These developments represent a missed opportunity for delegating the implementation of some activities to RHTs, thereby involving and empowering them.

Cost recovery, unit cost and cost effectiveness

Cost recovery is essential if the achievements of this project are to be sustainable. There is a national policy on cost recovery but it is not actively implemented owing to the poverty of the population: political and economic instability over the last five years has decreased people's ability to pay. Nevertheless, eye care services will now be dependent on cost-recovery in the absence of external funding; no clear policy was being implemented for this before the project ended and, without it, it is very likely that the units will be underemployed despite the continuing need for eye care.

Patients attending health centres and hospitals pay a consultation fee and purchase consumables for operations and any medicines prescribed. Typical consultation fees are 500CFA ($1) for children and 1,000CFA ($2) for adults. These charges are levied on walk-in patients by some vertical programmes and were established for eye care in Cacheu prior to PHFPI. However, it is widely recognised that the cost of treatment, especially when combined with travel costs, tends to exclude poor rural communities.

Services were provided free of charge for PHFPI outreach campaigns, including any associated operations and supplies of medicines. As shown by the numbers achieved in the final project year and the user-group testimonies, this strategy was effective for raising awareness, reaching marginalised populations and achieving project targets; however it also creates expectations of free services that cannot be sustained. It resulted in very few walk-in patients presenting at the eye units during the project.

There seemed to be some uncertainty whether the eye units visited will now charge for cataract operations, although a fee of CFA 25,000 was reported for Cacheu and is the standard fee cited by PNSV. Locally produced eye drops were provided free during the project but could now be provided through the central pharmacy using a cost recovery mechanism. The cost of consumables and medicines to patients has the potential to be reduced if they are now integrated into the national Standard List.

Women's group members at Contuboel, mostly farmers with some income sources, indicated their readiness to go the health centre and pay consultation fees and prescriptions but recognised that take up levels would be much lower for the remote communities unable to afford transport.

There is insufficient data to calculate unit costs and only anecdotal evidence for cost effectiveness. A senior Ministry source said that this project is considered among the Ministry's most cost-effective projects given the results achieved in relation to the budget. Cost effectiveness evaluation is the responsibility of a central Sightsavers unit and should feature in the annual reporting process; however, the RO was not aware of any specific calculations or findings in relation to PHFPI. Some basic cost effectiveness measures would clearly be useful for informing programme decisions.

3.4 Coordination and Coherence

AR

This section considers the coherence and coordination of the programme at country and at regional level.

Coordination within the Ministry of Health

There is certainly scope for more integration but eye health is nonetheless aligned with the health systems in Guinea Bissau and the programme is consistent with the objectives of the now out of date Guinea Bissau health strategy. Eye health indicators are yet to be articulated within the framework of a country eye health strategy or a V2020 plan, and there is no up-to-date national eye care vision within which to locate the work of the programme, engage with other actors such as DPOs, or promote influencing agendas. There are plans however for PNSV to identify eye health indicators for inclusion in the new five year national health strategy now being developed.

In theory there is a bottom-up approach to planning in Guinea Bissau, but the reality of Ministry of Health dependence on donor funding means that in practice many key decisions are taken top-down. This applied to PHFPI: initial development of the project concept involved the RHTs but did not include other relevant stakeholders such as the national pharmacy, nutrition unit, LPED unit and DPOs. There could thus be ownership and engagement issues from other stakeholders.

Eye care planning has followed the standard approach for all vertical programmes, whereby the RHTs draft their annual plans in consultation with district health teams; these drafts are consolidated by the MoH and brought to an annual planning meeting where donors present their funding available and desired activities for the year; after discussion, the regional plans are adjusted. However, in 2014, the donor meeting had not yet happened by February and no specific eye care activities had yet been planned for the year in the regions visited by the evaluation team, partly as a result of lack of funding but also because of a lack of guidance from PNSV.

Some senior Health Ministry managers suggested that a greater willingness by PNSV to share information and plans would have led to greater integration of eye care into health planning and management systems. This missed opportunity has contributed to eye health services still being viewed as a parallel programme at senior ministry level, in the same way as vertical programmes for TB and malaria.

The PHFPI has been a partnership programme between Sightsavers, PNSV and HKI. The key relationship is between the PMU and PNSV national coordinator, although some commentators suggested that engaging with a wider range of ministries and external stakeholders would have been advantageous for raising knowledge and understanding of the programme. A cross departmental workshop at the beginning of the project to explore its dimensions might have led to greater engagement and interest. The absence of other non state eye care actors in Guinea Bissau also limited opportunities for building synergy within the sector.

The ability of the PMU to coordinate the work of the programme effectively has been impacted at times by PNSV intransigence and limited capacity. Sightsavers staff acknowledge in hindsight, that a broader range of mitigation strategies could have been developed in order to identify solutions and circumvent obstacles.

Sightsavers coordination mechanisms

Programme coordination mechanisms put in place by Sightsavers have largely worked well. Quarterly reporting deadlines were adhered to ensuring a regular information flow on progress from the RHTs to the National Coordinator to the PMU. Quarterly planning and review meetings with the Sightsavers PO, PNSV Coordinator and RHTs did not always take place as health staff were not always available. Quarterly monitoring and supervision visits to project sites were regularly undertaken by the Sightsavers PO, the PNSV officer and latterly the Sightsavers Guinea Bissau PM. The National Coordinator made occasional field visits when alerted to the need. The PO shared detailed visit reports with a broad range of stakeholders although he noted a degree of unresponsiveness to recommendations and agreed action points. Annual country review and planning workshops took place as planned and were attended by Sightsavers programme staff, PNSV, and RHTs. The two experience sharing meetings were also used as opportunities for progress review and planning: disengagement plans were developed at May 2013 sharing forum held in Senegal.

