

Sightsavers, Trachoma Control Project - Marsabit, Kenya (funded by Comic Relief) Project Number 21026

Evaluation Report

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Table of Contents

Executive Summary	5
1. Introduction and Background	9
A. TRACHOMA - THE GLOBAL CONTEXT	9
B. TRACHOMA – THE KENYA CONTEXT	10
C. TRACHOMA – THE MARSABIT CONTEXT	11
D. THE TRACHOMA CONTROL PROJECT - MARSABIT	11
E. REPORT STRUCTURE	12
2. Methodology	13
A. PURPOSE OF THE EVALUATION	13
B. EVALUATION APPROACH	14
C. EVALUATION DESIGN	15
D. DATA COLLECTION AND SOURCES OF INFORMATION	16
E. DATA ANALYSIS	17
F. LIMITATIONS OF THE EVALUATION	18
3. Results Chapters	19
A. RELEVANCE	19
B. EFFECTIVENESS	24
C. EFFICIENCY	35
D. IMPACT	37
E. SUSTAINABILITY	40
F. SCALABILITY/REPLICATION	42
G. COHERENCE/COORDINATION	43
4. Summary/Conclusion and Recommendations	44
A. SUMMARY AND CONCLUSIONS	44
B. RECOMMENDATIONS	46
5. References and Appendices	49

List of Tables and Figures

Table 1: SAFE strategy	9
Table 2 Evaluation Criteria and corresponding questions	13
Table 3 Evaluation tools for data collection	15
Table 4 List of documents reviewed	16
Table 5 KNPET versus Sightsavers project objectives	23
Table 6 Surgery – targets and achievements Years 1-3 + NCE – In Summary	25
Table 7 Antibiotics – targets and achievements Years 1-3 + NCE – In Summary	27
Table 8 Facial cleanliness – targets and achievements Years 1-3 + NCE - Summary	29
Table 9 Environmental improvement – targets and achievements Years 1-3 + NCE	31
Table 10 GoK Capacity building – targets and achievements Years 1-3 + NCE	33
Figure 1 Sightsavers Trachoma Project Country structure	35

List of Annexes

Annex 1 Terms of Reference	50
Annex 2 Approved work plan	56
Annex 3 Evaluation matrix	57
Annex 4 List of informants interviewed	60
Annex 5 Output Indicator datasheet	61
Annex 6 Output Indicator datasheet – Summary sheet	63

Acronyms

BCC	Behaviour Change Communication
CD	Country Director
CDOM	Catholic Diocese of Marsabit
CHEW	Community Health Extension Worker
CHW	Community Health Worker
DALY	Disability Adjusted Life Years
FGD	Focus Group Discussion
GET2020	Global Elimination of Trachoma by 2020
GoK	Government of Kenya
HF	Health Facility
ITI	International Trachoma Initiative
KEMSA	Kenya Medical Supplies Agency
KII	Key Informant Interview
KNPET	Kenya National Plan for elimination of Trachoma
KSB	Kenya Society for the Blind
LLP	Limited Liability Partnership
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoPH&S	Ministry of Public Health & Sanitation
OECD	Organization for Economic Cooperation and Development
PC	Project Coordinator
PM	Programme Manager
PO	Programme Officer
SAFE	Surgery, Antibiotics, Facial cleanliness, Environmental hygiene
STI	Sexually Transmitted Infection
TF	Trachomatous follicular
The Trust	Queen Elizabeth Diamond Jubilee Trust
ToR	Terms of Reference
TT	Trachomatous trichiasis
URTI	Upper Respiratory Tract Infection
VFM	Value for Money
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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This evaluation was commissioned and financed by Sightsavers and was executed by an independent evaluation team and reviewed by senior staff from Tropical Health LLP.

Executive Summary

Introduction and Background

Trachoma is the leading infectious cause of blindness worldwide, and responsible for the loss of an estimated 1.3 million disability-adjusted life years (DALY), mainly in sub-Saharan Africa. Trachoma is caused by infection with the bacterium *Chlamydia trachomatis*, but the condition has a number of clinical manifestations that are the consequence of current or past infection.

In 1998, the World Health Organization (WHO) established an international alliance named the Alliance for Global Elimination of Trachoma by the year 2020 whose goal is to reduce the burden of trachoma. The strategy recommended by the WHO to reach these targets is based on a combination of interventions known as SAFE, standing for Surgery, Antibiotics, Facial cleanliness and Environmental improvements.

The trachoma baseline survey carried out in 2011 by the Ministry of Public Health and Sanitation, in collaboration with Sightsavers, found prevalence rates of Trachomatous follicular (TF), at 14.1%, and Trachomatous trichiasis (TT), at 1.7%, in Marsabit County and defined the situation as a public health concern, relative to the WHO thresholds.

Since April 2011, Sightsavers have been implementing a Trachoma Control Project with Comic Relief funding of £700,000 in Marsabit, Kenya focusing on the scale-up of the WHO SAFE strategy. In addition to the four SAFE components presented above, the project also adopted a fifth component focusing on Government of Kenya's capacity building for sustainability at the end of the project.

Purpose of the evaluation

The purpose of the evaluation is to assess whether the project attained the expected outcomes at the end of the Comic Relief funding. The latter was initially set to run from April 2011 until March 2014 but due to the time required to properly plan implementation at the onset of the project (nine months), a no cost extension was granted, extending the funding period until December 2014. This evaluation reviewed the achievements done from April 2011 to December 2014 but against the targets set for the first three years of the five-year Marsabit Trachoma Control Project.

The evaluation assesses the factors that have impacted on the final intended and unintended results of the project to date and examines also the following:

1. The extent to which the project has achieved its objectives as outlined in the project document.
2. What could have been done differently if anything and what needs to change to improve on the project's delivery.
3. Determine the relevance, effectiveness, efficiency and impact of the project interventions.
4. The extent to which the project interventions were sustainable; and
5. Document key lessons learnt from the project implementation and any best practices.

Methodology

The evaluation was designed to collect a combination of quantitative and qualitative data to inform responses to the key defined evaluation questions, focusing on relevance, effectiveness, efficiency, impact, sustainability, scalability and coordination of the project. The quantitative data was collected to provide evidence on whether the projects' original targets and objectives had been achieved and the qualitative data were collected to provide insights on how the project was perceived and to identify what was done well and what could have been improved to answer questions on lessons learned.

A set of six Tools was developed to facilitate the process. Data was collected through desk review of key documents, key informant interviews (KII's) and focus group discussions (FGD's) with project beneficiaries. Data collected through each of the above methods was analysed separately in user-friendly Excel databases.

Summary and conclusions

Overall, targets were met or nearly met for 12 of the 14 measurable indicators with only the target on number of surgeries performed not met (86% of target achieved). Serious delays in implementation were experienced in the first year of implementation (and for some activities in the second year too). These seem to be attributed to the initial project implementation structure working through the key implementing partner, KSB who were not present on ground and had limited trachoma experience. Overall, however, the project made significant progress in the third year, meaning that the overall cumulative performance at the end of the Comic Relief grant was good. Considering the achievements as at December 2014, the project is well placed to meet its end of five year targets.

Findings and conclusions by the five intervention areas are detailed below:

Surgery

The intervention was found to be very relevant to the local context and the cumulative achievement at the end of three years was good at 86%. The success of achievements can be attributed to active case-identification, community mobilization and outreach surgeries; beneficiary feedback has been very positive. While it is likely that the project will meet the target for this intervention by Year 5, long-term impact may be better complemented by rolling out 'F' and 'E' components more rapidly and widely. Immediate impact shows that the backlog in the intervention area has been reduced for now but longer term impact can only be measured by looking at future prevalence rates during post intervention or end of project assessments. With elimination being the ultimate goal, the reduction in transmission and resulting infections should diminish the need for surgeries entirely over time.

Antibiotics

Mass Drug Administration coverage was split by geographical location, with the Marsabit sub-counties completing three MDA's and Isiolo sub-county completing two rounds during this evaluation period. The MDA rounds all achieved a higher percentage coverage than is recommended by WHO. At the end of the evaluation period, one round of MDA was pending in Isiolo sub-county and an impact survey is needed to follow. The recommendation on timing for the impact survey is not before six months post MDA, it will determine whether or not a fourth round is required and if so, to see if it can be implemented within the project period.

Facial cleanliness

The target for the number of children with clean faces cannot be assessed by the Evaluator who noted methodological issues with the measurement of this indicator. The school health clubs were in place and were disseminating information regarding improved hygiene particularly with regard to face-washing and this is likely to have shown a resultant change of the behavior of individuals. The installation of water tanks at schools gave the children access to clean water ('E' component) and this would be able to facilitate the behavior change in messages regarding face and hand washing.

One of the limitations of this component has been the lack of a context specific BCC strategy and campaign. This should have been at the forefront of project implementation as behavior change takes time to be established in communities where their traditional behaviors are being addressed. Though the KAP survey was conducted to inform the development of materials, Sightsavers chose to postpone this activity. A comprehensive national F&E strategy has been developed and is set for roll-out in Q2 of 2015

Though this component was designed to be illustrative and used as a model to be replicated, the evaluation finds that a wider coordination with WASH partners including the government could have resulted in wider awareness and interest in trachoma and may have led to increased leverage in partnerships for dispersing BCC messages and potential resources for infrastructure development in the target areas.

Environmental improvement

Three out of the four targets were achieved. These were installation of water tanks at 11 schools, provision of hand-washing vessels at 11 schools and the rehabilitation of one community borehole. The number of villages with functional hygiene facilities were not monitored in line with the original log frame indicators because WASH infrastructure activities were replaced with the adoption of the CLTS approach and resultant ODF certifications, seven out of 11 villages were certified by the end of the NCE. The four villages that are not currently certified are expected to achieve this in 2015.

This component was also designed to be demonstrative and used as model to be replicated. The evaluation finds that increased coordination with WASH partners including the government may have enabled wider awareness and interest in trachoma and perhaps been able to leverage partnerships and potential resources for infrastructure development in target areas

GoK capacity building

In addition to all of the target meetings and sub-county health team sensitizations being met, the project also successfully trained 12 TT surgeons, it supported the training of one ophthalmic nurse and one cataract surgeon to run the eye health unit that was completed by the end of the NCE. The eye unit was completed and ceremonial handover had been agreed with the county health team. The handover of management and consumable expenses is expected to be phased annually. At the time of evaluation, surgeons in high prevalence areas had been trained but they had not been provided with the surgical tools and as such reported being restricted with regards to attending to walk-in TT cases at their facilities, though the reasons for the projects decision to not supply the tools has been outlined.

Relevance	Effectiveness	Efficiency	Impact	Sustainability	Scalability / Replication	Coherence / Coordination
Highly Satisfactory 	Satisfactory 	Satisfactory 	Satisfactory 	Caution 	Satisfactory 	Satisfactory 

Recommendations

Project level:

- 1) Continue to work closely on Inter and intra-sectoral collaboration and coordination at government, non-governmental and community level to ensure rapid scale up of 'F' & 'E' for sustainability of 'S' & 'A' achievements and improvements to health in general.
- 2) Further activities to be identified for increased sustainability and ownership which include partnership with the County Health Team and leveraged resources for funding of all elements of the SAFE strategy to take Trachoma to elimination by 2019.
- 3) Ensure that the project documents (proposal, log frame) include all interventions implemented by the project for more accurate and fair measurement of progress.
- 4) Developing a Monitoring and Evaluation (M&E) plan and framework for internal monitoring with structured, verifiable data collection systems and tools.
- 5) Reviewing indicators identified for methodological issues, these are number of surgeries with good outcome, number of school children with clean faces and number of schools and villages with at least 80% of children with clean faces.
- 6) Identifying data needs for impact assessment and Value for Money (VFM) (if desired).
- 7) Highlight geographical areas outside the project areas that may require roll out of activities.

Intervention level:

- 8) Distribution of surgery tools to HF's with trained eye health surgeons attached to them.
- 9) Refresher surgeon training prior to end of project.
- 10) Rapid survey to inform next steps regarding MDA during life of project.
- 11) Development of context specific BCC based on Marsabit KAP survey results.
- 12) Expansion of (Community Led Total Sanitation) CLTS through Community Health Workers (CHWs) at no cost to the project:

Evaluation Report

1. Introduction and Background

A. TRACHOMA - THE GLOBAL CONTEXT

Trachoma is the leading infectious cause of blindness worldwide, and responsible for the loss of an estimated 1.3 million disability-adjusted life years, mainly in sub-Saharan Africa¹. Geographically, trachoma is a greater public health risk in dry, dusty, and hot settings, where poor, rural communities suffer a disproportionate burden of disease. Trachoma is caused by infection with the bacterium *Chlamydia trachomatis*, but the condition has a number of clinical manifestations that are the consequence of current or past infection. Prevalence of infection and clinical signs of follicular conjunctivitis are highest in children under 10 years of age. Recurrent episodes of infection and associated inflammation can cause scarring, visual impairment, and potential blindness later in life².

In 1998, the World Health Organization (WHO) established an international alliance named the Alliance for Global Elimination of Trachoma by the year 2020 (GET2020). The goal of GET2020 is to reduce the burden of trachoma in any community to less than one case of trachomatous trichiasis (TT) per 1,000 total population, and to less than 5% prevalence of “trachomatous inflammation–follicular” (TF) in children aged 1–9 years of age³. The strategy recommended by WHO to reach these targets is based on a combination of interventions known as SAFE, standing for Surgery, Antibiotics, Facial cleanliness and Environmental improvements. The purpose of each of this strategy strand and what is required to implement them is presented in the Table below.

Strategy Component	Purpose	Implementation approach
Surgery	To correct trichiasis, i.e. repair in-turned eyelashes and thus prevent blindness	<ul style="list-style-type: none"> Train doctors to diagnose and perform surgeries
Antibiotics	To treat cases of <i>Chlamydia trachomatis</i> infection, also known as active trachoma/ TF, and reduce the community reservoir of infection	<ul style="list-style-type: none"> Mass drug administration (MDA) with azithromycin at 80% coverage N.B.: Azithromycin is currently donated by Pfizer through the International Trachoma Initiative (ITI).
Facial Cleanliness	To reduce transmission	<ul style="list-style-type: none"> Educational / behaviour change communication materials and campaigns to improve hygiene practices Materials needed for hygiene such as soap and clean water.
Environmental improvements	To increase access to water and sanitation to interrupt transmission and prevent re-emergence of infection.	<ul style="list-style-type: none"> Education materials and campaigns for communities on the benefits of sustainable Inter-sectoral engagement and collaboration Construction of sanitation facilities.

Table 1: SAFE strategy

¹ <http://www.who.int/mediacentre/factsheets/fs382/en/>

² Smith JL, Haddad D, Polack S, Harding-Esch EM, Hooper PJ, et al. (2011) Mapping the Global Distribution of Trachoma: Why an Updated Atlas Is Needed. PLoS Negl Trop Dis 5(6): e973.

³ Solomon AW, Zondervan M, Kuper H, Buchan J, Mabey DC, et al. (2006) Trachoma control—a guide for programme managers. Geneva: World Health Organization.

These four components form the foundation of the effort to eliminate blinding trachoma. All four components must be present for a trachoma control programme to be successful and equal attention should be given to providing surgery, antibiotics, hygiene promotion, and environmental improvements. If only surgery and antibiotic therapy are provided, and little effort is made for sustainable changes in hygiene and sanitation, the treatment side to reducing the disease will be addressed but for a sustainable trachoma control programme, the 'F' and 'E' components of the SAFE strategy must be strong in addition to the 'S' and 'A' components⁴.

