

Strategic Evaluation of Dhaka Urban Comprehensive Eye Care Project (DUCECP)

Executive Summary

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Published

March 2015

Description of Programme

In 2005 – 2008, Sightsavers supported an urban eye care project (Dhaka Urban Eye Care Project – DUECP) implemented by three non-government eye organizations, namely Islamia Eye Hospital as the lead hospital coordinating with the Dhaka Bangladesh National Society for the Blind (BNSB) and the Bangladesh Lions Eye Foundation (BLF), Dhaka. The successful completion of this project highlighted the need for testing feasibility of a larger demonstration approach that included other key stakeholders like the government, NGO and private sector services. On completion of the pilot project solely supported by Sightsavers till September 2008, the 'Dhaka Urban Comprehensive Eye Care Project' (DUCECP) was launched with financial support from Standard Chartered's 'Seeing is Believing' (SiB) Phase IV initiative. The DUCECP was designed more comprehensively in the context of the type of eye health services required. The overall budget of the project was USD 1,657,222 spread over a period of 5 years. In 2013, a no-cost extension was agreed for 15 months up to December 2014. Of this, USD 1 million was provided by Seeing is Believing programme, while USD 657,222 was contributed by Sightsavers.

The project aimed to:

1. Strengthen eye care facilities to cater for the eye care needs of the target population.
2. Increase level of awareness among poor urban communities about eye care and the treatments available.
3. Institute a positive change in the eye health care seeking behaviour of the urban community.
4. Increase access to appropriate eye services for people living in poor urban communities.
5. Create stronger links with community based organisations (CBOs) to enable greater case finding capacity

Its main outputs envisaged included 32,000 cataract surgeries, 111,278 refractions, 105,003 glasses dispensed, 550 treated for low vision, 330,410 eye patients examined, 1826 urban eye screening activities, 12,450 students screened with eye complaints, 2739 people benefitting from training and orientation.

The programme was implemented through three government and four NGO partners.

Evaluation Purpose and Objectives

The purpose of this end-line evaluation was to assess the project achievements against targets to date. The review also aimed to identify the internal and external factors influencing program delivery, capture key lessons learnt, and recommend strategic direction to further strengthen future programme design.

The evaluation aimed to answer questions under each of Sightsavers' 7 key evaluation criteria terms of reference based on OECD criteria of relevance, effectiveness, efficiency, impact, sustainability, coherence/coordination, and scalability/replicability.

The scope was the entire time from the launch of the project in 2008 to the anticipated end of project in 2014. It covered the level of activity and specific results as well as the strategy and intervention logic employed by the partners for achieving the objectives.

The geographic scope of the evaluation included visits to Dhaka and selected project sites and partners.

Brief Description of Methods and Analytical Strategy

A comprehensive document review of the project proposal, progress updates, key performance indicators was carried out and the methodology developed after consultation with Sightsavers Bangladesh Country Office and Sightsavers UK.

In order to conduct the evaluation, we developed a 'schematic diagram of intervention' that had two main 'arcs' of activity (one comprising the 'Supply' side, and the other the 'Demand' side). We further developed an evaluation matrix with indicators. A variety of data collection methods were utilized, which included interviews, focus group discussions and onsite observations. Separate instruments were developed for these. The detailed methodology was presented in an Inception Report, which after various inputs was approved by Sightsavers.

The evaluation team reviewed project reports, made onsite visits to interview partners, conducted focus group discussions and held a consultation workshop for all partners. Data analysis methods included systematization of data collected into relevant TORs and analysis as per TORs.

Summary of Main Findings/Conclusions

The evaluation revealed that the project has either fully met or even exceeded targets. The achievement in low vision treatments exceeds the targets by almost three times. Although the numerical target for vision centres was achieved, there were major challenges in their effectiveness and sustainability.

Relevance – the programme is well aligned with the Global Action Plan for Universal Eye Health 2014-2019, government health plan 2011-2015, MDGs and poverty focus, National Blindness Survey 2000, National Eye Care (NEC) plan, Seeing is Believing, UNCRPD, Vision 2020 – The Right to Sight and partially aligned with the WHO Health Systems framework. However, the institutional and stakeholder

analysis that had been done during the preparation of this project was insufficient and such a complex project warranted a much more detailed analysis. This has an important bearing on whether the project can be integrated, taken to scale and its overall sustainability, as the project did not derive synergies from policies and strategies of local government.

