Independent Final Evaluation Report
DFID GPAF-INN-010 Programme

Nationwide Primary Eye Care Training of Health Centre Nurses in Rwanda to provide Vision Assessments to an estimated 425,000 People and 30,000 Eyeglasses to those in need.

Vision For A Nation Foundation, Rwanda

December 2013
Acknowledgements

First, we acknowledge the participation of the eye health clients from Kigali City as well as the Eastern and Northern Provinces of Rwanda, who generously shared their experiences and perceptions about this programme.

Second, we appreciate the vast range of information and insights that we gathered from key informants, stakeholders and partners who participated in the nurses’ survey, evaluation workshops and one-to-one interviews. We are especially grateful to the Primary Eye Care nurses, heads of health centres, representatives from the Ministry of Health, local authorities, partner organisations, as well as other individuals who were involved with the programme in different capacities.

Third, we are grateful to staff from Vision for a Nation Foundation, both in Rwanda and in the UK. We are particularly indebted to the following people for ensuring that the evaluation process was as smooth as possible: Abdalla Uwihoreye, Azades Ray Karekezi, Chipa Nyambayaro, Eliane Ndererimana, Olivier Bizimana, Rose Gahire, Sebastian Ford, Sjoerd Hannema and Yaso Ariaratnam.

Finally, our utmost gratitude to the Evaluation Team who worked hard on this assignment: Caritas Uwimana, Jacqueline Abagwaneza, Josephine Uwumukiza, Pierre Irunga and Teddy Kamanzi. Thanks also to Stanford Senzere and Shampa Nath for the quality checks and support.

Evaluator
David J N Musendo (Lead Consultant)
Lifetime Consulting and Partners Ltd
E-mail: david@lifetimeconsulting.org
Web: www.lifetimeconsulting.org

Disclaimer: The views and opinions expressed in this report are those of the authors and do not necessarily reflect the official policy or position of VFANF, their partners or their funders.
# Table of Contents

Acknowledgements........................................................................................................... ii  
Table of Contents ................................................................................................................ iii  
Abbreviations/Acronyms ................................................................................................... iv  
Executive Summary ............................................................................................................. 1  
1. **Introduction** .................................................................................................................. 8  
   Contextual Analysis ......................................................................................................... 8  
   About Vision for a Nation and the GPAF Grant ............................................................... 9  
   Evaluation Purpose and Objectives .................................................................................. 9  
2. **Evaluation Methodology** .............................................................................................. 10  
   2.1 General Approach to the Evaluation ......................................................................... 10  
   2.2 Sampling and Selection of Respondents .................................................................. 10  
   2.3 Evaluation Tools, Instruments and Research Team ................................................... 12  
   2.4 Field Work and Data Collection ............................................................................. 13  
   2.5 Data Analysis and Report Writing ............................................................................ 14  
   2.6 Limitations of the Evaluation Process ..................................................................... 14  
3. **Evaluation Results and Analysis** ................................................................................ 15  
   3.1 Assessing Programme Relevance ............................................................................ 15  
   3.2 Assessing Programme Efficiency ............................................................................ 25  
   3.3 Assessing Programme Effectiveness ......................................................................... 28  
   3.4 Assessing Emerging Impact and Outcomes ............................................................... 41  
   3.5 Assess Programme Sustainability ............................................................................. 44  
4. **Conclusions and Recommendations** .......................................................................... 49  
   4.1 Conclusions and Findings ....................................................................................... 49  
   4.2 Recommendations .................................................................................................... 52  
5 **Annexures** ..................................................................................................................... 58  
   5.1 Annex 1: List of People Contacted .......................................................................... 58  
   5.2 Annex 2: List of Documents Consulted ..................................................................... 59  
   5.3 Annex 3: Programme for Field Work, November - December 2013 ....................... 60  
   5.4 Annex 4: Terms of Reference .................................................................................. 62
## Abbreviations/Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARP</td>
<td>Annual Report Process</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GoR</td>
<td>Government of Rwanda</td>
</tr>
<tr>
<td>GPAF</td>
<td>Global Poverty Action Fund</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>IAPB</td>
<td>International Agency for the Prevention of Blindness</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organisation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MoE</td>
<td>Rwandan Ministry of Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Rwandan Ministry of Health</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MPPD</td>
<td>Medical Procurement and Production Division</td>
</tr>
<tr>
<td>NCEH</td>
<td>National Committee for Eye Health</td>
</tr>
<tr>
<td>OT</td>
<td>Ophthalmic Technician</td>
</tr>
<tr>
<td>PBF</td>
<td>Performance Based Financing</td>
</tr>
<tr>
<td>PEC</td>
<td>Primary Eye Care</td>
</tr>
<tr>
<td>RAAB</td>
<td>Rapid Assessment of Avoidable Blindness</td>
</tr>
<tr>
<td>RwF</td>
<td>Rwandan Franc</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>URE</td>
<td>Uncorrected Refractive Error</td>
</tr>
<tr>
<td>VFANF</td>
<td>Vision for a Nation Foundation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive Summary