In order to reach the 2020 global trachoma elimination targets, it will be necessary to scale up the SAFE strategy to full implementation in all endemic districts by 2015⁵. Implementation of all components of the SAFE strategy relies on multiple partnerships in various sectors such as water, sanitation and education that are essential to achieving the goal of elimination.

The Center for Global Development's Success Stories Project cites the use of the SAFE strategy in Morocco as a major large-scale success story.

B. TRACHOMA – THE KENYA CONTEXT

Trachoma is considered to be the second leading cause of blindness in Kenya with over 85,000 people at risk of blindness and 370,000 children with active infections, it was suspected to be endemic in 18 out of 46 administrative districts⁶ but baseline surveys conducted between 2004–2012 confirmed that trachoma was endemic in 12 counties and ruled it out in six. There is evidence that over the last 30 years, since the first national blindness surveys were conducted to date, the prevalence of active trachoma in Kenya has been declining. What is remaining is a clustered disease; the rate of decline is however, not the same across all regions⁷. The Ophthalmic Services Unit (OSU) within the Ministry of Public Health & Sanitation (MoPH&S) and partners have been leading the effort to eliminate trachoma guided by the Kenya National Plan for Elimination of Trachoma (KNPET) 2008 – 2015 developed by the National Trachoma Taskforce.

It must be noted that following the Kenya Government devolution process in 2013, in an effort to boost efficiency and accountability, the Kenyan Government decentralized the provision of health services in line with the new constitution. It was anticipated that county governments would manage all aspects of service delivery while the central government would oversee policy formulation. For health, this has been a unique opportunity to highlight the significance of geographically specific health issues to be targeted and included in county plans to ensure ownership and sustainability of interventions.

For trachoma, and the Sightsavers project specifically, this has been timely as with constructive support and planning, counties could prioritise this largely neglected disease and this has presented an opportunity for the Sightsavers project to work closely with county government to advocate for its inclusion into the county strategic health plan to

⁴ <https://www.cartercenter.org/documents/2302.pdf>

⁵ Emerson PM, Burton MJ, Solomon AW, Bailey R, Mabey DCW. (2006) The SAFE strategy for trachoma control: using operational research for policy, and implementation. *Bulletin of the World Health Organization*. 84:613-619

⁶ Kenya Trachoma Action Plan 2011 - 2020

⁷ Draft Trachoma Report for Upper Eastern Kenya (Isiolo and Marsabit Counties). (2011) Ministry of Public Health and Sanitation.

ensure a smooth transition of activities and continued lobbying for it to be included in the government country health budget in the future.

C. TRACHOMA – THE MARSABIT CONTEXT

Marsabit County is the second largest county in Kenya, covering 12% of the geographical area of the country. It is located in one of the driest regions in Kenya and it is also one of the poorest counties with an absolute poverty index of 88.2%⁸.

The trachoma baseline survey carried out in 2011 by the Ministry of Public Health and Sanitation, in collaboration with Sightsavers, found prevalence rates of TF, at 14.1%, and TT, at 1.7%, in Marsabit County and defined the situation as a public health concern, relative to WHO thresholds.

The presence of several trachoma risk factors, including low latrine coverage, limited access to water and poor hygiene practices amongst community members predisposes them to trachoma infections as identified through the baseline survey. The survey also identified low access to trained eye care professionals and TT surgical coverage⁹.

D. THE TRACHOMA CONTROL PROJECT - MARSABIT

Since April 2011, Sightsavers have been implementing a Trachoma Control Project with Comic Relief (CR) funding of £700,000 in Marsabit, Kenya focusing on the scale-up of the WHO SAFE strategy. In addition to the four SAFE components presented above, the project also adopted a fifth component focusing on Government of Kenya's (GoK) capacity building for sustainability at the end of the project.

The goal of the project was to “contribute to the achievements of the goals for global elimination of blinding trachoma in line with national and international health commitments” through five specific objectives as detailed in the project proposal and listed below:

1. To reduce the TT backlog of 2,369 amongst adults \geq 15 years in Marsabit, Isiolo and Moyale Districts by 90% and maintain TT recurrence below 10% by 2016.
2. To reduce the overall prevalence of active trachoma (TF) in Marsabit Central, Laisamis and Loiyangalani Districts in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2016.
3. To improve access to reliable water supply for 21 schools and surrounding communities in one location in Gadamoji Division of Marsabit Central District by 2016.
4. To promote community behaviour changes in favour of face-washing, hand-washing and hygienic human waste disposal.

Comic Relief agreed to fund the first three years of this five-year project and Sightsavers was subsequently awarded a Queen Elizabeth Diamond Jubilee Trust (The Trust) five-year project across 12 counties in Kenya from 2014 to 2019, which provides funding for the last 2 years of the Marsabit Trachoma Control Project.

The project was designed for Sightsavers to have overall accountability and technical leadership with implementation being managed through a local civil society organization (CSO). The project partnered with Kenya Society for the Blind (KSB) taking the lead in

⁸ Comic Relief Trachoma Control Project – Marsabit – Project Proposal

implementation in the first year with the Catholic Diocese of Marsabit (CDOM) taking on specific components. As it became more apparent that KSB had limited experience on trachoma control and no implementation structures on the ground, it was determined that CDOM would be better placed to take the lead with a project coordinator (PC) from Sightsavers being seconded to their offices in Marsabit, starting from year 2.

E. REPORT STRUCTURE

The report has been presented in logically defined sections with clearly labelled sub-headings with relevant information for the convenience of the reader. The structure adopted is described below.

The Introduction and Background provide context for the project and help the reader to gain perspective in understanding the findings and recommendations.

The Methodology section sets the evaluation purpose and questions answered by the evaluation team. It then describes the evaluation and design proposed to, and approved by Sightsavers. It provides thereafter an account of the actual data that were collected and analysed before outlining some limitations of the methods used and experienced during the evaluation.

The structure for the Results chapter was designed to use the key evaluation criteria and their respective questions to document the findings of the evaluation in order to meet the ToR comprehensively; this was pre-agreed with Sightsavers Kenya Office and Headquarters.

The Summary and Conclusions provide an overview of the projects achievements in the defined period and the evaluators' conclusions on these.

The Recommendations link together the findings and the conclusions to provide constructive feedback to the project on considerations to strengthen implementation in the future.

All of the other sections were completed as per the Sightsavers Evaluation Report Guidelines & Template.

2. Methodology

A. PURPOSE OF THE EVALUATION

The purpose of the evaluation is to assess whether the project attained the expected outcomes at the end of the Comic Relief funding. The latter was initially set to run from April 2011 until March 2014 but due to the time required to properly plan implementation at the onset of the project (nine months), a no cost extension was granted, extending the funding period until December 2014. This evaluation reviewed the achievements done from April 2011 to December 2014 but against the targets set for the first three years of the five-year Marsabit Trachoma Control Project.

The project dates used in this evaluation are below:

Year 1	April 2011 – June 2012
Year 2	July 2012 – March 2013
Year 3	April 2013 – March 2014
Year 3 no cost extension (NCE)	April 2014 – December 2014

It must be noted that the NCE dates were given to the Evaluator but a formal contract extension document from Comic Relief could not be obtained.

The evaluation assesses the factors that have impacted on the final intended and unintended results of the project to date and also examined the following:

1. The extent to which the project achieved its objectives as outlined in the project document.
2. What could have been done differently if anything and what needs to change to improve on the project's delivery.
3. Determine the relevance, effectiveness, efficiency and impact of the project interventions.
4. The extent to which the project interventions were sustainable; and
5. Document key lessons learnt from the project implementation any best practices.

In order to comprehensively address the evaluation Terms of Reference (ToR) (Annex 1), the evaluators, in consultation with Sightsavers, opted to use the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) Evaluation Criteria and developed detailed evaluation questions under each. These are:

Evaluation criteria	Evaluation question
Relevance	Has the programme responded to the needs and priorities of its beneficiaries as identified in the proposal?
	Have the approaches and activities been relevant to the local context?
	Are the programme goal and objectives consistent with and supportive of county development and sector policies and strategies?
Effectiveness	To what extent have planned targets and objectives been delivered?
	What proportions of planned activities were successfully implemented and what proportion, if any, were not successfully implemented and why?
	To what extent did the activities implemented result in the desired outputs and solve the problems they were intended to solve? What aspects of the problem, if any, were not solved and why?
	Were the effects of the programme felt equally across the programme areas? If not,

Evaluation criteria	Evaluation question
	what was the difference and what are the reasons for this?
Efficiency	Were the resources planned for each activity adequate? If not why?
	Were programme resources managed in a transparent and accountable manner?
	Is there a competent and skilled team responsible for the management of the programme i.e. planning & budgeting, implementation, monitoring and evaluation?
	Is the programme structure adequate and if not, what adjustments are recommended?
	Assess the programme's management and coordination arrangements, in particular the extent to which timely and appropriate decisions were made to support effective implementation.
Impact	To what extent has the programme solved the problem it was intended to solve?
	What proportion of the target beneficiaries have benefited from interventions and in what meaningful ways have their lives changed?
	What, if any, have been any unintended outcomes on the target groups arising from the programme?
Sustainability	What are the views of the target group beneficiaries on the programme and what was the extent of their involvement in its implementation? What is the sense of community ownership of the programme?
	To what extent has the programme strengthened the capacities of local government / district capacities and can they sustain programme achievements after the end of external support? If so, how?
	What are the major factors which will influence the achievement or non-achievement of sustainability of the programme?
Scalability/ Replicability	What aspects of the programme are suitable for replication?
	Do the necessary conditions and capacity for scale-up exist within relevant agencies and government?
Coherence/ Coordination	Are the programme objectives, approaches and design coherent and complimentary with each other?
	Has the programme's design and implementation taken into account other sectoral interventions in the area?

Table 2. Evaluation criteria with corresponding questions

B. EVALUATION APPROACH

A phased approach was adopted in line with the ToR (Annex 1) primarily to ensure that the evaluation design took into consideration Sightsavers requirements and opportunities for feedback and clarifications, were built into the plan.

- Phase I - Desk Study: Review of documentation and elaboration of field study**
 Following the development and approval of the original work plan (Annex 2), the inception report was developed through desk review of relevant documents (detailed in the data collection section below) and was submitted to Sightsavers in December 2014. The evaluation proceeded to the next phase upon approval from Sightsavers of the inception report.
- Phase II - Data Collection**
 A five-day field visit to the project sites in Marsabit County was undertaken in January 2015 to collect primary data to answer the evaluation questions. In addition to this, in-depth desk review and Key Informant Interviews (KIIs) were also completed, as described in the data collection section below.
- Phase III – Data Analysis and Production of Evaluation Report**
 Upon returning from the field the team collated and categorized the data for analysis of the key findings. Clarifications were sought from Sightsavers and the report was written

using the Sightsavers evaluation report template and in accordance with the accompanying guidelines.

The evaluation was undertaken by a group of three consultants led by the Public Health and Evaluations Specialist, Sarah Saleheen, based in Nairobi, Kenya. Monitoring & Evaluation (M&E) Specialist, Rose Nzyoka participated in the initial development stages of the evaluation and Suzanne Penfold Taylor, from Tropical Health LLP, subsequently assisted with the data analysis for the evaluation report.

C. EVALUATION DESIGN

The evaluation was designed to collect a combination of quantitative and qualitative data to inform our responses to the key evaluation questions, focusing on relevance, effectiveness, efficiency, impact, sustainability, scalability and coordination of the project. The quantitative data was collected to provide evidence on whether the projects' targets and objectives had been achieved and the qualitative data were collected to provide insights on how the project was perceived and to identify what was done well and what could have been improved to answer questions on lessons learned. Annex 3 provides details on the sources and tools used to address each question. A mix of desk based review of key project documents, key informants interviews (KII) and focus group discussions (FGD) were used as methods to conduct the evaluation.

A list of 14 key documents to be reviewed was proposed by the evaluators and agreed with Sightsavers.

An original set of six tools were developed to facilitate the data collection process, as described in Table 1, below:

Tool #	Tool title	Respondents
Tool 1	Quantitative and qualitative summary financial information on the project	Sightsavers
Tool 2	Quantitative summary information on project achievements vis a vis targets	Consultants
Tool 3	Quantitative and qualitative information on project implementation and management approaches	Sightsavers staff at Country-level (NBO)
Tool 4	General quantitative and qualitative information on project strategies and sustainability approaches	National-level MoH, County Executive Committee, National collaborating partners
Tool 5	In depth quantitative and qualitative information project implementation and sustainability approaches	County-level programme staff, local implementing partners
Tool 6	General qualitative information on perceptions and experiences of programme beneficiaries	Project beneficiaries

Table 3: Evaluation tools for data collection

As the titles of these tools indicate, Tools 1 and 2 were designed to mainly derive the quantitative assessment although Tools 3 to 6 also include several multiple choice questions, from which trends in understanding and perceptions were analysed.

It was agreed subsequently that Tool 1 would be removed from the evaluation analysis because the financial data had been audited and had already been reported to Comic Relief.

The qualitative assessment, done using Tools 3, 4, 5 and 6, focused on general feedback around the Sightsavers trachoma control project.

Tools 3 to 5 described above were applied through KII's. The evaluators identified a list of 25 potential key informants for that purpose which was shared with Sightsavers to facilitate the meetings as agreed in the work plan. Key informants were selected based on a number of factors including:

- Government department relevant to project – national and county level
- Role of the organization in eye health globally
- Role of the organization in eye health in Kenya
- Involvement in the CR funded Sightsavers project
- Level of involvement of the organization in the CR funded Sightsavers project
- Role of the individual in the CR funded Sightsavers project

Tool 6 was applied through FGD. The evaluators planned to hold six FGD discussions with four beneficiaries groups, made up, in total of 28 participants.

The schedule and timing of planned evaluation activities was agreed with Sightsavers in the approved work plan as detailed in Annex 2.

D. DATA COLLECTION AND SOURCES OF INFORMATION

Desk review of relevant project related documents: An in-depth review of project documents was undertaken to provide the context and an understanding of the project. This allowed for both quantitative and qualitative analysis of project achievements. All the documents initially agreed with Sightsavers were received and reviewed; they are listed in Table 4 below.

#	Document
1	Project proposal
2	Project log frame
3	Project budget
4	Annual Narrative reports – Years 1, 2 & 3
5	Annual Financial reports – Year 1, 2 & 3
6	Draft end of project report
7	Trachoma Survey Report 2011
8	Kenya Health Policy 2012 - 2030
9	Kenya Trachoma Action Plan 2011 - 2020
10	Kenya National Plan for Elimination of Trachoma, 2008-2015
11	The Global Elimination of Blinding Trachoma by 2020 (GET2020)
12	WHO SAFE Strategy for Trachoma Control
13	WHO Global Action Plan for the Prevention of Avoidable Blindness and Visual Impairment 2014-2019
14	The 2020 Insight Global Strategic Plan
15	Selection of relevant publications referenced

Table 4. List of documents reviewed

As mentioned above, documentation around the Comic Relief funding nine months NCE could not be obtained and therefore was not reviewed.

Key informant interviews (KII): Out of the 25 respondents from four stakeholder groups initially identified to be interviewed, only 11 from three stakeholder groups could be

interviewed, due to a number of reasons described later. Annex 4 details the identified informants against those who were actually interviewed as part of the evaluation.

A combination of in-person and telephone interviews was undertaken by the evaluators to inform the assessment by applying the assigned tools to respective informants. In-person interviews were completed by interviews pre-arranged by Sightsavers. A field visit to Marsabit was made to view the project site and interview respondents at project level.