Effectiveness – the targets were generally exceeded and there was overall good performance in terms of achievement project outputs. Some of the factors that have contributed towards high uptake of services include a well structured community awareness mechanism (delivered through well established 4 NGO hospitals, 15 field level partners, 75 CBOs); Patient Screening Programmes (PSPs) (treatable cataract referred and expectations for other eye treatments managed); logistic support through free transport; free surgery for the poor; previous experience of NGO partners with Sightsavers in the DUECP project and capacity of clinical partners to deliver high volume surgery. Although the project was titled as ‘comprehensive’, it was in essence a cataract and refractive errors initiative. Slum dwellers required continuity of service and were more interested in a comprehensive service set-up that could cater to their other eye care needs as well. The guidelines for establishment of Vision Centres (VCs) were not available during the life of the project and it is only in May 2013 that a VC conceptualisation workshop took place, which was instigated by Sightsavers Programme Development Advisors. However, this left under a year (in the no-cost extension period) to establish four VCs. The proportion of patients referred for cataract surgery out of all patients referred remained steadily over 80% indicating an effective screening and referral service for cataract surgery.

Efficiency – for implementation of the project, appropriate partners were identified at each tier. Clinical partners with a history of high volume surgery served as the supply side of the project. The partnership arrangements of field level NGOs partnering with tertiary clinical partners, and CBOs partnering with field level NGOs were very effective in achieving the results. A Project Management Committee comprising of tertiary level partners provided stewardship, while a Working Group comprising of all implementing partners provided effective project decentralisation. The project efficiency could have been improved if schoolteachers focussed on vision screening and eye health promotion, as in this approach a large number of children with ‘any eye problem’ were referred to refractionists, while only 30.6% of them needed refraction and spectacles. By changing the school eye health screening procedure, fewer children would need to be referred for assessment by refractionists.

Impact – the project generated demand for eye health services, increased partner capacities in high volume activity, and reduced the magnitude of cataract in the target slum localities by 33,000. It also successfully refracted close to 130,000 slum dwellers and provided over 100,000 people with spectacles. Hospital attendances of outpatients at partner hospitals increased by almost 20% between 2008 and 2011, and this met the project target of 20% increase in access to appropriate eye services for people living in poor urban communities. The project strengthened most health systems building blocks, but was not as successful in aligning the information systems with the government e-health/health information system or that of Local Government, Rural Development and Cooperatives (LGRD&C), and did not adequately explore strategic entry points or options for synergy with other government initiatives. The overall project design could have been improved through

pre- and post- KAP studies, pre- and post- RAABs and by aligning the baseline with key logframe and impact indicators.

Sustainability – the community component of the project is likely to continue to some degree because the CBOs are already committed to other initiatives in the slum areas and have internalised eye health awareness into their community awareness activities. The frequency of the PSPs would reduce but are likely to continue intermittently as several NGO partners noted their value addition in increasing the uptake of services. During focus group discussions with communities, they indicated that they were willing to invest in local transport costs provided they were assured of quality and continuity of services i.e. a one-stop service for their eye health needs. With regards to spectacles, the community preferred to obtain these from private optical shops as they had a better range of spectacle frames and this was where family and friends usually went to buy spectacles. The NGO hospitals have provision for social protection of the extreme poor, while government hospitals provide a safety net for those who require surgery. Recent initiatives like the Slum Development Plans by the Dhaka City Corporations (DCC) provide strategic entry points for PSPs at poverty eradication centres to be established through these plans.

Vision Centres –the data shows that only the VCs at Mahanagar General Hospital (MGH) and Ad-din were able to achieve and sustain an operating cost coverage ratio (OCCR) of 1 or more, where an OCCR of 1 means that a revenue amount equal to the operational cost has been generated, or in other words has achieved break-even cost. The performance trends of the VCs showed that generally, hospital based VCs were more sustainable as the patients had continuity of service, access to ophthalmologists and surgical facilities. However, those established through the market-based approach of the project performed significantly below expectations. Overall, the evaluation team found that while all the other components of DUCECP worked in a coordinated manner and achieved high performance for a generally successful project, the VCs were a discordant component to the rest of the project design.