Programme Background
Vision for a Nation Foundation (VFANF) was established as a charity in January 2011 and works in collaboration with the Government of Rwanda (GoR) to create universal access to eye care services in Rwanda. Between September 2012 and October 2013 VFANF received a DFID grant under the Global Poverty Action Fund (GPAF) to introduce primary eye care services in 450 Rwandan Health Centres by training 900 Health Centre (HC) nurses and establishing a supply chain for eyeglasses through the Ministry of Health’s Medical Procurement and Production Division. Ultimately, it was intended that the nationwide primary eye care training of HC nurses in Rwanda will enable the provision of vision assessments to an estimated 425,000 people and 30,000 eyeglasses to those in need.

Purpose of the Evaluation
The purpose of this end-of-term evaluation was to determine whether the objectives of the VFANF Programme have been achieved by collecting quantitative and qualitative information on the objectively verifiable indicators in the log frame. The evaluation was guided by two key questions provided to GPAF grantees by Coffey International on independent evaluations: (1) What has happened because of DFID funding that wouldn’t have otherwise happened?; and (2) To what extent does the use of funding represent good value for money? The evaluation had the following objectives: (a) Assess programme relevance; (b) Assess programme efficiency; (c) Assess programme effectiveness; (d) Assess programme outcomes and emerging impact; (e) Assess programme sustainability; and (f) Draw lessons learnt, conclusions and provide recommendations for future programme design and implementation.

Study Methodology
The evaluation was conducted by Lifetime Consulting & Partners Ltd between 11th of November 2013 and 10th of January 2014, with the team consisting of one lead consultant and 5 Rwandan-based local research assistants. Fieldwork consultations were conducted from 25th November to 9th December 2013 across 9 districts from the Kigali City as well as the Eastern and Northern Provinces of Rwanda. A mix of evaluation methods, qualitative and quantitative were utilised to ensure triangulation, coherence and meaningful association of findings from different sources. The evaluation commenced with an intensive desk based review of programme documents. This was followed by fieldwork that combined evaluation workshops, focus group discussions, key informant interviews and the collection of Most Significant Change stories. The 3 evaluation workshops, one for each of the selected provinces, were attended by 41 primary health staff trained on primary eye care (PEC) through this programme and 5 district hospital representatives. The evaluation team also administered individual questionnaires to 67 PEC nurses and 214 beneficiaries who had been supported at 35 Health Centres (HCs). The 67 nurse survey participants represented 45 HCs, with 50.7% of them coming from rural based HCs. The 214 beneficiaries who participated in the survey were from 38 HCs, of which 71.8% were rural. In addition, 30 key informants participated in the evaluation. To complement it all, 15 Most Significant Change stories were collected from programme beneficiaries and supporters. Quotations from these stories are cited in this report.
Summary of Main Findings
The independent evaluation used questions that were formulated around the OECD-DAC criteria of programme Relevance, Efficiency, Effectiveness, Sustainability and Impact. Largely, the evaluation has established that VFANF has implemented a very innovative and ambitious programme aimed at making significant differences through a focus on the people who need the service most.