Regional health directors reported that eye care plans coming from PNSV are not communicated well in advance, even though they are expected to implement them. More notice would help improve the synchronisation of work and services at local level. Stronger technical coordination and collaboration was, however, achieved at regional and local levels, both within RHTs, secondary health centres and village health posts. This was largely due to the attendance of the cataract surgeons at RHT and health centre meetings. Cataract surgeons are invited to attend the monthly RHT meetings in both Farim and Bafata and regularly attend health centre management meetings. District health managers report that although eye care is not yet formally integrated into district annual health planning processes it will not be difficult to include it in routine hospital and public health planning and coordination. .

Challenges concerning linkages, technology and language were addressed to some extent with the arrival of internet and the 2012 opening of the Sightsavers Country Office in Bissau. The recruitment of a country based programme manager clearly gives Sightsavers the potential for promoting stronger coordination at local level as well as facilitating improved coordination between RHTs and PNSV.

External linkage with other eye service providers, rehabilitation organisations, BPO/DPO, INGOs, donors

V2020 committees can play a central role in influencing public policy on avoidable blindness and catalysing the development of national eye health plans. Given the degree of avoidable blindness, the dormancy of the V2020 committee in Guinea Bissau is a matter of concern. Sightsavers could have

made a significant contribution to developing a broad-based cross-sectoral V2020 committee in Guinea Bissau but it lacked strong links to WHO and other agencies with a health mandate. Sightsavers should work with disability NGOs, the Ministry of Health, WHO and West Africa Health Organisation (WAHO) to forward this agenda with the aim of developing a national eye heath care strategy that embeds eye care into national health planning, management and budgetary systems.

Although there are no other eye care international non governmental organisations (INGOs) operating in Guinea Bissau, Sightsavers does not appear to have pursued opportunities to collaborate with broader civil society on PHFPI, especially DPOs. This could have added significant value to the project in forwarding influencing agendas. A DPO president said that he did not know of the Sightsavers programme until 2013 when Sightsavers invited it to be part of the wider trachoma sensitisation campaign (not part of PHFPI). This led to the development of information, education and communication (IEC) materials and the training of local people provide information about free outreach treatment for cataract and trachiasis.

Coordination measures between the three country programmes to learn and share experience and good practice

Two experience sharing meetings were organised by Sightsavers, one in 2010 and one in 2013, for programme partners and stakeholders. Only those districts phased into the programme were invited to attend and so the 2010 meeting was much smaller than that organised in 2013. This restriction arguably limited interaction at a key moment as well as limiting programme understanding by some of the key stakeholders. These meetings gave all participants an oversight of project progress as well as providing a forum for exchange of learning, but they did not take a strategic look at the dimension of inter-country collaboration. The omission will have reinforced the project document in downplaying this aspect of the sub regional programme. It assumed that collaboration would happen as it did in the HFPI programme, but did not specifically plan for it.

The meetings were attended by national coordinators, senior ministry officials, cataract surgeons, RHT members from the three countries and Sightsavers PMU. They were considered useful by Guinea Bissau stakeholders and Regional health managers identified useful learning from Senegal on the organisation of surgical camps, increasing community involvement and using former patients for mobilisation. While the meeting themes focused on best practise, a considerable utility was attached by Sightsavers to exploring monitoring issues and reviewing performance against targets. The 2013 meeting also spent time developing country level disengagement strategies for further work and action by participants on their return.

It is not evident from reports or interviews that these meetings explored influencing agendas or the development of a common platform around regional support for eye services; this remained a gap in the programme. In general, no influencing initiatives emerged from country level to be developed and promoted sub regionally.

There was little further contact between eye care programmes outside the sharing meetings but it is broadly recognised that the potential for programme exchange was limited by language and resource challenges. Had more funding been available, Sightsavers could have done more to widen the range of opportunities for cross-programme visits and fostering a programme culture of sharing.

3.5 Impact

R

The evaluation assessed the programme's impact with respect to two key question areas: key changes to target groups and tangible outcomes achieved; and the extent to which the programme developed cross-regional relationships and agendas.

The overall objective of the programme was *to contribute to poverty eradication through the prevention of avoidable blindness in Guinea Bissau, Senegal and The Gambia by the end of five years.* Its specific objective was *to establish comprehensive, good quality, accessible and affordable eye care services reaching at least 60% of the population in intervention regions in Senegal, The Gambia and Guinea Bissau.*

Key pathways in theory of change

The PHFPI theory of change is based on an intervention premise that the achievement of outputs and outcomes against four key result areas will directly lead to the achievement of the overall programme goal and purpose. The result areas spanned eye cadre training; strengthening of infrastructures and procurement systems; empowering regional teams for greater decision making; and improved health planning and increased government budgetary commitment to eye care.

The issue is therefore whether planned outcomes have been realised and led to the desired impact. Much has been achieved at the level of result areas 1 and 2, less so at the level of result areas 3 and 4. Although overall service delivery targets were not realised, the output data and interviews with health actors suggest that eye health systems are strengthened as a result of the project; services are established, have minimum levels of staffing but are functioning, and with continued resourcing can be further strengthened and developed. This is an achievement in a difficult context and operating environment.