Focus group discussions (FGD): At county level, seven discussions with project beneficiaries from five beneficiary groups were completed. Selection of catchment areas / communities was done by Sightsavers project staff based on a number of factors. The fifth group interviewed that had not previously been identified were the CHW and Community Health Extension Workers (CHEW) who were trained to mobilise communities for project activities.

The qualitative data gained from these discussion greatly informed perceptions and first hand experiences of the target population as well as lessons learned from the project.

E. DATA ANALYSIS

Data was analysed as follows:

- All Tool 2 data (achievements against target data) were collected and analysed in Microsoft Excel. The findings were used to provide evidence for responding to the key evaluation criteria, specifically 'effectiveness'.
- As there were a limited number of Tool 3 (Sightsavers senior management staff for implementation and management approaches) key informants (four) statistical analysis was unfeasible. Instead, the data collected was analysed using qualitative methods as feedback in the report.
- Similarly, with only two national level respondents on project strategies and sustainability approaches, data from Tool 4 was also analysed as above.
- There were a total of seven respondents interviewed for Tool 5 (county level staff and implementing partners) and so some simple quantitative analyses have been applied here in addition to the qualitative data harnessed on implementation and management approaches.
- Qualitative analysis was also used to derive key information gathered using Tool 6.

F. LIMITATIONS OF THE EVALUATION

Limitations related to methods include:

- **Field visit and feedback**
 - The delays and reprogramming of the evaluation schedule was unavoidable due mainly to the security situation in Marsabit, teaching staff strikes and the long December holiday break which resulted in reduced availability during that period of Sightsavers' staff, and other key informants and beneficiaries.
 - Evaluation preparation in the field was not very smooth and communications between Nairobi and field not optimal which as a result required the whole field trip to be rescheduled once on site and resulted for example in:
 - some informants not being interviewed (KEMSA county pharmacist, higher education beneficiaries, school health club members and the Chief Officer of Health)
 - the evaluator completing a session with a focus group to later find out that 40% of the group were not the intended beneficiaries of the project. The findings of that FGD were not incorporated into the results chapters.

- **Data availability**
 - Availability of data was limited by the reduced number of key informants and beneficiaries available for the evaluators to meet with during the fieldwork; this meant that the sample size for some group of stakeholders were too small for simple statistical analysis to be undertaken.
 - Several changes in contract period, strategy, indicators and targets do not seem to have been properly documented internally and with Comic Relief; this is affecting the rigor of the evaluation and has led to a lot a communication loops between the evaluation and project teams.
 - A follow on prevalence survey 3 years after the initial baseline survey in the project areas to measure similar indicators would have made an impact assessment more robust.

- **Data analysis**
 - The evaluator noted methodological issues with the measurement of two indicators, one under the surgery objective ('% surgeries with good outcome, of those performed') and two under the facial cleanliness objective ('n of children with clean faces'). Details are provided in the results chapter.

3. Results Chapters

In order to comprehensively address the ToR and in an attempt to ensure that the evaluation questions are addressed to the extent possible, the findings have been presented by each evaluation criteria and detailed by the five intervention areas as agreed with Sightsavers. Where it has not been possible to answer a particular question, an explanation has been provided.

A. RELEVANCE

Relevance

Rating: Highly Satisfactory



- Has the programme responded to the needs and priorities of its beneficiaries as identified in the proposal?
- Have the approaches and activities been relevant to the local context?

Surgery

TT is the result of multiple infections from childhood with *Chlamydia trachomatis*, which causes recurrent chronic inflammation in the tarsal conjunctiva. The disease causes painful, usually irreversible sight loss¹⁰. Surgery to correct TT is a key component of all trachoma blindness control and elimination programmes and the recommended treatment by WHO and the SAFE strategy. The surgery essentially repositions the eyelid into such an orientation so as to prevent eyelashes scratching the cornea.

The project used an outreach approach to mobilise the communities with support by CHWs and a surgical team would travel to the closest HF to that community and carry out the surgery. There were no static facilities that had the tools to undertake surgeries for walk-in patients. All patients with eyelash problems were asked to report to the facility for screening by the surgical team on a specific day when the surgical team would be at the HF. The surgery was at no cost to the patient. The project used dissolving stitches and dispensed two tubes of tetracycline ointment for to be administered during the six-eight weeks which followed the surgery to post-operative patients. For patients without transport to the facility, pick up and drop off was arranged.

The trachoma baseline survey carried out in 2011 by the Ministry of Public Health and Sanitation, in collaboration with Sightsavers, found the prevalence of TT, at 1.7%, in Marsabit to be above the WHO threshold and thus a legitimate public health concern in the efforts for trachoma elimination; the elimination of trichiasis requires that that the prevalence of trichiasis is less than one per 1,000 population (< 0.001%)¹¹. On this basis, the project proposal addressed the 'S' (surgery) component of the SAFE strategy with a target of completing 2,369 TT surgeries over the course of the project period through Objective 1.

¹⁰ Rajak SN, Collin JRO, Burton MJ. Trachomatous Trichiasis and its Management in Endemic Countries. *Survey of Ophthalmology* 2012;57-341(2):105-135. doi:10.1016/j.survophthal.2011.08.002.

¹¹ <http://www.trachomacoalition.org/sites/default/files/uploads/resources/Trachoma%20Action%20Planning%20-%20A%20planning%20guide%20.pdf>

Objective 1 of the Sightsavers project, 'To reduce the TT backlog of 2,369 amongst adults \geq 15 years in Marsabit, Isiolo and Moyale Districts by 90% and maintain TT recurrence below 10% by 2016' is in line with the KNPET Strategic Objective 1 'To increase utilization and access to quality TT surgery by 2015' and made relevant to the local context through the use of the baseline survey data to target interventions at geographical areas of high prevalence.

A focus group discussion was carried out with a group of 10 surgical beneficiaries (four men and six women) at the Diocese of Marsabit Mission hospital in Sololo sub-county to understand perceived needs and priorities relating to trachoma and specifically surgical intervention. All of the beneficiaries were adults and had been living with TT for a number of years ranging from four to 20. All beneficiaries recognised the painful and debilitating nature of the disease and identified it as being an obstacle in carrying out their daily activities, having experienced it first-hand. They were all grateful for having received the surgery and majority of the beneficiaries (men and women), as pastoralists, were pleased to be able to look after their livestock again, a large part of the culture and predominantly what they subsist on. Others were happy to be self-sufficient again and being able to do housework. All beneficiaries reported access to health care to be a challenge due to the vast distances between communities and the closest health facility (HF). All beneficiaries were positive about receiving surgery free of charge through the project. Interestingly, all the beneficiaries, including the CHW for the catchment area, reported not knowing anything about trachoma prior to the Sightsavers project surgical intervention. They were not aware that it was an infectious disease, how it was transmitted or even that it could be treated. They simply believed that some people had the misfortune of living with it and they managed it by removing their own eyelashes; the baseline survey reported knowledge on trachoma to be low at 37.4%.

With Marsabit being the second largest county in Kenya and the nomadic lifestyle that the majority of the population, as pastoralists, live, access to health care and to health workers trained in TT surgery is very limited. From a public health/trachoma elimination standpoint, the statistics as per the project proposal illustrated a clear need for the surgical intervention, particularly in the sub-counties of Sololo and Moyale where the baseline survey identified the highest prevalence of disease. In line with the SAFE strategy for trachoma control and elimination it was a priority. The project has facilitated this through its active case detection and outreach surgery approach, which has been relevant to the local context considering the challenges with access to HFs. From the perspectives of the surgical beneficiaries, while extremely grateful for the benefits of the surgery, given the challenges in that part of the country, they have not prioritised eye health in the past and as such had previously never identified surgery as a need as they were unaware it was an option. Nevertheless, the evaluation finds this intervention to have been extremely beneficial to the lives of the beneficiaries and their livelihoods.

Antibiotics

The WHO recommends at least three annual MDA rounds of azithromycin at 80% coverage to eliminate trachoma in communities where prevalence is greater than 10% in children aged 1 to 9 years.

Recent studies have shown that coverage should not be less than 90% and the International Trachoma Initiative (ITI) has committed to provide enough antibiotic for a

country programme to achieve a 100% coverage rate of the eligible population, stating that an acceptable coverage rate would likely fall between 90-95% of the eligible population¹².

Objective 2 of the Sightsavers project 'To reduce the overall prevalence of active trachoma (TF) in Marsabit Central, Laisamis and Loiyangalani Districts in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2016' is in line with the KNPET Strategic Objective 2 'To reduce the prevalence of active trachoma (TF) among children 1-9y from the current level to less than 5% in all the endemic communities in the country by 2015'.

The project tackled MDA for TF through planning and administering MDA in 3 sub-counties of Marsabit county where prevalence of TF was 14.1% including: Marsabit Central, Laisamis, Loyangalani and Isiolo sub-county in Isiolo County. Using the 2011 baseline survey data to select target areas made the intervention relevant to the local context.

Group discussion, with the presence of the village chief, was undertaken with beneficiaries of three rounds of MDA through the Sightsavers project in the Kubi Qallo division of Marsabit Central. All of the 15 people present, out of a community of 212, reported being familiar with the Sightsavers eye health project and having taken three rounds of medicines under the project. Given the distance of 20 kilometres to the closest HF, the community were positive about receiving door-to-door administration of the antibiotics, making this approach relevant to the local context. They did not identify trachoma or eye health in general to have been a priority or identified need in their community prior to the Sightsavers project; they did notice an improvement in eye and general health since the start of drug administration. The project seems to have created a demand for azithromycin in the community who requested that it be administered more frequently or be made available at their closest HF at a higher dosage. Being a broad-spectrum antibiotic, azithromycin is likely to have also assisted with symptoms of upper respiratory tract infections (URTI), diarrheal diseases and sexually transmitted infections (STI). From a public health standpoint, the administration of MDA in areas above the WHO recommended prevalence threshold at 14.1% has indeed responded to a need and priority in relation to the elimination of trachoma.

Facial cleanliness and Environmental improvement

The F&E components of the SAFE strategy are inextricably linked. The SAFE strategy includes facial cleanliness or face washing as one of its pillars. Programmatically, this can be best interpreted as hygiene promotion in a broader sense because washing hands and faces usually go together.

Health promotion plays a key role in the implementation of the 'F' component and trachoma control in general and is essential in effecting behaviour changes that improve health outcomes. To be effective, health promotion should be planned in partnership with the community and delivered continuously or repetitively to the target population. Yet the changes advocated can only be implemented should the supporting facilities or services be in place.

The 'E' component of SAFE aims to reduce transmission of *Chlamydia trachomatis* by promoting better personal and environmental hygiene. To do this, the access of large

¹² http://www.cartercenter.org/resources/pdfs/news/health_publications/trachoma/ICTC_MDA-Toolkit.pdf

populations to latrines (or other methods of safe disposal of faeces) and water must be improved. These require specialist expertise and more money than is usually available to trachoma control programmes. The role of the programme might therefore be to find out which organizations are already working to improve water and sanitation, learn what they are doing, encourage them to give priority to communities endemic for trachoma in allocating resources, assist those communities in creating demand for water and sanitation improvements and monitor implementation. If little is being done, the trachoma control project might seek new partnerships to improve water and sanitation¹³.

The 2011 baseline survey reported 27.3% prevalence of dirty faces in Marsabit County. It is in this light that the project aimed to target the 'F' component, through Objective 4 of the proposal "To promote community behaviour changes in favour of face-washing, hand-washing and hygienic human waste disposal". Objective 4 of the proposal is linked to the KNPET Strategic Objective 3 "To improve access to water and sanitation and promote personal hygiene practices among the target communities". Similarly, the 'E' component was also targeted through Objective 4 of the project, also linking with Strategic Objective 3 of the KNPET.

While no large-scale BCC was implemented across trachoma-affected areas, the project opted to implement a 'pilot' on school-led hygiene and sanitation in 11 schools in Gadamoji Division of Marsabit Central sub-county; the project had originally targeted 21 schools for components of 'F' & 'E' but found the project budget allocated to be insufficient to cover planned activities. The 'F' component was initiated through the creation of school health clubs with the understanding that children would communicate message pertaining to hygiene at home and by association within the community. The 'E' component was addressed through the installation of water tanks and hand washing vessels as well as the addition of latrines at 11 schools. Access to the water tanks at the schools was extended to the communities surrounding the schools to facilitate better hygiene practices. In addition to this, the project adopted a community led total sanitation initiative where communities were educated and encouraged through CHWs and CHEWs on the importance of environmental sanitation and construction of their own pit latrines.

Traditional practices and the nomadic lifestyle of the majority of the population make clear the behaviors and challenges associated with poor hygiene. The need from a public health standpoint is immense, though the project was only able to address a very limited proportion of the population in need. The community need and priority for access to water, a key element of the 'E' component, cannot however be overlooked. Extending access to water from the tanks installed at schools to the local community was most certainly responsive to the needs and priorities of the community around access to water and very relevant to the local context.

Though the KAP survey was conducted to inform the development of a BCC campaign focusing on 'F' and 'E', Sightsavers chose to postpone this activity. At the time of this evaluation (14 months from the end of the project) no progress was seen on this.

GoK capacity building

Capacity building is a key component of health systems strengthening. The project addressed this through Objective 5 "To strengthen capacity of the coordination and

¹³ http://www.who.int/blindness/publications/tcm%20who_pbd_get_06_1.pdf?ua=1

implementation structures at the national and Marsabit County levels to facilitate effective and sustainable trachoma control management” linking this in with KNPET Strategic Objective 5 “To strengthen capacity of the coordination and implementation structures at all levels to facilitate effective and sustainable trachoma control and management”

The need for capacity building at county level was clear from the baseline survey results which reported very low access to trained eye care personnel and TT surgical coverage to also be very low at 5.3% and 9.0% respectively making this component of the project very relevant to the local context.

➤ Are the programme goal and objectives consistent with and supportive of country development and sector policies and strategies?

As demonstrated above, the Marsabit trachoma control project is fully in line with the Kenyan priorities for trachoma control as set in the KNPET 2008-2015. This is summarized in the Table 5 below.

#	KNPET Strategic Objectives	#	Corresponding Sightsavers Trachoma Control project Objectives	Related Sightsavers intervention areas
1	To increase utilization and access to quality TT surgery by 2015	1	To reduce the TT backlog of 2369 amongst adults ≥ 15 years in Marsabit, Isiolo and Moyale Districts by 90% and maintain TT recurrence below 10% by 2016	Surgeries through active case identification and outreach activities.
2	To reduce the prevalence of active trachoma (TF) among children 1-9 year old from the current level to less than 5% in all the endemic communities in the country by 2015'	2	'To reduce the overall prevalence of active trachoma (TF) in Marsabit Central, Laisamis and Loiyangalani Districts in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2016'	MDA in target communities with at least 80% coverage
3	To improve access to water and sanitation and promote personal hygiene practices among the target communities	3	To improve access to reliable water supply for 11 schools and surrounding communities in one location in Gadamoji Division of Marsabit Central District by 2016	Installation of water tanks and hand / face washing vessels in 11 target schools
		4	To promote community behaviour changes in favour of face-washing, hand-washing and hygienic human waste disposal	Rehabilitation of Goro Rukesa borehole and Community Led Total Sanitation (CLTS) in Gadamoji
4	To strengthen capacity of the coordination and implementation structures at all levels to facilitate effective and sustainable trachoma control and management	5	To strengthen capacity of the coordination and implementation structures at the national & Marsabit County levels to facilitate effective & sustainable trachoma control management	GoK Capacity building

5	To generate and share evidence and best practices to inform policy	n/a	Quarterly planning meetings at national and county levels
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Table 5: KNPET and Sightsavers project objectives

B. EFFECTIVENESS

Effectiveness

Rating: Satisfactory



- To what extent have planned targets and objectives been delivered?
- What proportions of planned activities were successfully implemented and what proportion, if any, were not successfully implemented and why?
- To what extent did the activities implemented result in the desired outputs and solve the problems they were intended to solve? What aspects of the problem, if any, were not solved and why?