Below, a summary of the key findings under each of these themes is presented.

Programme Relevance
The programme was rated highly relevant with the aim of contributing towards achieving seven of the eight Millennium Development Goals (MDGs), in particular MDG 1 (eradicating extreme poverty and hunger). More work was needed to demonstrate the programme’s contribution towards MDG 2 (universal primary education). The programme was clearly consistent with GPAF’s mandate and was relevant to needs of poor and vulnerable people in Rwanda. Most importantly, the programme was found to be appropriately responding to the strategic priorities of the GoR in their efforts to increase investment in eye health. Ninety seven percent (97%) of the evaluation respondents agreed that PEC services were needed in Rwanda. By October 2013, 32,509 people had benefitted from the programme, 57% of who were women and girls. In terms of the programme strategies, the evaluation team confirmed that these were appropriate and timely. Up to 70% of the survey respondents (both nurses and patients) considered the training of PEC nurses as one of the most effective strategies employed by the programme, followed by the provision of vision assessments (66%) at HCs. The review of the Community Health Worker (CHW) training, a pilot scheme which was conducted in Musanze district, revealed that awareness levels about PEC services were on the increase. While the programme has supported people who needed the service, more attention should be made on people with disabilities, young people and children as well as those out of school. In addition, some clearly defined strategies for reaching women, girls and the poorest need to be in place.

Programme Efficiency
The evaluation has concluded that the implementation of the programme was conducted in an efficient manner and has demonstrated good value for money in its delivery. Considering the results achieved, the evaluators have concluded that there was a sound association between the budget allocation and the achievement of the results confirmed by this evaluation. The revised agreed contribution from DFID to the total programme was £243,857.07. Overall, the evaluators have considered VFANF a transparent organisation that observes clear accounting procedures and has successfully demonstrated positive compliance to the requirements of the grant. Among some of the key lessons learnt, VFANF recognises the importance of rigor and attention to detail for future budgeting and planning. Although the programme was largely on track in its expenditure against the agreed budget and deliverables, the original time-scale had to shift due to some external factors, such as protracted registration processes. In addition, it was observed that the design of the programme targets was rather over-ambitious and optimistic for a limited period of one year. In terms of efficiency, economy and effectiveness, VFANF has successfully match-funded programme activities with resources from different sources, hence optimising on the results of their efforts in efficient ways. The evaluation confirmed that VFANF has done its best to buy and employ inputs at an optimum value-for-money price as demonstrated by their
policies and practices. Good value for money was also demonstrated by VFANF’s human resource utilisation strategy. Besides utilising existing health staff at HCs for implementing the programme, VFANF were able to allocate all staff costs to other funding sources and none to DFID. VFANF are strongly encouraged to consider full cost recovery approaches as simply relying on resourcing programme personnel using unrestricted funding may not be sufficient in the long run.

Programme Effectiveness

The introduction and implementation of the programme in Rwanda has indicated that the provision of eye care services can occur successfully at primary health centres through a multi-faceted approach that encompasses training of primary health nurses, provision of appropriate equipment and infrastructure, strengthened referrals that are supported by clear guidelines for the management of patients, as well as advocacy. The assessment of the programme outcomes and outputs revealed that substantial achievements were made within a year. Within one year, the VFANF programme benefitted 32,509 beneficiaries by the end of October 2013, 57% of whom were women and girls. A total of 986 nurses (52% female) from 473 HCs (including 5 Health Posts and 3 Prison HCs) had been trained on PEC provision by October 2013. All the HCs from a sample of 38 HCs visited during this evaluation had effectively started implementing eye care services immediately after the training. The 473 HCs were equipped with appropriate start up packs to implement eye care services at HC level, including vision assessment materials and glasses. Of the 33,530 glasses purchased through this programme, 27,984 had been delivered to 473 HCs by the end of October 2013. According to programme reports, a total of 5,961 glasses had been distributed by HCs by the time of this evaluation. Satisfaction levels at HC levels were generally high, with an average 83% of the patients reporting high satisfaction levels with the delivery of PEC services at their nearest HC.