The evaluation team assessed progress against key impact indicators identified at overall objective and specific objective level using monitoring data collected by the programme as well as information from SSIs (Table 6). The team also assessed changes to the lives of targeted service users through FGDs and a survey of 250 randomly selected people exploring service satisfaction levels, quality of life changes, and eye heath knowledge, attitudes and practices. Baselines had not been established for qualitative indicators such as quality of life and therefore the survey design deliberately employed a *before and after* questioning line. RAABs were conducted in 2011 to establish a baseline on blindness prevalence and surgical coverage rates but will not be undertaken again for several years so it is not possible to quantify change.

Table 6 Results against outcome indicators for overall and specific objectives

Indicator	Result
CSR	From 111 in 2009 to 916 in 2013. A large increase, but well below 2000, WHO standard needed to address ongoing incidence.
Blindness prevalence	RAAB baseline: prevalence rate of 6.4% for over 50s. All ages is 1.2%. Too soon to conduct follow on RAAB survey
Quality of Life	Survey of 250 people suggests significant impact on lives
Percentage referrals from TPs	Not monitored by Ministry of Health. No statistics available
Surgical coverage	2010 RAAB baseline established baseline of 37% bilateral cataract patients had surgery. No follow on survey organised.
Percentage positive surgical outcome	Audit tool inconsistently used and records of surgical outcome not maintained
Number cataract surgeries with IOL	100%
Percentage facilities with stock outs	81%
Number of patients presenting receiving eye care service	Total of 1274 in period 2011-13
Percentage committed expenditure on eye care met	Only salaries, and utility costs covered by MOH national budget.

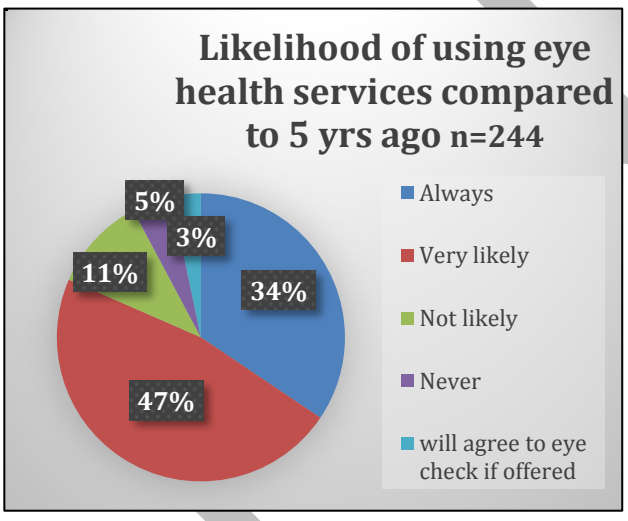
These statistics illustrate some of the challenges in establishing comprehensive and accessible services. Cataract surgery numbers remained very low from 2009 to 2012, only increasing in 2013 after a strategy of successive outreach campaigns was adopted, transporting patients to the eye units for surgery and then back home. Of the total 2918 cataract operations performed in the project area 2009-13, 1226 (42%) were undertaken in 2013. This is not sustainable and with the end of funding cannot be maintained. Two of the 4 regions exceeded the West Africa V2020 target of 2000 in 2013 however (Table 7), the estimated level required to address current incidence rates and begin to clear backlogs. National CSR was 916. No data is currently available to indicate the impact of the programme on prevalence rates.

Table 7 Change to regional CSR figures 2009 to 2013

Region	2009	2010	2011	2012	2013
Oio	752	214	95	50	2320
Farim	0	0	178	763	3935
Bafata	0	0	529	768	1183
Cacheu	0	0	438	597	1182
National average	169	70	243	432	916
No cataract ops performed in project area	169		240	404	1226

There is some evidence that the programme is having an impact on reducing the cultural reticence to seeking eye health treatment. The sensitisation programmes, plus the positive outcomes of surgical interventions, has made a difference to attitudes. In SSIs many respondents, including officers in charge, women's groups, village development committees and village health workers, reported growing community confidence with the quality of eye health services being provided locally and less hesitation to use these services (chart 7). All knew of people or family members who have received treatment and are pleased with the results. Senior ministry officials also suggest that there have been important changes to attitudes as people gain confidence in the eye health service.

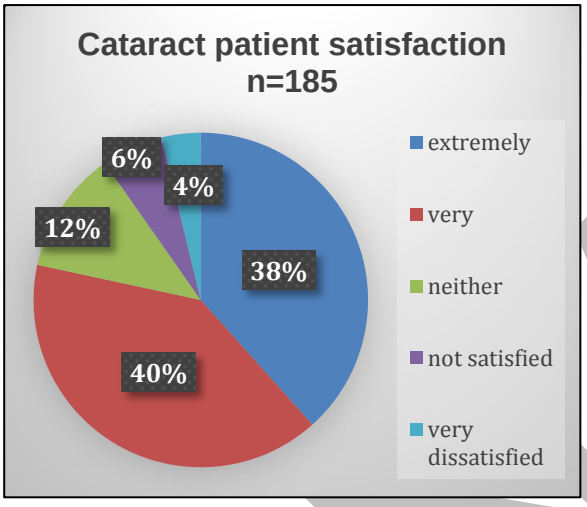
Chart 7 Likelihood of using eye health services compared to 5 years ago



The MoH does not monitor referrals, so it is not possible to comment on whether referral levels increased. Traditional practitioners (TPs) were however targeted for sensitisation by the programme and in a small number of instances used as CHWs. Discussions with several groups of TPs suggest an increased awareness of eye disease, growing acknowledgement that eye patients should be referred to the formal health sector, and that traditional practices can cause damage. Most say that they refer more people than was previously the case, but it wasn't possible to verify this claim against health registers or any other records.