Stakeholder perceptions documented through KIIs were positive over all with all respondents, external to Sightsavers, stating that the project had for the most part achieved the planned activities and targets. There was consensus that significantly more had been achieved towards ‘S’ and ‘A’ components of the SAFE strategy and that the ‘F’ and ‘E’ were lagging behind. Some attributed this to the limited resources available for ‘F’ and ‘E’ while others felt that they had not been prioritized and implementation of these had started late.

Similarly, with regards to achievement of the project objectives, respondents felt that objectives pertaining to the ‘S’ and ‘A’ had been met however, they noted that there was yet more to be done under the ‘F’ and ‘E’ components and suggested that this could be limited given the budget constraints.

Overall, targets were met or nearly met for 12 of the 13 measurable indicators with only the target on number of surgeries performed not met (86% of target achieved). Serious delays in implementation were experienced in the first year of implementation (and for some activities in the second year too). These seem to be attributed to the initial project implementation structure working through the key implementing partner, KSB who were not present on ground and had limited trachoma experience. Overall, however, the project made significant progress in the third year, meaning that the overall cumulative performance at the end of the Comic Relief grant was good. Considering the achievements as at December 2014, the project is well placed to meet its end of five year targets.

This section presents a detailed review of the effectiveness of each project component, including indications where it has not been possible to measure performance and why. Where possible, the reasons for why targets were or not achieved have been detailed. The conclusion part of this section provides a justification for the satisfactory rating despite the high achievement level reported above and detailed below.

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
1	To reduce the TT backlog of 2,369 amongst adults > 15 years in Marsabit, Isiolo and Moyale by 90% and maintain TT recurrence to below 10% by 2015	At least 2,132 TT patients in the Upper Eastern zone operated on by 2015	N of surgeries performed	2,132	2,132	1,832	86%
		At least 90 % of TT surgeries result in good outcome	<i>ORIGINAL INDICATOR: % surgeries with good outcome, of those performed</i>	1,919	1,832	1,320	72%
			% of surgeries with good outcome, of those followed-up		1,491	1,320	89%

Table 6: Surgery - targets, achievements and performance, Years 1 – 3 + NCE - In summary

The cumulative target for the first output under this objective was 90% of the 2,369 TT surgeries backlog, which equates to 2,132 surgeries. While the number of surgeries performed in Years 1 and 2 were substantially lower than targeted (26% and 50% of those planned, respectively), due to initial limitations with the key implementing partner at the time, the targets were exceeded in Year 3 and during the NCE meaning the cumulative performance was good at 86%; that represents 1,832 surgeries performed by December 2014. It is anticipated that the remaining number of surgeries will be completed during the remaining period of the project.

The second output indicator for this objective was 90% of surgeries performed resulting in a good outcome with 'good outcome' defined as no over or under correction and no complications, infections or damage to the eye as a result of the operation and, conversely, 'bad outcome' defined as over or under correction or complication, infection or damage to the eye resulting from the operation. The outcome of the operation is determined during patient follow post-surgery. The patient follow up schedule was one day post-operative – to confirm the wound was holding well, seven days post-operative to remove the sutures and check for infection, at a central point and not necessarily at the HF and during the 8th week following the surgery which was mainly by CHW's or by the surgical team if they were in the area for other outreaches.

When looking at the proportion of the surgeries with good outcome out of those surgeries performed, it shows a proportion of 72% with good outcome. This is however an incorrect measurement of performance because the indicator implies that all surgeries were



followed up (as it should be), which has not been the case. Only 1.491 or 81% of the performed surgeries have been followed-up, leaving 341 surgeries outcome unknown. The reasons for this incomplete follow-up could not be obtained.

When considering the followed-up surgeries only, the proportion of those with good outcome rose significantly to 89%, very close to the target of 'at least 90%'. This was observed consistently throughout the period when broken down per year, i.e. 97% in Year 1, 87% in Year 2, 88% in Year 3 and 93% during the NCE.

Overall, this particular activity achieved what it set out to do; with 19% of the operated patients not followed up it is however not possible to make a definitive assessment on the surgeries outcome indicator.

The proactive approach in case detection and outreach surgery applied to achieving surgery targets is what allowed the desired outputs to be achieved and largely attributed to 89% of the surgeries that were followed up to have a good outcome. The project did not make provision for passive case management outside of the planned outreach surgeries, as a result of which patients were unable to come and receive trachoma surgery at HFs; this is an additional intervention that could have accelerated attainment of surgery targets and possibly improved follow-up. The project team attributed this decision of not providing passive case management services to the fact that surgeons trained on eye health were deployed to other areas of surgery or transferred to locations outside of the project site. There were also a few instances of misuse of and inadequate maintenance of the equipment needed for eye health operations when left at the HFs. This could not be ascertained by the evaluation team during the field work; only one case of a trained surgeon transferred was reported and the latter had been replaced by a newly trained surgeon. The eye surgery equipment were also reported to always have been used under supervision of the Sightsavers team.

All data can be found in the data table in Annexes 5 and 6.

Antibiotics

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
1, 2	To reduce the overall prevalence of active trachoma (TF) in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2015	At least 80% of people living in Marsabit treated with Azithromycin & TEO annually for 3 years as needed;	N treated with antibiotics In Marsabit County	357,086	357,086	327,743	92%
			N treated with antibiotics In Isiolo County	289,899	190,899	181,288	95%

Table 7: Antibiotics – targets, achievements and performance, Years 1 -3 + NCE – In summary

The original log frame objective was “to reduce the overall prevalence of TF in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2015.” On further definition based on the baseline and prevalence surveys, the population targeted was determined and calculated as proportion of the population to be reached with treatment in specific areas and not coverage of the entire county. Total population for MDA was identified in a county or sub-county where TF prevalence was identified as 10% and above. Based on these criteria, the selected areas for targeted MDAs were Isiolo County (within which Isiolo sub-county only) and Marsabit County (within which Loyongalani, Laisamis and Marsabit Central sub-counties only). The combined populations of targeted sub-counties constituted the total population for the purpose of calculating MDA population coverage. The target population increased with each succeeding year of MDA as it took into account annual population growth rates based on percentages provided by the County Health Records Information Office and it was based on the average national population growth that has ranged between 2.6%-3.6%.

No MDA was carried out in either county in Year 1 for logistics and planning lead time reasons. The MDA in the Marsabit sub-counties commenced in Year 2 and three rounds of MDA were completed there before the end of the NCE with 96% of the 357,086



number of treatment target reached. Isiolo completed over 95% of its targets over two rounds MDA and, as the project plans, has one round of MDA outstanding, which will be completed in Year 4.

It is anticipated that total coverage will exceed the WHO recommended 80% of population coverage once the final Isiolo MDA has been completed. This high coverage can be attributed to the static and active approach adopted for MDA delivery where drugs were available at HFs on the appointed days and health volunteers also moved through communities, ensuring people who had not accessed treatment at HFs could be administered with the antibiotics.

There was no independent verification of coverage through a treatment coverage survey. The reason provided for this is that the Kenya MOH policy is to only rely on summary data submitted from the MDA field work for coverage data. The drugs were being administered through a Directly Observed Treatment (DOT) protocol, the *MoPH&S* believes the margin of error is limited especially since during treatment there is continuous supervision to ensure drugs are being administered by trained medical personnel at the right dose and entries are being made correctly.

Facial cleanliness

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
4	To influence community behavior change in 11 partner schools & surrounding communities in favor of face and hand-washing, hygienic human waste disposal and garbage management	At least 80% of children in 11 partner schools & 11 villages have clean faces	<i>N children with clean faces in 11 schools</i>	4,842	4,842	4,842	Indicator presents methodological problems
			<i>N schools and villages with at least 80% of children with clean faces</i>	11	11	11	Indicator presents methodological problems

Table 8: Facial cleanliness – targets, achievements and performance Years 1 – 3 + NCE – In summary

The project defined facial cleanliness by the number of flies on a child's face with a child with above five flies on the face considered to have a dirty face and with five flies and below a clean face; measurement is done by counting the flies on sampled children's faces. According to information provided by the Sightsavers team, and thus assuming the above definition, the number of children with dirty faces noted at the beginning of the project was 28%. In the 2011 Trachoma Upper Eastern Kenya survey report, a clean face is defined as one with no eye and/or nasal discharges. According to the survey results, prevalence of dirty faces in Isiolo district was 19.3% and in Marsabit 21.9% in 2011.

For the first indicator under this objective and output, the project has set the target for children with clean faces as the number of children enrolled in the 11 schools supported by the project, using the enrolment rate at the beginning of the project (i.e. 4,842

children). Whilst in Year 1 the project reported 80% (or 3,858 children with clean faces) achievement, it consistently reported 100% of children (or 4,842) with clean faces for Year 2 and Year 3. The Evaluators could not obtain a clear answer from the project on how this was measured but the project team confirmed that, by reporting the total number of children enrolled as achievement, it is assumed that all children enrolled had clean faces, because the infrastructure improvements were completed and the health clubs were functional at these schools. The Evaluators note a couple of issues with this indicator. First, environmental improvements and the initiation of health groups are only the activities that should lead to improvement in clean faces prevalence but it cannot be assumed that, because these are in place, all children have changed their practices and have clean faces; therefore, enrolment numbers at the schools do not constitute an accurate proxy measurement to determine the number of actual clean faces. Second, even if the assumption would hold, the school enrolment numbers should have been adjusted year on year. Because of these methodological concerns, the Evaluators cannot comment on the project performance against this indicator and would recommend reconsideration of the methodology for measurement of clean faces. Proportion of clean faces would be best measured through a survey using an appropriate sample of children.

Similar concerns are noted for the second indicator under this objective and output. It refers to the number of schools and villages with at least 80% of children with clean faces. First, if the same assumption using enrolment figure to report achievement here is used, the observation made is equally valid for this indicator. Second, the indicator concerns the children population in both the 11 schools and the 11 villages, with the children at school coming from the villages and with most likely children in the villages not enrolled in school. Here again, the Evaluators cannot comment on the project performance against this indicator.

Environmental improvement

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		Performance (%)
					Target	Achievement	
3	To improve access to water services for 11 partner schools and surrounding communities in Gadamoji	11 water tanks/gutters constructed and/or rehabilitated in 11 partner schools	N schools with functional water tanks	11	11	11	100%
		1 borehole serving 11 villages rehabilitated	N functional borehole	1	1	1	100%
4	Division of Marsabit Central District by 2015 and To influence behaviour change in 11 partner schools & surrounding communities in favour of face and hand-washing, hygienic human waste disposal and garbage management	Hand-washing vessels installed in 11 partner schools	N schools with hand-washing vessels	11	11	11	100%
		Hygienic sanitation facilities (latrines) constructed and/or rehabilitated in 11 partner schools	N schools with functional hygienic toilets	11	11	11	100%
		Open Defecation Free Certification attained	N villages with ODF Certification	11	11	7	64%
		<i>Hygienic sanitation facilities (latrines) constructed and in use in 11 villages</i>	<i>N villages with functional hygienic sanitation facilities*</i>	11	11	0	N/A
		<i>Compost pits dug and in use in 11 villages</i>	<i>N villages where community members have compost pits</i>	11	11	0	N/A

Table 9: Environmental improvement – targets, achievements and performance, Years 1-3 + NCE - in summary

Implementation of activities under this intervention was partly carried out as initially planned. The target number of schools with functional water tanks and hand-washing vessels was achieved (100%). Rehabilitation of the community borehole was completed in Year 3.



The reasons why the target of 11 villages with functional hygienic sanitation facilities and compost pits was not achieved is due to a change of 'F' and 'E' strategy which made the activities associated with these indicators redundant. The original 'F' and 'E' strategy included four major components:

1. Behaviour change communication (BCC) to promote facial cleanliness and sanitation in 26 schools in Marsabit County and environmental hygiene amongst communities in three sub-counties through construction of hygienic sanitation facilities;
2. Clean water supplies using water boozers (use lorries to transport water to schools; and for the general community, sink boreholes to support behaviour change practices and for domestic use
3. Construction of toilets in the community;
4. Advocacy with key stakeholders to replicate interventions to areas not covered by the project and to scale it up to cover the entire Marsabit county

After analysis of the survey findings and due to lack of resources, the 'F' and 'E' interventions reduced in scope to:

1. Confine intervention to one Division in one district instead of one entire district
2. Reduction in the number of schools from 26 to 11
3. Enhance access to school water through construction of concrete tanks that would get water through roof-catchment instead of transporting water from far off places using lorries;
4. Adoption of Community Led Total Sanitation (CLTS) approach to environmental hygiene improvement instead of construction of toilets

By the last quarter of Year 3, the CLTS initiative was able to classify seven villages out of an expected 11 villages as ready for certification as Open Defecation Free (ODF) areas. Certification ODF areas is planned for Q2 of Year 4 when it is envisaged the remaining four villages will also have achieved ODF status.

GoK capacity building

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
5	To strengthen capacity for Trachoma implementation and management at the District and County levels	Trachoma District Implementation Teams (DIT) established and functional	N DHMTs/CITs sensitized on trachoma control (cumulative)	3	3	3	100%
			N coordination meetings held by DHMT/CIT (annual)	56	32*	34*	106%
		Marsabit Eye-Unit constructed & functional? Yes/No	Marsabit Eye-Unit constructed & functional? Yes (1) / No (0)	1	1	1	100%
6		HRH Development	Training of MOH staffs in Post basic ophthalmic work		2	2	100%
			Training of TT Surgeons		10	12	120%

* As there were no coordination meeting reported to be supported by the Comic Relief grant during the NCE period, this indicator reviews achievements until March 2014 only.

Table 10: GoK capacity building – targets, achievements and performance, Years 1-3 + NCE - in summary

The target of sensitizing three DHMTs or CITs on trachoma control was achieved by Year 2 of the project. The number of coordination meetings held by the DHMT/CIT was short of the target in Year 1 (75%), the number was exceeded in Year 2 (117%) and Year 3 (117%), meaning that overall 106% of the target of 34 to the end of March 2014 was met.

By the end of the NCE, the Marsabit Eye-Unit construction was complete and functioning.

In addition to the work plan listed activities, the project reported training 12 health professionals, from different facilities in high prevalence TT areas, to carry out trachoma surgeries these surgeons were a mix of government and FBO employees. The project also sponsored the training of one cataract surgeon and one ophthalmic nurse who would be operating the referral eye unit.

- Were the effects of the programme felt equally across the programme areas? If not, what was the difference and what are the reasons for this?

The SAFE strategy was not applied universally across the project area. Interventions were targeted based on the results of the 2011 baseline survey and each intervention targets varied according to planned the desired outcome.