Despite the establishment of a clear operational definition during a consensus workshop in 2013 there appeared to be a lack of awareness or disparate understanding of this amongst the operating partners. There were definitional gaps about VCs in the project design, which is understandable as this was a new experiment in Dhaka City, but the VC approach was not available until after the formal project life. Only two out of the six had any value addition to offer. The no-cost extension period may have been better served if time was spent to first understand the context of the VCs and then develop a business model, rather than try and establish four more VCs. Due to the fact that the VCs effectively took off only during the last project year, the objective was not to get them all to run a profit within 1 year, but to bring them on the right path to become sustainable businesses.

Coordination/Coherence – the project generated synergies between different stakeholders. Project Management Committee (PMC) adopted a joint approach towards addressing project deliverables and ensured that each tier was aware of interaction with respective tiers. PMC and Working Group meetings provided an effective platform to resolve issues and improve project planning and execution. The project demonstrated good complementarity between community mobilisation and

PSPs, and between PSPs and clinical services facilitated by logistic arrangements. The project mobilised a network of NGOs and CBOs that contributed significantly to the success factor of PSPs. The project had some contradictions. For instance, the VCs did not have a broadly accepted operational definition and the operational approach was not well defined in the project proposal. The VC design did not involve implementing partners, and although information sharing took place, there was no consultative planning.

Scalability/Replicability –several project components have shown potential for scalability, For instance, the PSPs have been accepted by the slum communities as an effective screening and referral option. Secondly, health staff of high performing field level NGOs and CBOs who collaborated in DUCECP can be trained for improved patient screening. The project as a whole is not at a stage where it can be said to have developed a model or approach for scalability. The gaps identified by the evaluation would need to be addressed and this may require a follow-up phase of the project in which deficiencies can be addressed and approaches and scalability options clearly documented. Dhaka is one of the top ten cities globally that is at high risk to the effects of climate change. Future urban eye health interventions would need to give consideration to building in a component of eye health preparedness in emergencies so that collaborating NGOs, field level partners and CBOs can integrate emergency eye health in their overall organisational programme portfolio, so that in the event of water-logging and flooding, a rapid response mechanism would exist to provide coverage of eye care services to affected slum dwellers.

Overall Ratings for Review Criteria (please see methodology section for details)

	RELEVANCE
	EFFECTIVENESS
	EFFICIENCY/COST EFFECTIVENESS
	IMPACT
	SUSTAINABILITY
	COORDINATION/COHERENCE
	SCALABILITY/REPLICABILITY

Recommendations

1. Undertake a thorough institutional and stakeholder analysis to identify strategic entry and synergy points for urban eye health, and complement this with

information on spatial mapping of slum areas, vulnerable communities and service providers

2. Adopt a three tiered approach for effective service delivery, whose components include competent clinical partners, intermediary field-level NGOs and CBOs, as a modality for urban eye health to enhance coverage and uptake of services
3. Ensure a decentralised management structure in large urban eye health projects and locate the project management unit or secretariat in a leading implementing partner to enhance ownership and build capacities for improved project management
4. Deploy a team with the right skill mix and expertise to meet the advocacy needs of large and complex urban eye health projects
5. Use large scale urban eye health projects as a springboard to leverage community, organisational and institutional change through well planned and executed advocacy
6. Enhance engagement with higher levels of local government and jointly design and align eye health strategies with slum development plans of local government
7. Treat Vision Centres as a separate project linking with entrepreneurship models or establishing business oriented ventures with the private sector and NGOs
8. Determine existing coordination mechanisms and options from which synergies can be derived, while conducting institutional mapping of actors and stakeholders in urban health, and aim at targeting multi-level coordination
9. Pursue a follow-up phase to DUCCEP to address gaps and deficiencies identified in the evaluation to develop a scalable model for urban eye health
10. Build and strengthen the capacities of civil society and public sector actors (involved in urban health) in eye health preparedness in emergencies