Because of the supply of consumables provided by the programme, standard strength IOLs were used in all cataract operations. There are no surgery records maintained and therefore it wasn't possible for the evaluators to undertake an analysis of a random selection of patient records. In 2010 the RAAB reported a national good outcome of just 25.2%. It should be noted that the MTR recommendation for cataract surgeons to consistently use the WHO audit tool has not been rigorously taken forward and this issue remains a problem within the eye health service. The survey suggests that 78% of respondents were very or extremely pleased with surgery outcome (Chart 8).

Chart 8 Proportion of cataract patients satisfied with eye outcome



Quality of life

Both survey results and FGDs evidence the significant impact of restoration of sight on the quality of life of eye health service users, confirming changes to quality of vision, confidence and self-esteem. Cataract patients in the FGDs spoke of greater independence and reduced sense of burden, ability to assist with domestic duties, look after children and care for themselves. Many are able to do farm work and earn livelihood. Charts 9 to 15 below present the survey results on the changes to people's quality of life since treatment.

Chart 9 Changes to life since treatment

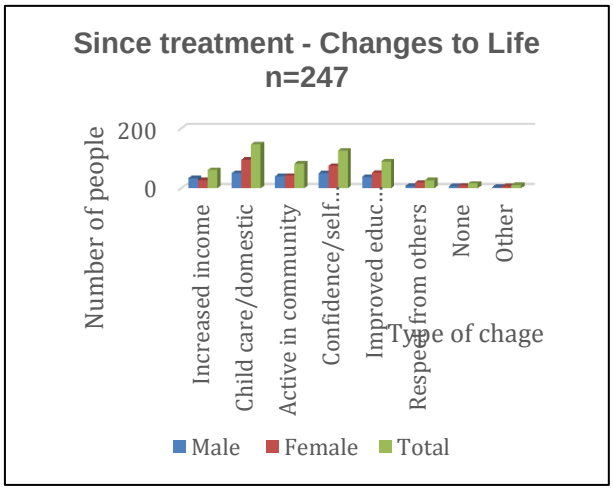


Chart 10 Impact on quality of life

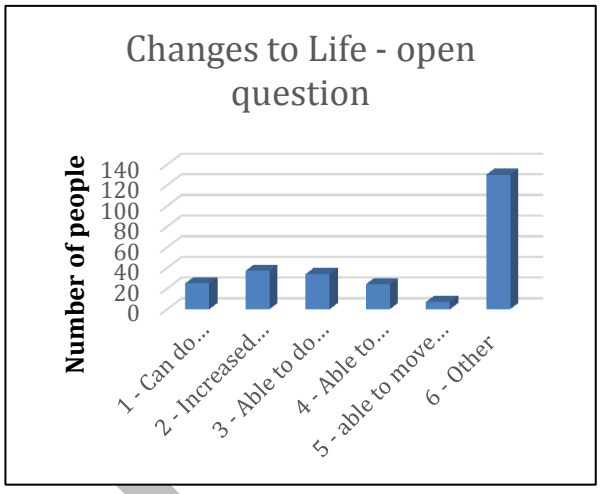


Chart 11 Difficulty with outside activity

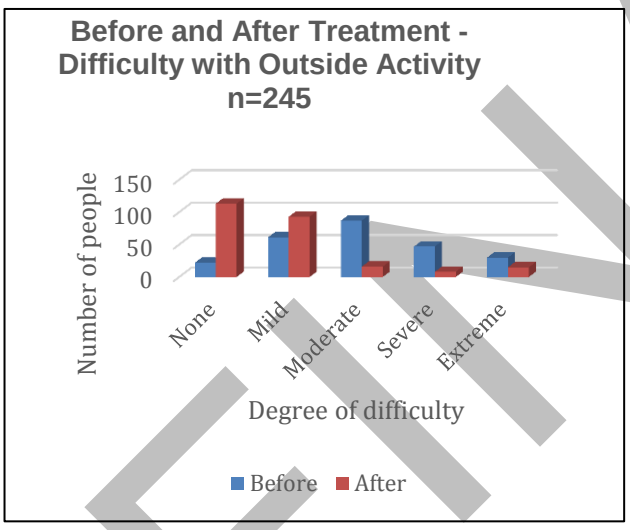


Chart 12 Change in other difficulties

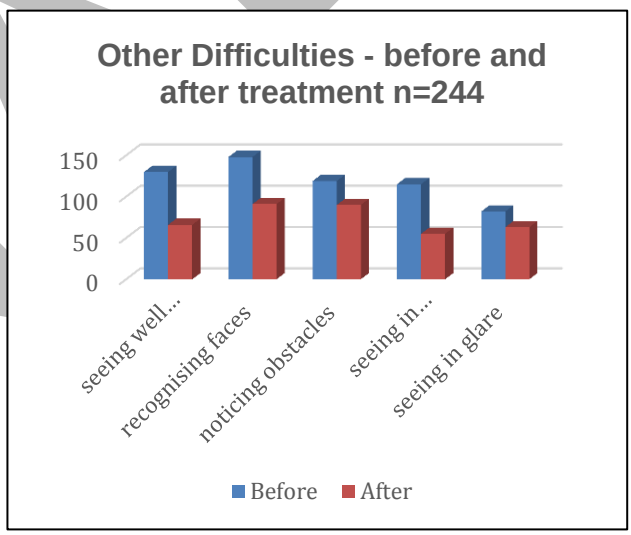


Chart 13 Sense of burden

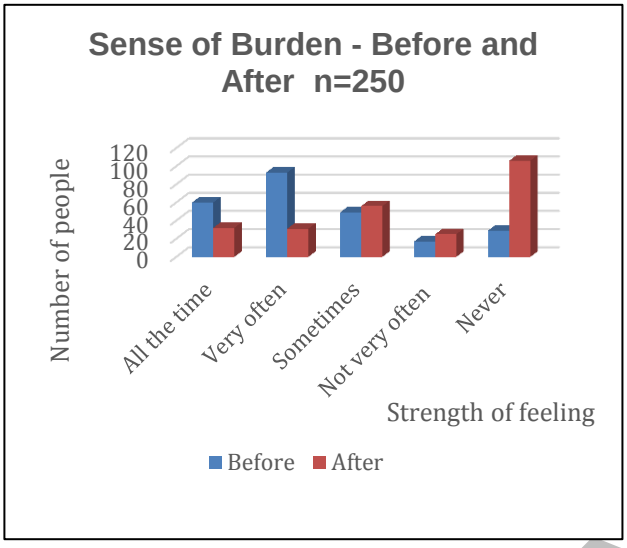


Chart 14 Difficulty with usual work

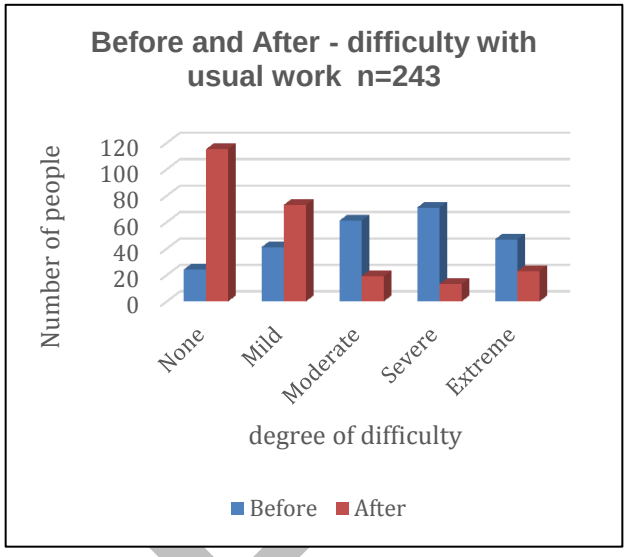
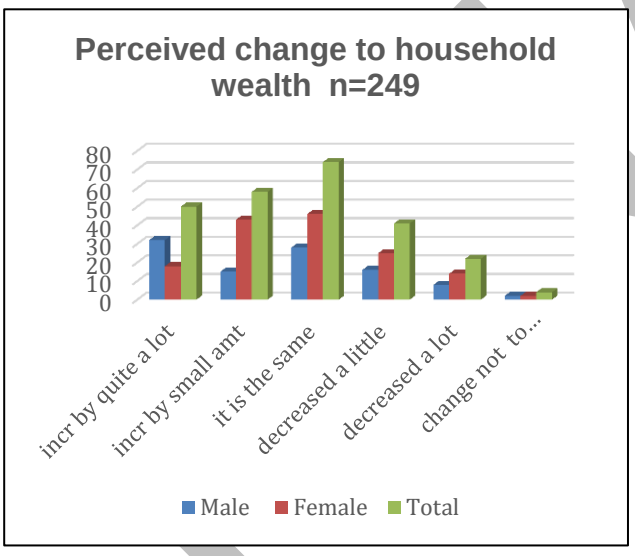


Chart 15 Changes to household wealth



Knowledge and attitudes

The survey explored changes to community eye health knowledge compared to five years ago with 70% of respondents indicating that they felt quite or very informed about eye health matters and where to go for referral and treatment, and 62% reporting supportive community attitudes to people with visual impairment.

Budget allocations