By the time of the evaluation, 84% of the nurses participating in the evaluation survey confirmed that their HCs had since dedicated at least one day for eye care services each week. In addition, the number of appropriate cases being referred to district hospitals for specialised eye care services was on the increase, reporting a total of 6,284 referrals made from HCs between September 2012 and October 2013. In addition, a pilot training of Community Health Workers programme was implemented, benefiting 1296 CHWs in Musanze District. An assessment of the CHW pilot and non-pilot intervention districts revealed a marked difference between the number of people accessing and utilising eye care services in Musanze District compared to the rest of the districts across Rwanda.

Notwithstanding these outstanding achievements, the evaluators identified some areas that VFANF must attend to. The setting of the targets was regarded unrealistic, for example aiming to reach 425,000 people with vision assessments within the first year of establishing this programme was rather over-ambitious. Some of the other challenges noted included: weak feedback mechanisms between HC and district hospitals; stock-outs of medication and glasses, especially at the inception of the programme; poor management and supervision resulting from untrained heads of HCs; increased workload on the part of trained PEC nurses; staff turnover at HCs; and adjustable glasses not being well received by clients. In addition, although the programme has invested some very impressive tools for routine data collection, there is still need to strengthen the Monitoring and Evaluation (M&E) component of the programme.
Programme Outcomes and Emerging Impact
While the attribution of impact was difficult to ascertain due to the short implementation period, the differences made by the programme pointed to suggesting that the outcomes would lead to lasting impact on equitable poverty reduction and the empowerment of Rwandan citizens in the long run. Some of the direct beneficiaries included: health staff from primary HCs who were trained on PEC delivery; patients who presented with eye problems at HCs, CHWs who were also trained on eye care issues in the northern provinces; teachers from the nursing training schools of Rwanda. Indirectly, the programme has started to benefit the wider Rwandan community, especially through awareness raising campaigns. With increased awareness about the availability of PEC services at their HCs, about 80% of respondents mainly from underserved communities had begun to access eye care services within 5km proximity of their homes. In general, the introduction of PEC services through this initiative has led to an increase in the utilisation of eye care services at local levels within proximity of people’s homes. Some individuals who participated in this evaluation reported improved eyesight as a result of this intervention. At HC level, the provision of training to 986 nurses and the supply of eye care materials and equipment to 473 HCs in Rwanda has resulted in some notable differences at both individual (nurse) and HC level. A marked decrease in the number of walk-in patients has been realised and the evaluation results also verified and confirmed that the district hospitals have also witnessed an increase in the number of referrals for issues that could not be managed at local level. At national level, a policy environment that is conducive for eye care services has been created in Rwanda. Nevertheless, the evaluation has also highlighted the need for continuous advocacy for eye care services beyond the life of this programme as critical for the maintenance and continued implementation of PEC services across all the HCs in Rwanda.

Programme Sustainability
The programme was rated as highly sustainable. Most important, the programme was developed within the Rwanda national framework and infrastructure. The delivery of the programme focused on utilising existing health workforce who are now playing a key role in expanding the coverage of eye health services across 30 districts. The initiative was not implemented in a vacuum and neither was it introduced as a parallel intervention to government’s efforts. In an appropriate manner, VFANF provided PEC training to nurses who were already providing primary health care at HCs and who are on the regular budget of existing institutional supports, such as Government workers. Small efforts such as building a pool of unrestricted funding from the minimal contributions of 1000 Rwandan Francs made by patients towards the cost of eyeglasses was noted. In addition, it was reassuring to find 82% of the patients stating that they were willing to pay for future eye care treatment to cover costs. Another effort contributing to sustainability that the evaluators noted with satisfaction was that PEC had been included as part of the basic curricula taught in all the nurse training schools of Rwanda. This means that all nurse graduates will leave their training institutions with the skills and knowledge to provide primary eye care services by the time they are deployed to their respective HCs. This action recognises that relying on continuous in-service training is costly and unsustainable. To sustain the work further, the evaluators recommend that VFANF should mobilise more agencies and stakeholders to support the provision of eye health services. The additional role for advocacy has also been highlighted so as to sustain the existing efforts.
Summary of Recommendations

In this section, a brief overview of the key recommendations is provided. Detailed explanations of the recommendations that follow the main conclusions and lessons learnt are presented in Section 4 of this report. As noted below, specific recommendations are made for VFANF, HCs, district hospitals and the Ministry of Health.