While we can say that the work plan implementation performance was overall very satisfactory, we cannot provide a rigorous assessment on the outcomes or effect of the project at this time and in the absence of a similar survey as the one done by the MoPH&S and which served as baseline for the project. The project set its targets for 'S' and 'A' in line with the WHO targets, taking into account the baseline for each indicator. By the end of the NCE there had been three rounds of MDA administered in the sub-counties of Marsabit and two in Isiolo sub-county. Coverage had been higher than the WHO recommendation of 80% coverage for a target population and the target population was chosen based on prevalence rates. The project achieved 86% of the surgical target at the end of the NCE, with the expectation of outstanding surgical being completed in Years 4 and 5. No impact assessment can be planned until after three rounds at a minimum of an MDA and this is a planned future activity.

There were limited resources and reported cultural barriers to address for the 'F' and 'E' elements of the strategy and due to these limitations the evaluators would anticipate the project itself having less of an effect on a wider outcome on these elements of the strategy in terms of coverage across Marsabit. The project did succeed however in what it set itself to do in these areas as demonstrated by the high performance against the corresponding indicators above, although performance against the 'F' component could not be accurately measured. In order words, whilst the revised 'F' and 'E' might have been successfully implemented, it is its limited scope that raises concerns in terms of the effectiveness of this part of the project.

In conclusion to this effectiveness results chapter, the evaluation team wishes to note that the project has recorded overall a very satisfactory performance against the measurable indicators of the log frame and, if the overall effectiveness rating was determined only on that basis, the project would have earned a highly satisfactory rating. In the view of the evaluators, it falls short of that though because of the unbalanced attention given to each of the four components of the SAFE strategy, which is likely to reduce the cumulative effects of the project, and because the inability to measure the effectiveness of certain activities due to issues with indicators. .

C. EFFICIENCY

Efficiency

Rating: Satisfactory



- Were the resources planned for each activity adequate? If not why? Were programme resources managed in a transparent and accountable manner?

Responses from key informant interviews suggested that limited resources were available for the 'F' and 'E' components of the project. This required the initial 'F' and 'E' targets to be adjusted to fit within the budget available and as a result fewer people benefitted from the interventions.

The evaluation finds that while the set targets were achieved, for the most part, there may have been room to broaden the reach of the 'F' & 'E' components within the existing resources through better planning, more inter-sectoral engagement and collaboration with other stakeholders in the water, sanitation and hygiene (WASH) sector.

- Is there a competent and skilled team responsible for the management of the programme i.e. planning & budgeting, implementation, monitoring and evaluation?
- Is the programme structure adequate and if not, what adjustments are recommended?
- Assess the programme's management and coordination arrangements, in particular the extent to which timely and appropriate decisions were made to support effective implementation.

The project management structure for the Sightsavers Trachoma Control Project is compact with clearly defined roles and responsibilities. At national level the Country Director (CD) is ultimately responsible for the Sightsavers Trachoma Control Project. The Programme Manager (PM), is accountable to the CD and both the Programme Officer (PO) and the Project Coordinator (PC) report up to the PM. The Project Coordinator, as described in the introduction, was seconded to CDOM to coordinate the project on the ground and operating through the implementing partner. As such he also reports to the Development Director at the Diocese.

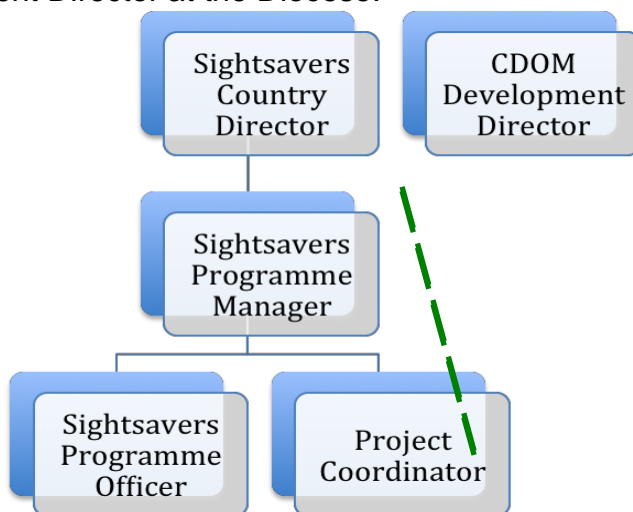


Figure 1: Sightsavers Country Trachoma Project structure

As a trained ophthalmic surgeon, the PC was competent and qualified to undertake surgical activities as planned under Objective 1 and also act as the trainer of surgeons for the capacity building component of the project. His role and skills are highly valued not only by the CDOM staff but also members of the county health management team. Key informant feedback revealed that all individuals interviewed, external to Sightsavers, found a skilled and competent team in place to manage and implement the project. The evaluation finds the project structure to be adequate.

Initial planning and budgeting for the project was done by Sightsavers with some consultation with the Ophthalmic Services Unit at the MoPH&S. From the start of implementation, an even more consultative approach was adopted with quarterly review meetings at both at national and county levels to enable an open forum for involvement of stakeholders in planning and decision making and to share progress and achievements of the previous quarter and to plan implementation of activities for the next quarter. All respondents, external to Sightsavers, reported being involved at some level in the following project activities: planning, decision making, implementation, monitoring and evaluation and reporting.

At the start of the project, KSB were the key implementing partners and responsible for project implementation, however implementation was sub-optimal due to limited presence on the ground and limited trachoma experience. Some of the project's activities experienced delays whilst Sightsavers negotiated the new management/implementation arrangements.

From Year 2, day-to-day management and coordination of the project has been administered through the PC based at the CDOM in Marsabit County. The quarterly meetings and revision of work plans allowed the previous quarters' achievements to be used to facilitate forward effective implementation and avoid delays where possible. The PC has a relatively high level of authority and flexibility in decision making facilitating timely decision making. Being based at CDOM allows the PC quick and easy access to one of his line managers and as depicted in Figure 1 above, the PC has a direct line of communication to the Sightsavers CD enabling appropriate decisions to be approved in a timely fashion particularly for unforeseen circumstances.

The evaluators note that there was no M&E framework or plan developed for this project. This was attributed to it not being a donor requirement. The evaluators identify this to be a limitation in terms of internal project monitoring as well as data availability for external evaluation and lessons learning.

Quality assurance for donor reports at country level is the responsibility of the Country Director (CD) after which there is review structure in place at headquarters, Sightsavers UK, for reviewing and finalising the report prior to submission to Comic Relief (CR). Feedback from CR is fed back along the same chain to country level through the CD down to project staff.

D. IMPACT

Impact
Rating: Satisfactory


➤ To what extent has the programme solved the problem it was intended to solve?

Without data from an impact survey, it is not possible to measure the extent to which the project has solved the problem it was intended to solve or will in the future. The project is also still in full implementation mode. The data presented under the 'effectiveness' criteria illustrates an emphasis predominantly on the 'S' and 'A' components, and suggests that project impact could be short-term with a potential for resurgence of TT and TF cases over time unless 'F' and 'E' components are significantly and rapidly scaled-up; all of the SAFE components are equally important in trachoma elimination and must be given the level of effort and scale of intervention.

➤ What proportion of the target beneficiaries have benefited from interventions and in what meaningful ways have their lives changed?

Surgery

At the end of the NCE, 86% of project target beneficiaries had benefitted from TT surgery.

In a focus group discussion group with 10 surgical beneficiaries (four men and six women) all respondents reported having benefitted from the project and the surgery offered. Originally, the knowledge on trachoma amongst the group was poor, access to health facilities was limited and there was a high fee at government health facilities of KSH 3,000 for the eye surgery service, so the approach taken by the Sightsavers project was well received.

The reported ways in which the surgery has changed/improved their lives include being able to:

- Look after their livestock – a key part of the culture and their livelihood
- Look after themselves and not be reliant on friends and relative to help with household tasks
- Go to the market to provide for the family
- Fetch firewood
- Visit friends and relative
- No longer experience pain and runny eyes (symptoms of TF) or have to pull out their eyelashes

Antibiotics

The MDA rounds had the following coverage of target communities that were administered azithromycin and all rounds to date have exceeded the current WHO recommended target of 80%.

First round	Marsabit	84%	Isiolo	96%
Second round	Marsabit	95%	Isiolo	96%
Third round	Marsabit	96%	Isiolo	N/A

In a focus group discussion with 15 MDA beneficiaries (nine men and six women) all respondents reported that they and their families had benefitted from the MDA campaign. They reported having received door-to-door administration of the drug and found this to be very convenient as the closest HF was 20 km away.

The reported ways in which the MDA campaign has changed/improved their life include:

- Access to the intervention through the active door-to-door delivery approach
- Improvement in community eye health
- Improvement in general community health

Facial cleanliness

While the evaluator noted methodological concern regarding this how facial cleanliness is measured earlier in the report, within its limited scope, it is likely though that the results of this activity are positive. The same proportion would have had access to other interventions under this including access to information on trachoma through school clubs, use of extra latrines and access to hand and face washing vessels with water from the tanks installed at 11 schools.

The evaluators did not have a chance to meet with any of the school children however FGD with five school administrators documented the changes they had seen since the inception of the project:

- Higher rate of attendance/less absenteeism due to ill health (predominantly diarrheal diseases)
- Higher rate of attendance of girls to school with access to more latrines
- Improved hygiene practices among children with regard to hand/face washing and use of latrines
- Community access to water from school water tanks
- Better community awareness regarding trachoma and better hygiene practices through trachoma songs, poems and plays carried out by school children in communities

Environmental improvement

While the project documents do not quantify the target population to benefit from the rehabilitation of the community borehole, given the population movements it can be expected that the proportion of people benefitting from the borehole is larger than the intended group of beneficiaries.

Community discussions in one village of the intended beneficiary groups revealed how their lives have changed/improved since the borehole was rehabilitated (which included the extension of the pipeline and construction of two accessible water tanks). Previously, the community, who had been living there for over 20 years would have to walk for six hours to the borehole to collect water which is 22kms away.

The project has changed/improved their day to day lives which have been made easier to manage including:

- Cooking food
- Watering the farms
- Looking after the animals – healthier donkeys

- Children being able to attend school (having been fed and cleaned better)
- General hygiene

As previously discussed the village latrines and compost pits were not funded or constructed as part of this project. The village latrine construction was indeed vetoed by the county planning team, giving the following two reasons:

1. It goes against community culture as there are those, who view it as relieving oneself inside a house which is considered to be highly unhygienic and those families will not use constructed toilets;
2. The nature of the soil in Marsabit tends to sink after some time rendering constructed toilets a danger and unusable.

As a result, there was a change of strategy following stakeholder engagement and, instead, latrines were provided in 11 schools in 11 different villages. The MoPH&S also recommended the project adopt the CLTS approach, which has resulted in seven communities being certified as open defecation free (ODF) by March 2014. The project worked with the MoPH&S in sensitizing the community and compelling them to use hygienic ways of solid waste disposal.

GoK Capacity building

Though not clearly identified in the log frame, a total of 12 health professionals were trained as TT surgeons through the project.

The evaluators interviewed 4 of the 12 surgeons all of who reported that their knowledge and skills relating to trachoma had been upgraded and that they were grateful to now be able to identify and operate on TT patients.

➤ What, if any, have been any unintended outcomes on the target groups arising from the programme?

Through KIs the evaluators were able to document a number of largely positive unintended outcomes for the target groups arising from the project. These were:

- a) Identification and treatment of other eye health issues – as a result of the active case detection and encouraging people with eye health issues to attend the outreach activities a number of other eye ailments were identified and referred to the eye hospital outside Nairobi. The Sightsavers project covered the associated costs including travel to Nairobi, accommodation, and surgery costs etc.
- b) Treatment of a host of other illnesses – as a broad spectrum antibiotic with administration of azithromycin would have also most likely cured other illnesses including chronic URIs, diarrheal diseases and STIs.
- c) The WFP school feeding programme could recommence – prior to the installation of tanks there was no water available to cook the school lunches provided by the World Food Programme (WFP). No children can be fed in school and this is likely to affect retention and ultimately improve literacy.
- d) Requests for tank installation from other schools – the project installed water tanks at 11 schools within Gadamoji division and as a result more schools have seen the positive impact and are requesting the same.

E. SUSTAINABILITY**Sustainability****Rating: Caution**

- What are the views of the target group beneficiaries on the programme and what was the extent of their involvement in its implementation? What is the sense of community ownership of the programme?

The views of the target group beneficiaries have been documented under the 'relevance' and 'impact' criteria.

With regards to community involvement in the implementation of the project, Community Health Workers and Community Health Extension Workers have played a key part in mobilizing communities for the interventions carried out under the project particularly in the areas of surgeries and MDA as well as CLTS in the 11 areas in Gadamoji division. Implementation of the project on the ground through CDOM has also contributed towards community involvement as the staff are an integral part of the community in Marsabit.

The evaluators observed a limited sense of ownership of the project as much of the interventions implemented have been service delivery on the 'S' and 'A' side of SAFE. Wider roll out of the 'F' and 'E' would require more understanding and ownership of the concepts from the community with regards to behaviour change to see a longer term impact and sustainability for trachoma but also health in general.

- To what extent has the programme strengthened the capacities of local government / district capacities and can they sustain programme achievements after the end of external support? If so, how?
- What are the major factors which will influence the achievement or non-achievement of sustainability of the programme?

Feedback from KII, across the group interviewed, with regards to the approach the project has taken towards ensuring sustainability of the project suggest that it has largely focused around service delivery pertaining to surgeries for TT. This has included the building and equipping of the eye unit at the Marsabit County referral hospital and training of health personnel. Even so, interviews with trained TT surgeons revealed that they felt that not having access to the surgery tools beyond the outreach activities has hampered their ability to attend to walk in TT patients. The reasons for why the tools were not supplied were given by the Sightsavers team and were discussed in the Effectiveness Section of the Results under Surgery.

The second approach reported was the engagement and information sharing with national and county government and more specifically the establishment of the county trachoma task force and linking this to the national trachoma task force through quarterly review meetings. The sub-county medical health team however, reported having had minimal contact from and involvement with the project except for assistance with identification of health professionals to be trained as TT surgeons and HR and logistics assistance for the rollout of the MDA.

Across the board, respondents highlighted the limited achievements under the 'F' and 'E' components and the need for a greater investment in these two areas in order for community ownership, behaviour change and ultimate impact and sustainability.

Key informant interviews around sustainability, 14 months prior to the end of the five year project, revealed that limited discussions had been held with the county government with regard to handover of the project interventions/activities other than the ceremonial handover of the completed eye clinic but the Sightsavers Team have highlighted that "Discussions on hand-over of the project have been in process since the project's inception" citing that "this is how a decision that local people already in government employment should be trained as OCO and ONO to be permanently attached to run the eye-unit was agreed upon." The County Government gave land for the construction of the eye-unit and is a plan for the Government to eventually take over the eye unit consumables supply which will be a progressive decrease from the project side across the remaining years of the project. Supplies of pharmaceuticals are not currently planned for handover in the short term due to lack of Government funds.

The Sightsavers team have met with the Marsabit County Government to lobby for the inclusion of eye-health in its county health strategic plan since January 2014 and the County Director of Health has recognised it as a priority. Once it is included in the county health strategic plan eye health will be budgeted for alongside other health priorities in the county of Marsabit. The project is still waiting to hear if eye-health has been included in the plan.

The ability of the county government to sustain the achievements very much depends on a) access to data on what impact has been achieved to date and b) having the resources planned, either through government or partner funds to be able to support follow on interventions beyond the life of the Sightsavers project.