The Ministry of Health has limited funding but the overall budget has remained fairly stable in terms of its proportion of the overall government budget. However, in practice, the amounts fluctuate as the allocated budget is not always received in full. It is, at best, able to pay salaries of health personnel, utility bills and cover some repairs. All funds for health activities – equipment, consumables, transport, outreach costs, etc – come from donor-funded vertical programmes.

Although a key indicator against the specific objective, the project wasn't able to develop influencing strategies aimed at integrating eye health care into overall health plans and budgets. This could have increased the amount of funding available for eye services and thus improved overall project sustainability. The project team prioritised service delivery and, while regional Sightsavers managers certainly pursued some of these strategic agendas at

ministry level during occasional country visits, there is little evidence of a sustained influencing strategy being systematically pursued at country level by Sightsavers in conjunction with wider civil society networks. Progress here was hampered by the fact that until 2013 there was no permanent presence in country to promote the Sightsavers brand or to strategically network.

Multi-country collaboration

Multi-country collaboration was the key feature of the first Health for Peace Initiative 2001-2006,with high profile multinational eye camps being held in the participating countries and 'Sight by Wheels' mobile services. This initial project enabled participating countries to learn about eye health conditions in the other countries, their models of service delivery and the level of service delivery development.

The PHFPI project document reflects the spirit of HFPI and mentions three strategies for continuing collaboration under PHFPI, but these were not translated into explicit activities or targets in country plans or budgets. The ability to build on the relationships established in the HFPI project, albeit with a lower profile, was also affected by a major Sightsavers regional restructure. The PHFPI programme manager in The Gambia was replaced with a different team led from Senegal, which had neither this relationship history nor familiarity with HFPI activities and successes. Several meetings were held by the PMU with national coordinators in order to discuss inter-country collaboration and this led to ministry meetings on the issue as well as a regional meeting at project end, held in The Gambia in December 2013 and facilitated by WAHO.

A key implicit aim was, however, to reawaken sub-regional interest and support for the HFPI-initiated Sheikh Zayed Regional Eye Care Centre (SZRECC) in The Gambia. The full construction programme had not been completed and there was a perceived risk that it would not fulfil its intended sub-regional role. It was hoped that multi-country partnership would, with the aid of WAHO, help resolve both governance and management issues.

The sub-regional nature of the project and its name meant that it was accepted by stakeholders as a logical follow-on. Importantly, it provided a formally recognised structural framework without which Guinea Bissau would not have managed to staff and equip the eye units or to achieve the project output targets:

- The training of eye health personnel could not have happened without training provided by SZRECC; in addition to technical competencies this provided staff with a general understanding of how The Gambia eye care system worked.
- The Senegalese approach to running successful outreach camps was discussed in an experience sharing meeting and subsequently explained in detail by the Sightsavers PO to the Guinea Bissau PNSV. Without this, it would not have been possible to achieve so much progress in Guinea Bissau during the final year.
- Eye care messages and IEC concepts from Senegal fed into the development of those used in Guinea Bissau.

- The sub-regional project MoU facilitated administrative approvals for government employees to travel and train abroad and other aspects of international working.

Inter-country collaboration was not mentioned spontaneously by stakeholders in Guinea Bissau as a benefit or as a perceived weakness. When probed, it was evident that more opportunities to meet and visit might have been useful, but stakeholders were primarily concerned with their own programmes. The working context, administrative culture and stage of development of eye health services in Guinea Bissau means that models and policies are not always transferable.

There was some inter-country sharing of experience. A guided tour was organised to visit SZRECC, although this was not supported by detailed exposure or exchange visits for health system personnel. Some inter-country learning also happened indirectly through the Sightsavers personnel. The two experience sharing workshops were recognised to have been interesting and useful to the extent of learning about progress in other countries, although it was not apparent that any major strategic learning or policy directions had been acquired and translated into use in Guinea Bissau. The Sightsavers supported meeting in December 2013 facilitated by WAHO was also useful for Guinea Bissau Ministry of Health officials in that it enabled them to meet a wider range of eye care organisations and potential partners. This meeting highlighted the sub-regional role of SZRECC and considered the possible potential for Guinea Bissau to play a role in its governance. However, Ministry of Health officials recognised that Guinea Bissau participation was likely to require financial contribution that they would have difficulty providing.

Although partners were consulted about the experience sharing meeting agendas, the concept of joint planning and synchronisation of cross-border activities was neither raised nor explored. Synchronised campaigns have been organised for some other vertical programmes in this sub-region, notably vaccinations, and it would have been relevant to at least discuss this for MDA of Azithromycin even if this was rejected on logistical or epidemiological grounds. The Guinea Bissau regional staff were clear that any such cross-border collaboration would need to be initiated by PNSV centrally. One suggestion made to Guinea Bissau for the provision of cross-border assistance to help it reach its project surgery targets was not initially accepted, although later requests for assistance were submitted to The Gambia and Senegal they were not actioned.

Changes in the patterns of population movements in search of eye care – formerly from Guinea Bissau to Senegal and, during the project, from Senegal to Guinea Bissau – were cited as an impact indicator for the success of the project but strangely given the interest in cross-border collaboration there was no attempt to measure these patient flows. The porous nature of the borders and treatment of nationals from neighbouring countries may be accepted as the norm, but any significant shifts in these movements may affect the validity of national and project CSR indicators and assessments of the extent to which services are meeting eye care needs in Guinea Bissau.

At national level, the PNSVs already had existing contacts developed through HFPI and other forums, notably Sightsavers and WAHO meetings, so this project supported rather than created linkages: no significant changes were evident in partnership building for Guinea Bissau although with its more limited resources, it had the potential to benefit the most. The building of informal relationships, linkages and learning between regional level teams and health service delivery staff might have had longer-term practical benefits but would have required more support.

From Sightsavers perspective, there was an additional advantage of the sub-regional structure: it enabled a single PMU rather than three separate country administrative structures and also provided the facility, in negotiation with the PNSVs, to manage budget lines across countries, thereby increasing efficiency.

3.6 Sustainability

R

The evaluation sought to assess programme sustainability, reviewing the extent to which the programme is likely to sustain its gains in providing accessible and affordable eye health services, especially for the poorest; the inclusion and recognition of the programme in health and development plans; the level of cost sharing with government; and exit strategies.

To what extent is the programme likely to sustain its achievements and continue implementation after external funding comes to an end? What mechanisms / systems have been put in place to ensure this?

Eye care in Guinea Bissau is very much dependent on the presence of Sightsavers as there are no other eye care agencies currently operating in country. Sightsavers support has improved the resourcing and effective delivery of eye health services in the four regions, without which undoubtedly there would be an overwhelming shortage of trained staff, equipment and consumables.

Sustainability of achievement presents a major challenge without further Sightsavers investment for a period of 2 to 3 years. Arguably, Sightsavers should have negotiated an MOU with the Guinea Bissau government highlighting roles and responsibilities after the end of the funding period as health sector officials confirm that it is highly unlikely that the government will now pick up the funding for consumables, fuel for outreach or top up salaries. Even with political will, the Guinea Bissau government lacks resources to fund any aspect of health care apart from salaries. It is dependent on long term donor support to vertical health programming. Nonetheless, while there is no meaningful decentralisation of health care to regional level, it remains important that eye care is identified as a separate health issue in national health plans and budgets for sustainability reasons. Sightsavers surprisingly did not develop influencing strategies on this during PHFPI but progress would have been challenging given the ongoing national financial and political crisis.