The major factors that will influence the achievement or non-achievement of sustainability of the project are:

- 1) Rapid scale-up 'F' and 'E' components – the project has made impressive gains on the clinical components of trachoma control but how quickly and at what scale 'F' and 'E' can be rolled out will influence the sustainability of achievements to date. A large component of this is context specific BCC which the project was not successful to implement at scale in the first three years. The KAP survey was conducted to inform the development of materials, Sightsavers chose to postpone this activity but currently, a comprehensive national F&E strategy is in development and is set for roll-out in the second quarter of 2015. This strategy will focus on the promotion of behavior change and advocacy for enhancing access to water to the wider community in Marsabit amongst other trachoma endemic counties in Kenya. Materials will be developed for national BCC coverage across all counties with a simultaneous roll out.
- 2) County government ownership of the trachoma project – as at the time of the evaluation, while there have been impressions of close collaborations there cannot be true ownership when management and coordination are largely through a non-governmental body. Trachoma needs to be recognized as a public health concern reflected by its inclusion in the county annual health plan and budget until this happens, the sustainability of efforts to date could be compromised.

- 3) Inter-sectoral engagement – while some level of engagement with other sectors than health was undertaken under the project this was limited to the Gadmoji and Goro Rukesa when specific ‘F’ and ‘E’ activities were being implemented. Engagement at a broader level and lobbying for government investment in these components countywide would have wider and longer-term value.
- 4) Stakeholder collaboration – engagement of stakeholders other than the two implementing partners and the government have been extremely limited. Understating the resource intensive nature of the ‘F’ & ‘E’ components and rapid linkages with WASH partners in the region would provide an opportunity to leverage other resources to complement and impact the sustainability of trachoma elimination interventions.
- 5) Hospital fees for eye surgery – the Sightsavers Trachoma Project offered surgery at no cost to the beneficiaries however beyond the project period, at the end user level, payment of government imposed hospital fees for surgery remain a barrier. At KSH 3,000 per surgery, this remains unaffordable for a large proportion of the community.

F. SCALABILITY/REPLICATION

Scalability/replication

Rating: Satisfactory



➤ What aspects of the programme are suitable for replication?

The project has adopted the WHO recommended SAFE strategy for trachoma control and elimination which is suitable for replication in most local contexts. As documented above, they however have had only limited interventions in the ‘F’ and ‘E’ areas. A comprehensive package of water and sanitation infrastructure supported by context specific BCC could be tested before being rolled-out.

➤ Do the necessary conditions and capacity for scale-up exist within relevant agencies and government?

In theory, should all the SAFE principles have been applied at scale and simultaneously then there should be no need for scale up of the ‘S’ and ‘A’ components unless the impact survey shows otherwise. The ‘F’ and ‘E’ components of the project however, will require replication as these are only implemented as demonstration projects in one division of Marsabit Central sub-county – Gadamoji.

Stakeholder feedback on existing capacity within relevant agencies and the government to take on project activities and scale-up as required have been mixed. Some have reported the county government having the technical capacity and knowhow but not the finances, while feedback from one respondent in the county government said that should they be aware of the activities in enough time to incorporate them into the annual work plan and budget, then the county government would be able to take it on. Others have not identified the county government at all and rather highlighted the role of CDOM thus far and as a skilled partner to continue working in this area as well as other eye care and WASH and health agencies at national level.

G. COHERENCE/COORDINATION

Coherence/coordination

Rating: Satisfactory

- Are the programme objectives, approaches and design coherent and complimentary with each other?

In essence, the project design objectives and approaches were based on the four components of the WHO SAFE strategy and the KNPET, and included the fifth element of GoK capacity building. The four SAFE components form the foundation of the effort to eliminate blinding trachoma. All four components are expected to be present for a successful trachoma control programme, this is translated to equal attention being given to providing surgery, antibiotics, hygiene promotion, and environmental improvements and have been designed to be complementary. The addition of the GoK capacity building was to strengthen county-level capacity to manage effective and sustainable trachoma control beyond the life of the project. The original design of the project strategy is therefore coherent but as noted above, the evaluators feel that the scale at which the 'F' and 'E' components were implemented raise concern and the project need to address this at the risk otherwise to lose the gains made in the other project components. The evaluators were informed of a comprehensive national 'F' & 'E' strategy which is currently in development for roll out in 2015 which focuses on promotion of behavior change and advocacy for enhancing access to water to the wider community in Marsabit and other trachoma endemic counties in Kenya. This will result in the development of materials for national BCC coverage across all counties with a simultaneous roll out.

The project may benefit further from intra and inter sectoral collaboration for the 'F' and 'E' elements of the SAFE strategy.

- Has the programme's design and implementation taken into account other sectoral interventions in the area?

Implementation of all components of the SAFE strategy relies on multiple partnerships in various sectors such as water, sanitation and education that are essential to achieving the goal of elimination.

The project has engaged with the Ministry of Education (MoE) and Ministry of Water (MoW) in the implementation 'F' & 'E' components. However, engagement has been limited to one division in Marsabit Capital sub-county. The evaluation has not found that the project engaged with these ministries or other potential collaborating partners in the WASH sector to raise trachoma awareness, lobby for support or to leverage funds to complement efforts and increase the opportunity for impact.

5. Summary/Conclusion and Recommendations

A. SUMMARY AND CONCLUSIONS

In order to most concisely address the conclusions from the findings of this assessment, this section will focus on addressing two broad areas: summarizing firstly the findings by area of intervention and secondly a successes, weaknesses and lessons learned analysis from stakeholders interviewed.

Surgery

The intervention was found to be very relevant to the local context based on data from the 2011 trachoma baseline survey carried out in Marsabit. Though achievements in Year 1 and 2 were low, Year 3 NCE exceeded the target and the cumulative achievement at the end of three years was good at 86%.

The success of achievements can be attributed to active case-identification, community mobilization and outreach surgeries; beneficiary feedback has been very positive. With 12 TT surgeons trained and an eye unit constructed, with an addition two health staff trained to operate the unit, this activity can in theory be continued beyond the life of the project. While it is likely that the project will meet the target for this intervention by Year 5, long-term impact may be low should the complementary 'F' and 'E' components not be applied rapidly and more widely. With elimination being the ultimate goal, the reduction in transmission and resulting infections should diminish the need for surgeries entirely over time.

Antibiotics

Though MDA was not implemented in Year 1 as planned, coverage from both rounds in Years 2 and 3 and during the NCE was higher than WHO recommendations.

High coverage suggests that the process was managed well and success can be attributed to the mobilization of communities and the campaign model employed which uses both a static and an active approach to ensure that high proportions of the community were administered antibiotics. Beneficiary feedback in this regard was positive. It suggests good collaboration and coordination with the county medical health teams and training of CHWs. At the end of Year 3 NCE, one round of MDA was pending in Isiolo sub-county and an impact survey is needed to not before six months following the third round of MDA, which will determine whether or not a fourth round is required and if so, to see if it can be implemented within the project period.

Based on beneficiary feedback the door-to-door approach/model was perceived as being very effective and has been attributed to the projects high level of coverage and success for MDA.

Facial cleanliness

The target for the number of children with clean faces cannot be assessed by the Evaluator who noted methodological issues with the measurement of this indicator. The school health clubs were in place and were disseminating information regarding improved hygiene particularly with regard to face-washing and this is likely to have shown a resultant change of the behavior of individuals. Secondly, the installation of water tanks at schools gave the

children access to clean water ('E' component) and this would be able to facilitate the behavior change in messages regarding face and hand washing.

One of the limitations of this component has been the lack of a context specific BCC strategy and campaign. This should have been at the forefront of project implementation as behavior change takes time to be established in communities where their traditional behaviors are being addressed. Though the KAP survey was conducted to inform the development of materials, Sightsavers chose to postpone this activity. A comprehensive national F&E strategy has been developed and is set for roll-out in Q2 of 2015 which focuses on promotion of behavior change and advocacy for enhancing access to water to the wider community in Marsabit amongst other trachoma endemic counties in Kenya. This will result in the development of materials for national BCC coverage across all counties with a simultaneous roll out.

Though this component was designed to be illustrative and used as a model to be replicated, the evaluation finds that a wider coordination with WASH partners including the government could have resulted in wider awareness and interest in trachoma and may have led to increased leverage in partnerships for dispersing BCC messages and potential resources for infrastructure development in the target areas.

Environmental improvement

Three out of the four targets were achieved at 100%. These were installation of water tanks at 11 schools, provision of hand-washing vessels at 11 schools and the rehabilitation of one community borehole. The number of villages with functional hygiene facilities were not monitored in line with the original log frame indicators because WASH infrastructure activities were replaced with the adoption of the CLTS approach and resultant ODF certifications, where seven out of 11 villages were certified by the end of the NCE. The four villages that are not currently certified are expected to achieve this in 2015.

Feedback from school administrators details the immediate positive impact that the installation tanks and washing vessels has had on the student's attendance to school and general health, including that of the surrounding communities. The rehabilitation of the borehole has also facilitated target community access to water and significantly improved their daily lives. The findings are illustrative of a good approach towards improving health in general.

Like the 'F' component above, this component was designed to be demonstrative and used as model to be replicated. The evaluation finds that increased coordination with WASH partners including the government may have enabled wider awareness and interest in trachoma and perhaps been able to leverage partnerships and potential resources for infrastructure development in target areas.

GoK capacity building

In addition to all of the target meetings and sub-county health team sensitizations being met, the project also successfully trained 12 TT surgeons, it supported the training of one ophthalmic nurse and one cataract surgeon to run the eye health unit that was completed by the end of the NCE. The eye unit was completed and ceremonial handover had been agreed with the county health team. The handover of management and consumable expenses will be phased annually. At the time of evaluation, surgeons in high prevalence areas had been trained but they had not been provided with the surgical tools and as such

reported being restricted with regards to attending to walk-in TT cases at their facilities, though the reasons for the projects decision to not supply the tools has been outlined.

Complementing the conclusions drawn and transitioning through to recommendations are the successes, weaknesses and lessons learned reported and analyzed from stakeholders feedback across all categories and at all levels. Below the top-two of each category are discussed.

Successes:

- 1) MDA was reported as being one of the most successful interventions of the project particularly in light of the high coverage reached over the last year.
- 2) Surgery for the reduction of TT backlog was considered to be a success given the high number of target TT patients operated on at the time of the evaluation.

Weaknesses:

- 1) BCC for facial cleanliness and general hygiene and environmental sanitation was considered to have been limited to pilot areas throughout the project period to date and was identified as a barrier to sustainability by all respondents.
- 2) Community water services were considered to have been lacking with the rehabilitation of only one borehole however, the project had only made provision to directly support one community.

Lessons learned:

- 1) There is a need to focus on 'F' and 'E' for trachoma elimination.
- 2) A more integrated approach is required not only with the government and external stakeholders but at community level and to leverage other interventions.

B. RECOMMENDATIONS

Project level:

- 1) *Inter and intra-sectoral collaboration and coordination at government, non-governmental and community level for rapid scale up of F&E for sustainability of 'S' and 'A' achievements and improvements to health in general:* the first three years saw limited engagement with other ministries key to supporting the 'F' and 'E' components of the project and little evidence of collaborations with implementing partners in the WASH sector. While it is recognised that budget can often be a sensitive issue when planning activities, the evaluation advocates for better planning and collaboration in implementation of activities that require no extra costs to either party. For example: 1) planning with Waters Department to prioritise improving access to water points in high prevalence areas, 2) leverage WASH partners on BCC opportunities to include trachoma messages
- 2) *Continued advocacy for the development and execution of a plan for integration of project activities in the next county strategic health plan, and inclusion into the annual plan and budget which are developed annually for sustainability and ownership:* the impression among the county health team was that the Sightsavers project is an external project that at the present stage might hope to receive continued external funding thought there has been involvement from the county health team in the planning and implementation of activities, further activities could be identified for increased sustainability and ownership. The evaluation has shown that the County Director for Health has agreed verbally that eye health should be

included in the county health strategic plan and Sightsavers is awaiting confirmation that it has been included. Following its inclusion in the strategic plan, Sightsavers can continue to lobby for a budget provision in the annual health planning , and the evaluation recognizes a continued need for advocacy on eye health and to ensure that it continues to be included in future plans and gains government funding to ensure that the elimination of trachoma becomes part of a sustained approach to public health planning in Marsabit and this includes the continued inclusion of county health team in project planning.

- 3) *Ensure that the project documents (proposal, log frame) include all interventions implemented by the project for more accurate and fair measurement of progress:* the evaluation found that the project had undertaken a number of complementary activities under certain objectives however, these had not been clearly identified in any of the background documentation. While efforts have been made to ensure that these achievements are highlighted, analysis and ensuring coverage of all elements would have been made easier should these have been documented better.
- 4) *Developing an M&E plan and framework for internal monitoring with structured, verifiable data collection systems and tools:* Initially, the only data that was available for the evaluation was in annual reports with limited explanation and opportunities for clarification. The evaluation finds that the project would benefit from an M&E database to collect and monitor project related data and indicators. At the point of setting up the M&E plan and framework, each indicator and what it means and how it is monitored, should be discussed with team consensus and clarity on how it is measured. During the writing of this report and during the data analysis, we have tried triangulate data from a number of sources, one example is looking at data in the end of project report, shared with Comic Relief stated that the number of surgeries completed was 1,777 but the Excel database shared by Sightsavers with the evaluators highlighted 1,832 with no clear explanation as to why there were differences in total surgeries completed, it also showed different figures for number of follow ups and total percentage of good outcomes on those follow ups. A well thought out M&E plan and framework would help to capture project wide data and would improve clarity and ongoing internal performance monitoring.
- 5) *Reviewing indicators:* There were also some methodological issues concerning three indicators used to track work plan implementation performance and these should be addressed for Year 4 and 5. 1) They include:
 - a. Number of surgeries with good outcome - this need to be refined to read 'number of surgeries with good outcome, of those followed-up and efforts should be made to increase the current follow-up of 81% to close to 100%.
 - b. Number of school children with clean faces - the number of children enrolled in the schools is an inaccurate proxy measurement for clean faces; this should be measured through a survey and appropriate sampling. The project should also re-consider the definition of clean face in line with the indicator used as standard in trachoma surveys.
 - c. Number of schools and villages with at least 80% of children with clean faces present the same issue as the indicator above. In addition there is an overlap between the school and village children populations.

- 6) *Identifying data needs for impact assessment and Value for Money (if desired):* with the anticipated impact survey in 2015 the evaluators recommend that the project begin to identify their information needs to build the impact survey should this not already be underway. Similarly, should the project have any interest in value-for-money analysis, the same should be considered. The project could identify and start monitoring unit costs and benchmarks from other projects and agree what would be the indicators of impact and VFM.
- 7) *Highlight geographical areas outside the project areas that may require roll of activities:* the project, selected the areas of highest prevalence to be targeted with the funds available through Comic Relief. It is recommended that should there be other areas in the region that require trachoma control interventions that these be identified and highlighted to potential donors and the government for planning purposes.

Intervention level:

- 8) *Distribution of surgery tools:* with training of surgeons having been completed, it is proposed that the surgical tools required for TT surgery be allocated to the HFs at which there are trained surgeons to allow for walk-in TT patients to be attended to and reduce a 100% reliance on the outreach approach.
- 9) *Refresher surgeon training prior to end of project:* while all trained surgeons have been practicing surgeries during outreach sessions under supervision, a refresher theory course is recommended along with a list of consumables required for surgeries to ensure that a high quality of information is retained and that they are able to procure consumables on time.
- 10) *Rapid survey to inform next steps regarding MDA during life of project:* should the planned impact assessment not transpire, it is recommended that a rapid survey is undertaken to inform on the prevalence of TF to determine whether or not there will be a need for another round of MDA and if required how best to cater for this within the project period.
- 11) *Development of context specific BCC based on Marsabit KAP survey results:* the evaluators were informed that while a KAP survey was undertaken to inform the development of BCC material for Marsabit County, the development of these was postponed as a national level BCC campaign for trachoma was being designed under The Trust project. It is recommended that the data from the KAP survey are used to make BCC context specific to ensure as best possible that behavior change can indeed be initiated.
- 12) *Expansion of CLTS through CHWs at no cost to the project:* The CLTS initiative under the project is currently being rolled out in one division of Marsabit sub-county through CHWs and CHEWs. It is recommended that the project work with the county government to train CHWs and CHEWs to extend this to all project areas at no, or minimal costs to the project.