Cost recovery is ministry policy with the RHTs fixing the tariffs. Given the levels of poverty in Guinea Bissau, however, a strategic programme decision

was made to offer free eye health services to all people, irrespective of point of access. There are therefore no cost recovery measures for operations or medicines at outreach clinics or at fixed facilities. This strategy has ensured access to services by large numbers of people, especially in 2013 but it does not promote sustainability. People have come to expect free services including outreach, but the supply of free consumables and drugs has ended and there is no revolving fund mechanism in place to ensure new supplies and no funding from central government.

Various medical professionals expressed a view that cost recovery and sliding fee scales will have to be introduced, but there is little evidence that this can generate sufficient funding in the short term to cover the cost of outreach or medical consumables. In the Guinea Bissau context, these will prove unaffordable to many and will create barriers to access by poor people that will reduce demand and undermine the financial viability of the eye units. There is a significant risk that progress made over the past five years in strengthening eye heath systems including HReH and building user confidence could be undermined. The programme should have anticipated this risk and prepared contingency plans.

How effective are the systems developed by the programme to sustain project achievements to target communities at the expiry of the programme funding?

Unfortunately there are barriers to continuing the approaches that sustain access to eye services by the most marginalised and vulnerable people. Although outreach to hard-to-reach groups had a significant impact on surgery numbers in Guinea Bissau in 2013, it is not a sustainable approach. According to in-country Sightsavers staff as well as some health officials, top ups and per diems do not necessarily promote the right motivation . Crucially, without funding for fuel and consumables, the outreaches cannot happen. In reality, at secondary level some health campaigns and outreaches may include eye health and request an eye worker accompany them, often a CON, to talk about eye health issues and treat any eye cases that arise. This approach should be actively promoted and institutionalised by RHTs with lobbying by eye care managers and support from Sightsavers.

Although inability to pay is a significant limiting factor, Sightsavers communications and community awareness raising strategies could have been broader and more inclusive. A stronger campaign involving a range of media, community and peer approaches may have raised awareness to levels that encouraged more sustained use of services, even when they are no longer free. At the least, volunteer peer mechanisms would be more likely to continue after programme end.

There are scarce resources across the health sector and eye care is not considered the highest priority when allocating limited resources. At national level, therefore, Sightsavers needs to work closely with disability agencies to lobby government, especially pushing for the integration of eye health into health service plans and budget lines. This would lay the foundation for future advocacy on increased funding. Sightsavers should also put in place

strategies to profile its brand and agendas and to building strong relationships with power holders, including at governor level.

PNSV and Sightsavers should give attention to service delivery components that are not currently integrated and that operate inefficiently. A cost recovery system and revolving fund could for example be established for LPED production with galenical procurement and country-wide distribution coordinated by the central pharmacy, which is currently undergoing modernisation with EU funding. Advocacy could also include softer targets, such as lobbying HRD to maintain key staff such as cataract surgeons and CONs within the region.

To help convince the government that it needs to plan and budget eye health within the overall health system, Sightsavers should also undertake a Guinea Bissau specific impact case study capturing the changes to individual and community lives to provide evidence that the eye care approaches promoted by Sightsavers deliver sustainable gains as well as value for money and wherever possible should be funded by the Ministry of Health.

Exit strategies

Currently there is no overarching exit strategy in place for the sub regional programme although each country team developed disengagement strategies in April 2013. These were shared in Guinea Bissau with all RHT members and MOH at national level. It is unclear whether they are being actioned. The evaluation team was concerned by the number of local medical personnel, including regional health directors, apparently unaware that the programme had actually ended. Overall, perhaps Sightsavers and PNSV gave insufficient attention to developing and communicating a clear exit strategy including post project sustainability strategies and business planning. What is clear at local level is that highly motivated eye health and medical staff will ensure that eye care is integrated as much as possible into other outreach programmes such as PIMI. Volunteer community health workers are also likely to continue to include eye health talks as part of their role, especially those working on PIMI.

The view of the evaluation team is that if Sightsavers withdraws from all funding commitment to the nascent eye heath programme at this stage it will significantly undermine progress made to date. Sightsavers should consider a financial contribution to support basic inputs for a further two-to-three year period. With clarity on this, it should agree an MOU with the Guinea Bissau government on the scale of support as part of a negotiated exit strategy of the support elements over time.

3.7 Scalability and Replicability

R

The MoH now recognises the value of eye health provision at district level where the needs of underserved and marginalised populations can be met. The model of using eye health system professionals in coordination with primary and community level health professionals and community-level actors and volunteers reflects similar approaches adopted by other vertical programmes in Guinea Bissau. The MoH would like to replicate this

programme in other districts and ministry planners are hoping to find other potential partner or donor organisations.

While the general model is valid, the way in which it is replicated in Guinea Bissau will need to be informed by what happens after the withdrawal of PHFPI and the specificities of the working context. The following adjustments are already indicated:

- Eye health services should be integrated into the RHTs by giving these teams some planning and management responsibilities for the eye units and outreach activities. The PNSV would retain strategic management responsibilities and continue to provide technical guidance and support with the regional ophthalmologist (where appropriate). The PNSV would no longer have full responsibility for all aspects of the eye units including technical supervision.
- The current system of PNSV procurement and delivery of medicines and consumables is not scalable given PNSV capacity. Procurement needs to be integrated into the national pharmacy system and regional personnel need to be empowered to make their own orders.
- All health post nurses should be trained in primary eye care and PEC should be integrated into CHW core training with provision of refresher training.
- There needs to be greater involvement of civil society organisations, notably DPOs, in raising awareness and mobilising communities;

If the demand by patients presenting at eye units does not develop to the minimum level for cataract surgeons to maintain their skills, it may be more appropriate to assign CONs to manage eye units, treat trichiasis cases and diagnose cataract cases but place all cataract operations with the regional ophthalmologist

4 CONCLUSIONS & RECOMMENDATIONS

The implementation challenges facing the project in Guinea Bissau were greater than in either Senegal or The Gambia but this was not reflected in the initial generic project design. Nevertheless, good progress has been achieved given the starting situation with a severe shortage of human resources available to be trained, poor communications infrastructure, frequent issues with political insecurity and high demands being placed on the time of the few professional staff; five (soon to be six) eye units now exist in the four northern regions of Guinea Bissau. Considerable time was needed forgetting the trained eye health personnel in post and, while a lot of ground was covered in the final year, there was insufficient time for properly establishing and consolidating the provision of eye health services at all levels and for seeking ways of maximising their sustainability.

The service delivery targets set for Guinea Bissau, both the initial generic district targets and the post-ROM targets agreed with PNSV in 2012, were very ambitious. By adopting implementation strategies focused on achieving service delivery targets, existing health-seeking behaviours of waiting for free treatment during outreach campaigns were clearly reinforced. To be

accessible to poor rural populations, eye care services ideally need to be free, but the government is not in a position to fund this strategy.

The profile of eye health has been raised at all levels of the health system and it is now important that this gain is maintained and used to advantage. The involvement of primary and community level actors in eye health activities has shown the potential benefits of involving them but this now needs embedding and expanding as they will need to play a key role in helping establish routine services and attempting to shift community expectations of free surgery campaigns.

While much has been achieved due to the commitment and hard work of all involved, even greater results might have been achieved if a more strategic vision had been maintained with a greater focus on sustainability and if there had been better planning, coordination and communication particularly between PNSV and other stakeholders at national and regional levels.

Little progress was made in empowering RHTs and integrating eye care into the health system, but this remains essential in all respects and especially for the primary and community level linkages. It reflects an evident gap in the project design: the focus was placed too strongly on the physical requirements for establishing eye units in response to PNSV priorities. This issue could have been addressed had Sightsavers had a staff member based in Guinea Bissau from the outset, who could work with and support PNSV and the Ministry of Health on a continuous basis. The full potential for multi-country collaboration as outlined in the project proposal was not realised, although the project structure provided a very important framework that facilitated training arrangements for Guinea Bissau personnel in The Gambia and that raised but it did not resolve the SZRECC governance issues. Owing to the lack of capacity in Guinea Bissau, the project did not result in any concrete new partnerships nor synchronised cross-border activities or collaboration on sub-regional policy or advocacy other than that around SZRECC..

If there is no further funding provided to eye care services in the intervention area, there is a clear risk that they will cease to function effectively and that this will threaten the considerable investments made and gains achieved. Given Guinea Bissau's challenging working context and limited eye health resources compared with the other two countries, a longer funding period was clearly indicated from the outset.

Recommendations

Country specific for Guinea Bissau

1. Sightsavers should ensure that the 2013 disengagement plan is reviewed and adjusted in light of the evaluation findings with an appropriate range of stakeholders, including the RHTs. The focus should be on sustainability strategies for consolidating the provision eye care services with particular attention to the supervision systems for eye health and

other cadres. Putting this in place will require further funding for a two-to-three year period in order to action key areas of work.

2. The outdated PNSV strategy should be reviewed and the process used as an opportunity to revive the dormant V2020 committee and to involve all key players in taking responsibility for embedding eye care into health planning, delivery, monitoring and budgetary systems. Sightsavers should work closely with Guinea Bissau disability NGOs together with the Ministry of Health, WHO and WAHO to forward this agenda and build a working partnership.

3. The provision of capacity building support for regional health teams and their empowerment for supervising eye health activities and managing the linkages with primary and community-level health staff should be part of 1 and or 2 above in order to promote sustainability.

4. An integrated system for the supply of eye health consumables to regional eye units and pharmacies needs establishing. This process should involve Ministry of Health planners, regional health teams, eye health staff, the LPED technician and pharmacy representatives as well as the PNSV staff. This should include discussion of the most appropriate cost recovery mechanisms.

General relevance including for Guinea Bissau

5. In future projects, HR development should be prioritised and begin as early as possible, prior to construction work, so that the trained personnel are well established before the end of the project.

6. Sightsavers to undertake KAP surveys and RAAB studies as a starting point in establishing a comprehensive baseline for future monitoring and analysing changing attitudes to eye services, especially at rural level.

7. In addition to consulting regional/district teams on indicators to ensure their fit with the context and their agreement on how these will be collected, training should be provided on both the rationale and the formats/tools to be used for any additional information not collected through the HMIS.

8. Sightsavers should develop guidelines on the construction of eye units against which local norms can be compared and differences discussed. These should set out the general principles to be observed (for example, on patient flow, sterile areas, quality of plumbing fitments) and provide some sample layouts and specifications. A regional construction advisor should also be consulted for projects with a substantial construction component – able, for example, to comment on local norms and quality of work – since London-based advisors are remote from these working contexts and technical expertise is required in situ.

9. Sightsavers should support PNSVs to develop a document package setting out how the eye units were established and providing an

assessment of their cost and cost effectiveness. This will provide useful learning for future Ministry of Health or donor investments.

10. Sightsavers to continue to foster sub regional collaboration and sharing through ongoing support to WAHO and with particular respect to sub regional engagement with SZRECC ROTP and governance structure.

11. In future multi-country programmes, opportunities for exchange visits for health system workers and managers below national level should be built in to enable more detailed sharing and learning about what happens in practice at different health delivery levels.