6. References and Appendices

<https://www.cartercenter.org/documents/2302.pdf>

http://www.cartercenter.org/resources/pdfs/news/health_publications/trachoma/ICTC_MDA-Toolkit.pdf

<http://www.trachomacoalition.org/sites/default/files/uploads/resources/Trachoma%20Action%20Planning%20-%20A%20planning%20guide%20.pdf>

http://www.who.int/blindness/publications/tcm%20who_pbd_get_06_1.pdf?ua=1

<http://www.who.int/mediacentre/factsheets/fs382/en/>

Comic Relief Trachoma Control Project – Marsabit – Project Proposal

Draft Trachoma Report for Upper Eastern Kenya (Isiolo and Marsabit Counties). (2011) Ministry of Public Health and Sanitation.

Emerson PM, Burton MJ, Solomon AW, Bailey R, Mabey DCW. (2006) The SAFE strategy for trachoma control: using operational research for policy, and implementation. *Bulletin of the World Health Organization*. 84:613-619

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Rajak SN, Collin JRO, Burton MJ. Trachomatous Trichiasis and its Management in Endemic Countries. *Survey of Ophthalmology* 2012;57-341(2):105-135. doi:10.1016/j.survophthal. 2011.08.002.

Smith JL, Haddad D, Polack S, Harding-Esch EM, Hooper PJ, et al. (2011) Mapping the Global Distribution of Trachoma: Why an Updated Atlas Is Needed. *PLoS Negl Trop Dis* 5(6): e973.

Solomon AW, Zondervan M, Kuper H, Buchan J, Mabey DC, et al. (2006) *Trachoma control— a guide for programme managers*. Geneva: World Health Organization.

Annex 1 Terms of Reference

Title: Trachoma Control Project - Marsabit

Background

Sightsavers Kenya Country Office has been supporting the implementation of the Marsabit Trachoma Control Project in 5 sub counties¹⁴ in Kenya's Upper Eastern Region, with an estimated population of 291,166 people since April 2011. Sightsavers has been running this programme with funding from Comic Relief to the tune of £700,000. The programme's intervention logic is based on the World Health Organization recommended 4-pronged strategy for the elimination of blinding trachoma.

Popularly referred to by the acronym SAFE, the 4 major components of the programme include Surgery for Trachomatous Trichiasis (TT) patients; annual Mass Distribution of Antibiotics (MDA) that targets a minimum of up 80% of district-wide population for a period ranging 3-5 years, depending on prevalence levels; Facial Cleanliness and Environmental Hygiene. A fifth component of the programme focuses on capacity building for sustainability of programme achievement at the end of external support in 2016. These interventions were community-targeted and sought community involvement through the primary health care approach.

The programme was implemented in partnership with two key partners, namely: Catholic Diocese of Marsabit, who was responsible for the overall project Management & implementation of the F&E components of the programme and mobilization for MDA; and Government of Kenya /Ministry of Health who were responsible for the medical component which included TT Surgery & Antibiotic administration. The programme also supported capacity building interventions which included infrastructure development, capacity building of eye health workers, and community sensitization on trachoma elimination.

The overall objective of the programme was to '*contribute to the achievements of the goals for global elimination of blinding trachoma in line with national and international health commitments*'.

The specific objectives were;

- a) To reduce the TT backlog of 2,369 amongst adults ≥ 15 years in Marsabit, Isiolo and Moyale Districts by 90% and maintain TT recurrence below 10% by 2016;
- b) To reduce the overall prevalence of active trachoma (TF) in Marsabit Central, Laisamis and Loiyangalani Districts in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2016;
- c) To improve access to reliable water supply for 21 schools and surrounding communities in one location in Gadamoji Division of Marsabit Central District by 2016; and,
- d) To promote community behavior changes in favor of face,-washing, hand-washing and hygienic human waste disposal.

The key project outcomes were;

- a) At least 2,132 TT patients in the Upper Eastern zone operated on by 2015;
- b) At least 1,918 of TT surgeries result in good outcome;
- c) Children under 6 and pregnant women treated with Tetracycline Eye Ointment (TEO);

¹⁴ Moyale; Isiolo; Laisamis; Marsabit Central; and, Loiyangalani

- d) 26 schools and 5 dispensaries benefit from Emergency Water Trucking; and,
- e) 26 schools in Gadamoji Division benefit from construction of toilets & provision of hand-washing vessels;
- f) 53% of households in Gadamoji Division have functional toilets & compost pits;
- g) A well-established Trachoma prevention and control mechanism in place within Marsabit County;
- h) Enhanced National Prevention of Blindness Working Group (NPBWG) to influence policy; and,
- i) Enhanced Capacity of National Trachoma Coordinating Desk

The key beneficiary figures were:

- a) 10 TT Surgeons trained and certified;
- b) 2,369 adults benefit from TT interventions;
- c) At least 232,932 people living in Marsabit treated with Azithromycin & TEO annually for 3 years as needed;
- d) 525 Households have improved access to water; and,
- e) At least 104,819 children in Marsabit County have clean faces.

Purpose of Evaluation

The general objective of the end of project evaluation is to assess the extent to which the project has contributed towards elimination of trachoma amongst the communities in Marsabit County. The evaluation will also examine the following;

- a) The extent to which the project has achieved its objectives as outlined in the project document;
- b) What could have been done differently if anything and what needs to change to improve on project delivery;
- c) Determine the relevance, effectiveness, efficiency and impact of the project interventions;
- d) The extent to which the project interventions were sustainable; and,
- e) Documentation of key lessons learnt from the project implementation any best practices.

Overall, the evaluation is expected to provide a good description of the project context and key factors that have influenced the final results

Evaluation criteria

The end of project evaluation is expected to provide information to all questions under each of the following specific areas:

Relevance

- Has the programme responded to the needs and priorities of its beneficiaries as identified in the proposal?
- Have the approaches and activities been relevant to the local context?
- Are the programme goal and objectives consistent with and supportive of county development and sector policies and strategies?

Effectiveness

- To what extent have planned targets and objectives been delivered?
- What proportions of planned activities were successfully implemented and what proportion, if any, were not successfully implemented and why?

- To what extent did the activities implemented result in the desired outputs and solve the problems they were intended to solve? What aspects of the problem, if any, were not solved and why?
- Were the effects of the programme felt equally across the programme areas? If not, what was the difference and what are the reasons for this?

Efficiency

- Were the resources planned for each activity adequate? If not why?
- Were programme resources managed in a transparent and accountable manner?
- Is there a competent and skilled team responsible for the management of the programme i.e. planning & budgeting, implementation, monitoring and evaluation?
- Is the programme structure adequate and if not, what adjustments are recommended?
- Assess the programme's management and coordination arrangements, in particular the extent to which timely and appropriate decisions were made to support effective implementation.

Impact

- To what extent has the programme solved the problem it was intended to solve?
- What proportion of the target beneficiaries have benefited from interventions and in what meaningful ways have their lives changed?
- What, if any, have been any unintended outcomes on the target groups arising from the programme?

Sustainability

- What are the views of the target group beneficiaries on the programme and what was the extent of their involvement in its implementation? What is the sense of community ownership of the programme?
- To what extent has the programme strengthened the capacities of local government / district capacities and can they sustain programme achievements after the end of external support? If so, how?
- What are the major factors which will influence the achievement or non-achievement of sustainability of the programme?

Scalability/replication

- What aspects of the programme are suitable for replication?
- Do the necessary conditions and capacity for scale up exist within relevant agencies and government?

Coherence/coordination

- Are the programme objectives, approaches and design coherent and complimentary with each other?
- Has the programme's design and implementation taken into account other sectoral interventions in the area?

Review Team

Interested candidates will have an overall understanding of the Kenyan health sector policies and health systems as well as WHO VISION 2020 framework and policies. Familiarity with Global Elimination of Trachoma (GET) 2020 Goal, purpose, policies and guidelines and the National eye care & Trachoma plans will be an added advantage. He/she should have demonstrated experience in project management, monitoring & evaluation particularly in the health and eye health sector.

The suitable candidate should also possess the following;

- a) Experience with public health policy with special focus on eye-health;
- b) Experience conducting programme evaluations;
- c) Experience conducting population based surveys of trachoma;
- d) Strong analytical and writing skills; and,
- e) A Postgraduate degree in Public Health, Development or other relevant field.

Methodology

The evaluation will be conducted in a participatory manner using a combination of information gathering methods including a review of the key project documents, Key Informants Interviews (KII) targeting key personnel amongst different stakeholders, beneficiary consultation through Focus Group Discussions and site visits to the field as deemed necessary, to mention but a few. The Consultant will triangulate and validate information gathered, process and analyze it, prepare a report of findings based on the analysis. Throughout the evaluation process; there will be continuous communications between the consultant and the partners as the need may be.

Reference Material

Sightsavers will provide all relevant reference material, including;

- Project Proposal;
- Progress reports;
- Financial reports;
- Contract with Comic Relief; and,
- Trachoma survey report

Timeframes

The evaluation will take approximately 17 the days. These days will include time for desk review, field activities, travels and report writing. It is suggested the evaluation follows the following key phases:

Phase I - Desk Study: Review of Documentation and Elaboration of field Study

The lead consultant/evaluation team will review relevant documentation from section 5 above (Reference material). Based on this review, they will produce an *inception report* which will include an elaborate plan, methodology and sampling strategy of the data collection for evaluation study. The evaluation will only proceed to the next stage upon approval of this inception report. An appropriate inception report format will be made available to the team as part of this TOR.

Phase II - Data Collection

This phase of the evaluation will seek to collect primary data on the key evaluation questions explained under evaluation criteria. The team will use the agreed plan, methodology and sampling strategy from phase 1 to conduct the field work.

Phase III – Data Analysis and Production of Evaluation report

The team will draw out key issues in relation to evaluation questions and produce a comprehensive report.

The table below summarizes the key activities under the 3 phases outlined above envisaged for this assignment:

Phase	Activity	No of Days
Phase I – Desk study: Review of documentation and elaboration of field Study	Desk research /literature Review	1 day
	Inception Report	1 day
	Development of Data Collection Tools & Pre-Testing	2 days
	Revision of tools based on feedback from the field	1 day
Phase II: Field Data Collection	Field Visits & Data-collection	7 days
Phase III – Analysis and production of evaluation report	Data analysis and preparation of draft report	2 days
	Presentation of Findings & Feedback	1 day
	Review of Draft Report based on Feedback.	2 days
	Submission of final report	1 day
Total		18 days

Outputs/Deliverables

The consultancy deliverables will include;

Inception report

The evaluation team is expected to submit an inception report detailing their understanding and interpretation of the TOR within 5 working days of commencing this evaluation. The purpose of this report is to ensure that the evaluator covers the most crucial elements of the exercise including the appropriateness and robust methodology to be employed. The inception report provides the organization and the evaluators with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset. The report should reflect the team's review of literature and the gaps that the field work will fill.

Field work will only commence once this report has been reviewed and approved.

Draft Report

A draft report in the approved format from the evaluating team will be expected 5 days after the completion of field work and will be produced by the lead consultant. Sightsavers will provide the consultants with written feedback on the draft within **three weeks** of acknowledged receipt. Feedback should be included in the final report.

Final Report

The final report (not more than 40 pages including executive summary and excluding annexes) will be submitted to Sightsavers within 5 working days after receiving the feedback from Sightsavers on the draft report. Findings and recommendations from the Final Report will be used to assist Sightsavers and partners for future planning.

Data Sets

The evaluation team will be expected to submit complete data sets (in SPSS/Access/ Excel) of all the quantitative data as well as the original transcribed qualitative data gathered during the exercise. These data sets should be provided at the time of submission of the final report.

Summary findings

On submission of the final report, the team is expected to submit a PowerPoint presentation (**maximum 12 slides**), summarizing the methodology, challenges faced, key findings under each of the evaluation criteria and main recommendations.

Reporting Format

Detailed guidelines on how to structure the evaluation report will be provided to the evaluation team prior to commencement of the activity. The team should conform to this format.

Please note that penalties up to 10% of agreed fees will be imposed for noncompliance with the requirements 7.1 to 7.4 and reporting format provided.

Administrative/Logistical support

Budget

The consultant shall submit to Sightsavers an expression of interest indicating their daily rates for the assignment. Sightsavers will negotiate with the consultant the final fees in line with the budget available for this evaluation. The daily fees proposed exclude cost of economy class flights (where applicable), in-country accommodation (bed, breakfast, evening meals), local transport and stationery, which will be covered by Sightsavers.

Logistics

Sightsavers will cover the following costs;

- Economy class airfares and VISAs. (where applicable);
- In-country transportation;
- Hotel accommodation (*bed, breakfast and even meals taken at the place of accommodation*);
- Stationery and supplies; and,
- Meeting venue hire and associated equipment e.g. projectors

The consultant/team is expected to cover all other costs and materials not mentioned above related to this exercise as part of their daily fees or equipment (e.g. laptops)

SCHEDULE OF PAYMENT

The following payment schedule will be followed;

- On signing the contract: 20%;
- Submission of draft report: 30%; and,
- On acceptance of final report: 50%

MODE OF PAYMENT

As agreed by Sightsavers and the consultant

Annex 2 Workplan

	Dates	Sarah Days	Rose Days	Sightsavers Days
PHASE 1 Desk Study and Review of Documentation				
Mobilisation of team	26 – 28 th Nov			
Desk Research/Literature Review/policy reviews	20 – 21 st Nov + 1 -5 th Dec	0.5	0.5	
Development of methodology, development of Inception Report	20 – 21 st Nov + 1 -5 th Dec, 8 – 12 th Dec	2.5	0.5	
Development of data collection tools	8-12 Dec	2	1	
<i>Inception Report submitted to Sightsavers</i>	<i>12th Dec</i>			7
<i>Meeting with Sightsavers and approval to go to PHASE 2 – Technical questions posed and answered includes organising logistics</i>	<i>19th Dec</i>	<i>0.5</i>	<i>0.5</i>	<i>0.5</i>
PHASE 2 – Field Data Collection				
Sightsavers staff interviews (follow on from Phase II approval meeting)	Thu – Fri 15-16 Jan	0.5		
Stakeholder interviews – phone – Nairobi	Thu – Fri 15-16 Jan	0.5		
Travel	Mon 19 Jan	1	1	
Pre-testing and refinement of tools	Tue 20 Jan	0.5	0.5	
Data collection/interview	Tue – Fri 20–23 Jan	3.5	3.5	
Travel	Sat 24 Jan	1	1	
<i>Post fieldwork meeting with Sightsavers – technical questions</i>	<i>Mon 26 Jan</i>	<i>0.5</i>	<i>0.5</i>	<i>0.5</i>
PHASE 3 – Analysis and production of evaluation report				
Data analysis	Tues 27 Jan	1	1	
Preparation of final report & presentation	Wed – Fri 28-30 Jan	2.5	0.5	
Presentation of findings and feedback	Mon 2 Feb	0.5	0.5	
Draft Report - Submission	Mon 2 Feb at meeting			
<i>Sightsavers review period for draft report</i>	<i>Mon – Fri 2-6 Feb</i>			5
Review of draft report based on Sightsavers feedback	Sat – Tue 7-10 Feb	1.5		
Submission of final report	Tue 10 th Feb			
	TOTALS	19	11	

Annex 3 Evaluation Matrix

	Key Evaluation question to be addressed	Data Collection Technique		
		Primary Data Source	Secondary Data Source	Data Tools
	<i>Relevance</i>			
1.	Has the programme responded to the needs and priorities of its beneficiaries as identified in the proposal?	<ul style="list-style-type: none"> Field visit Contextual understanding, Desk review of project documents, national policy/strategy docs 	<ul style="list-style-type: none"> KII with local stakeholders FGDs with beneficiary communities 	Tools 5 and 6
2.	Have the approaches and activities been relevant to the local context?	<ul style="list-style-type: none"> Field visit 	<ul style="list-style-type: none"> KII with local stakeholders and FGDs with beneficiary communities 	Tools 5 and 6
3	Are the programme goal and objectives consistent with and supportive of county development and sector policies and strategies?	<ul style="list-style-type: none"> Desk review of project documents including project proposal, budget and national and international policy documents 	<ul style="list-style-type: none"> KII with Sightsavers, national and local level stakeholders 	Tools 3, 4 and 5
	<i>Effectiveness</i>			
4.	To what extent have planned targets and objectives been delivered?	<ul style="list-style-type: none"> Desk review of project documents including project proposal, log frame, annual reports, end of project report 	<ul style="list-style-type: none"> KII with Sightsavers, national and local level stakeholders 	Tools 2, 3, 4 and 5
5.	What proportions of planned activities were successfully implemented and what proportion, if any, were not successfully implemented and why?	<ul style="list-style-type: none"> Desk review of project documents including project proposal, log frame, annual reports, end of project report 	<ul style="list-style-type: none"> KII with Sightsavers staff and local stakeholders 	Tools 2, 3 and 5
6.	To what extent did the activities implemented result in the desired outputs and solve the problems they were intended to solve? What aspects of the problem, if any, were not solved and why?	<ul style="list-style-type: none"> KII with Sightsavers staff and local stakeholders and beneficiaries 	<ul style="list-style-type: none"> Desk review of project reports 	Tools 2, 3, 5 and 6
7.	Were the effects of the programme felt equally across the programme areas? If not, what was the difference and what are the reasons for this?	<ul style="list-style-type: none"> KII with Sightsavers staff and local stakeholders and beneficiaries 	<ul style="list-style-type: none"> Desk review of project reports 	Tools 3, 5 and 6
	<i>Efficiency</i>			

8.	Were the resources planned for each activity adequate? If not why?	<ul style="list-style-type: none"> • Desk review of project budget and log frame 	<ul style="list-style-type: none"> • KII with Sightsavers staff 	Tools 1 and 3
9.	Were programme resources managed in a transparent and accountable manner?	<ul style="list-style-type: none"> • Desk review of project budget and log frame 	<ul style="list-style-type: none"> • KII with Sightsavers staff 	Tools 1 and 3
10.	Is there a competent and skilled team responsible for the management of the programme i.e. planning & budgeting, implementation, monitoring and evaluation?	<ul style="list-style-type: none"> • Desk review of project organogram 	<ul style="list-style-type: none"> • KII with Sightsavers staff 	Tool 3
11.	Is the programme structure adequate and if not, what adjustments are recommended?	<ul style="list-style-type: none"> • Desk review of project organogram 	<ul style="list-style-type: none"> • KII with Sightsavers staff 	Tool 3
12.	Assess the programme's management and coordination arrangements, in particular the extent to which timely and appropriate decisions were made to support effective implementation.	<ul style="list-style-type: none"> • KII with Sightsavers staff and local stakeholders 	<ul style="list-style-type: none"> • Desk review of project reports 	Tools 3 and 5
	Impact			
13.	To what extent has the programme solved the problem it was intended to solve?	<ul style="list-style-type: none"> • Desk review trachoma survey, project reports statistics 	<ul style="list-style-type: none"> • KII with local stakeholders and Sightsavers staff 	Tool 3 and 5
14.	What proportion of the target beneficiaries have benefited from interventions and in what meaningful ways have their lives changed?	<ul style="list-style-type: none"> • FGD with beneficiaries 	<ul style="list-style-type: none"> • Desk review of project reports 	Tool 6
15.	What, if any, have been any unintended outcomes on the target groups arising from the programme?	<ul style="list-style-type: none"> • KII with Sightsavers staff 	<ul style="list-style-type: none"> • Desk review of project reports 	Tool 3
	Sustainability			
16.	What are the views of the target group beneficiaries on the programme and what was the extent of their involvement in its implementation? What is the sense of community ownership of the programme?	<ul style="list-style-type: none"> • FGD with beneficiaries 	<ul style="list-style-type: none"> • Desk review of project reports 	Tool 6
17.	To what extent has the programme strengthened the capacities of local government / district capacities and can they sustain programme achievements after the end of external support? If so, how?	<ul style="list-style-type: none"> • KII with Sightsavers staff and stakeholders 	<ul style="list-style-type: none"> • Desk review of project reports 	Tools 3, 4 and 5
18.	What are the major factors which will influence the achievement or non-achievement of sustainability of the programme?	<ul style="list-style-type: none"> • Contextual understanding, • field visit, • triangulation of data 	<ul style="list-style-type: none"> • KII with Sightsavers staff and stakeholders 	Tools 3, 4 and 5
	Scalability / replication			

19.	What aspects of the programme are suitable for replication?	<ul style="list-style-type: none"> • KII Sightsavers staff 	<ul style="list-style-type: none"> • Desk review of latest national and global policies 	Tools 3, 4 and 5
20.	Do the necessary conditions and capacity for scale-up exist within relevant agencies and government?	<ul style="list-style-type: none"> • KII with Sightsavers staff and stakeholders 	<ul style="list-style-type: none"> • Field visit, contextual understanding 	Tool 3, 4 and 5
	<i>Coherence/coordination</i>			
21.	Are the programme objectives, approaches and design coherent and complimentary with each other?	<ul style="list-style-type: none"> • Desk review, • triangulation of data 	<ul style="list-style-type: none"> • KII with Sightsavers staff and stakeholders 	Tool 1, 2, 3, 4 and 4
22.	Has the programme's design and implementation taken into account other sectoral interventions in the area?	<ul style="list-style-type: none"> • Desk review of project documents 	<ul style="list-style-type: none"> • KII with Sightsavers staff and stakeholders 	Tools 3 and 5

Annex 4 List of Informants Interviewed

Stakeholder group	Level / organization	Target informant	Number of informants planned	Number of informant actually interviewed	Position and institution of key informant
Sightsavers	Nairobi	Program management	2	1	Country Director
		Technical implementation staff	2	1	Programme Officer
		Finance and administration staff	1	0	
	County	Technical implementation staff		1	Project Coordinator
MoPH&S	National	HOD Ophthalmology/Eye Unit	1	1	Head of OSU
		National Trachoma Coordinator	1	1	National Trachoma Coordinator
	County	County Executive for Health or County Chief Health Officer	1	1	County Public Health officer
		County Director of Health	1	1	Deputy Director of Medical Services
		County programme officer in-charge of eye interventions	2	1	Sub-county public health nurse
	Facility	Medical superintendent of county / sub-county facilities within the catchment area	2	0	
Implementing partners	Catholic Diocese of Marsabit	Program management	1	1	Former Director
		Technical implementation staff	2	2	Deputy Director
					Health Coordinator
	Kenya Society for the Blind	Program management	1	0	
		Technical implementation staff	1	0	
CBOs/FBOs implementing interventions through the DoM	Program management or technical staff	1	0		
Collaborating partners	Comic Relief	Management	1	0	
	WHO	Management	1	0	
	Fred Hollows Foundation	Management	1	0	
	Helen Keller International	Management	1	0	
	AMREF	Management	1	0	

Annex 5 Output Indicator datasheet

Output indicators	Baseline	Targets and Achievements														
		Year 1 (Apr-11 - Jun-12)			Year 2 (Jul-12 - Mar-13)			Year 3 (Apr-13 - Mar-14)			NCE			Total Performance years 1-3 + NCE (cumulative)		
		Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	% of total target
N of Trachoma Trichiasis surgeries performed	16	320	83	26%	896	445	50%	900	1,175	131%	429	129	30%	2,132	1,832	86%
N of Follow ups		90% of 83 or 74	77	104%	90% of 445 or 400	316	79%	90% of 900 or 810	974	120%	90% of 129 or 116	124	107%	1,400	1,491	107%
N surgeries with good outcome	14	288	75	97%	806	274	87%	810	856	88%	386	115	93%	1,918	1,320	89%
% surgeries with good outcome, of those performed	88%	90%	90%	100%	90%	62%	81%	90%	73%	81%	90%	89%	99%	90%	75%	83%
N treated with antibiotics In Marsabit County	0	0	0	0%	115,184	96,806	84%	117,947	111,680	95%	123,955	119,257	96%	357,086	327,743	92%
N treated with antibiotics In Isiolo County	0	0	0	0%	0	0	0%	93,823	89,212	96%	97,076	92,076	95%	190,899	181,288	95%
% of sub-county population annually treated with antibiotics	0	0	0		27%	22%	84%	48%	46%	95%			#DIV/0!	74%	68%	91%

Output indicators	Baseline	Targets and Achievements														
		Year 1 (Apr-11 - Jun-12)			Year 2 (Jul-12 - Mar-13)			Year 3 (Apr-13 - Mar-14)			NCE			Total Performance years 1-3 + NCE (cumulative)		
		Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	Performance (%)	Target	Achievement	% of total target)
N children with clean faces in 11 schools	0	3,744	0	0%	4,842	3,858	80%	4,842	4,842	100%				4,842	4,842	100%
N schools and villages with at least 80% of children with clean faces		0	0		6	55%	6%	11	100%	100%				11	11	100%
N schools with functional water tanks	0	0	0		6	7	117%	11	11	100%			0%	11	11	100%
N functional borehole	0	0	0		1	0	0%	1	1	100%			0%	1	1	100%
N schools with hand-washing vessels	0	0	0		11	11	100%	11	11	100%			0%	11	11	100%
N schools with functional hygienic toilets	0				6	10	167%	11	1	9%			0%	11	11	100%
N villages with functional hygienic sanitation facilities*	0	0	0		6	0	0%	11	7	64%			0%	11	7	64%
N villages where community members have compost pits		0	0		6	0	0%	11	7	64%			0%	11	7	64%
N DHMTs/CITs sensitized on trachoma control (cumulative)	0	2	2	100%	3	3	100%	3	3	100%			#DIV/0!	3	3	100%
N coordination meetings held by DHMT/CIT (annual)	0	8	6	75%	12	14	117%	12	14	117%			#DIV/0!	32	34	106%
Marsabit Eye-Unit constructed & functional? Yes/No		0	0		1	0	0%	1	0.5	50%	1	1	100%	1	1	100%
Training of 2 MOH staffs in Post basic ophthalmic work.		0	0	0%	0	0	0	2	2	100%	0	0	100%	2	2	100%
Training of TT Surgeons.		10	7	70%	4	4	100%	0	0	0	0	0	0	10	11	110%

Annex 6 Output Indicator datasheet – Summary sheet
SURGERY

Obj.	Specific Objective	Expected Output	Output Indicators	End of 5Y project log frame target	Targets and Achievements Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
1	To reduce the TT backlog of 2,369 amongst adults > 15 years in Marsabit, Isiolo and Moyale by 90% and maintain TT recurrence to below 10% by 2015	At least 2,132 TT patients in the Upper Eastern zone operated on by 2015	N of surgeries performed	2,132	2,132	1,832	86%
			<i>ORIGINAL INDICATOR: % surgeries with good outcome, of those performed</i>	1,919	1,832	1,320	72%
		At least 90 % of TT surgeries result in good outcome	N of surgeries followed up		1,832	1,491	81%
			N of surgeries with good outcome, of those followed up		1,342	1,320	98%
			% of surgeries with good outcome, of those followed-up		90%	89%	98%

MDA

Obj.	Specific Objective	Expected Output	Output indicators				
				project log frame target	target	Achievement	Performance (%)
1, 2	To reduce the overall prevalence of active trachoma (TF) in Marsabit County from the current 14.1% amongst children aged 1-9 years to less than 5% by 2015	At least 80% of people living in Marsabit treated with Azithromycin & TEO annually for 3 years as needed;	N treated with antibiotics In Marsabit County	357,086	357,086	327,743	92%
			N treated with antibiotics In Isiolo County	289,899	190,899	181,288	95%

FACIAL CLEANLINESS

Obj.	Specific Objective	Expected Output	Output indicators				
				project log frame target	target	Achievement	Performance (%)
4	To influence community behaviour change in 11 partner schools & surrounding communities in favour of face and hand-washing, hygienic human waste disposal and garbage management	At least 80% of children in 11 partner schools & 11 villages have clean faces	<i>N children with clean faces in 11 schools</i>	4,842	4,842	4,842	<i>Indicator presents methodological problems</i>
			<i>N schools and villages with at least 80% of children with clean faces</i>	11	11	11	<i>Indicator presents methodological problems</i>

ENVIRONMENT

Obj.	Specific Objective	Expected Output	Output indicators	Targets and Achievements			
				End of 5Y project log frame target	Apr 2011 - Dec 2014 (Years 1-3 + NCE)		
					Target	Achievement	Performance (%)
3	To improve access to water services for 11 partner schools and surrounding communities in Gadamoji	11 water tanks/gutters constructed and/or rehabilitated in 11 partner schools	N schools with functional water tanks	11	11	11	100%
		1 borehole serving 11 villages rehabilitated	N functional borehole	1	1	1	100%
4	Division of Marsabit Central District by 2015 and To influence community behaviour change in 11 partner schools & surrounding communities in favour of face and hand-washing, hygienic human waste disposal and garbage management	Hand-washing vessels installed in 11 partner schools	N schools with hand-washing vessels	11	11	11	100%
		Hygienic sanitation facilities (latrines) constructed and/or rehabilitated in 11 partner schools	N schools with functional hygienic toilets	11	11	11	100%
		Open Defecation Free Certification attained	N villages with ODF Certification	11	11	7	64%
		Hygienic sanitation facilities (latrines) constructed and in use in 11 villages	N villages with functional hygienic sanitation facilities*	11	11	0	N/A
		Compost pits dug and in use in 11 villages	N villages where community members have compost pits	11	11	0	N/A

GoK CAPACITY BUILDING

Obj.	Specific Objective	Expected Output	Output indicators	End of 5Y project log frame target	Targets and Achievements		
					Apr 2011 - Dec 2014 (Years 1-3 + NCE)		Performance (%)
					Target	Achievement	
5	To strengthen capacity for Trachoma implementation	Trachoma District Implementation Teams (DIT) established and functional	N DHMTs/CITs sensitized on trachoma control (cumulative)	3	3	3	100%
		Marsabit Eye-Unit	N coordination meetings held by DHMT/CIT (annual)	56	32*	34*	106%
	and management at the District and County levels	constructed & functional? Yes/No	functional? Yes (1) / No (0)	1	1	1	100%
6		HRH Development	Training of MOH staffs in Post basic ophthalmic work		2	2	100%
			Training of TT Surgeons		10	12	120%