Recommendations for VFANF

1. Provide further training, support and supervision to HC staff at primary health centres and ensure that constant numbers of personnel are in place at HCs until a time that schools of nursing are fully graduating trained PEC nurses.

2. The pilot intervention to train and engage Community Health Workers (CHWs) in Musanze District towards the end of the project has already shown evidence of positive impact. As a result of CHW training in Musanze, the number of people receiving vision assessments increased from 965 in Quarter 3 to 2,018 in Quarter 4. Likewise, the number of people referred to the district hospital increased from 126 to 249 during the same period. We strongly recommend that this initiative be scaled up to a nationwide programme. The pilot has already demonstrated that the training of CHW workers does not only help increase awareness and uptake of eye care services, but also sustain the efforts beyond the life of the project.

3. Build the capacity of the heads of HCs and key personnel at district hospitals to provide effective supervision, logistics, and support to trained PEC nurses.

4. Improve on the M&E and Data Management systems for the programme. This is particularly important since the programme is relatively new in Rwanda and will, therefore, require robust M&E systems that capture and utilise the data. Some of the key action points for consideration will include developing a comprehensive M&E Plan for each new programme; conducting baseline studies before the inception of any new programme.

5. Increase VFANF’s role to influence policy and practice on eye health issues in Rwanda through modeling: Increase focus on influencing policy and practice by continuously engaging with decision makers on pertinent issues affecting the delivery of eye health in Rwanda at all levels. At national level, VFANF is encouraged to enhance their collaboration with other strategic partners and actors to advocate for, and secure the necessary resources, to scale up the provision of PEC services at HC and Health Post levels.

6. Strengthen strategic partnerships and coordination activities with other partners. VFANF are encouraged to identify and strengthen linkages with other like-minded organisations who may be interested in eye health issues, even if they are currently not engaged.

7. Increase engagement with local media to raise awareness about PEC services. In particular, the radio has the potential to initiate and strengthen dialogue on specific issues, swiftly spread the agenda, and channel public support.

8. Cultivate a strong documentation, research and learning culture. It is, therefore, necessary for VFANF to consider playing a ‘learning and modelling’ role where they should aim to demonstrate and document best practices / approaches which can be adopted or replicated by others to bring wider improvements in eye health policy and practice.

9. Conduct a closer review and analysis of patients’ satisfaction levels with the quality of
eye glasses and respond to their needs accordingly. It is vital to ensure that acceptable quality glasses are made available as this is essential to avoid refusal or discontinuation of their use. It is recommended that patients be offered a variety of spectacle frames to reflect personal and local preferences, even if it means they will have to pay extra money for these. In addition, ensure that there is a constant power supply and availability of necessary accessories at HC level, for example, glass cases and cleaning materials.

10. VFANF are strongly encouraged to consider full cost recovery approaches rather than relying on resourcing programme personnel using unrestricted funding.

Recommendations for Health Centres
1. Improve awareness of PEC services through the utilisation of CHWs, a variety of media and where appropriate, public educational materials. HC should not only cater for those who come to the centre, but should also proactively seek out those who are in the community and do not visit the HC.
2. HC staff should strengthen linkages between service sites and the communities in which they are located, mainly through the CHWs. Linkages could be strengthened by sensitising and updating CHWs and volunteers on PEC issues and by enlisting their support.
3. Improve the recruitment and selection processes for staff who participate in PEC related training.
4. Aim for full integration of PEC services into primary health centre services: Heads of HC are encouraged to give value to PEC services and particularly support PEC nures to deliver on their work. This will include ensuring that adequate time, space, budget and personnel are allocated to this work. Where possible, PEC work should be integrated to complement other existing activities at HC level.

Recommendations for District Hospitals and Pharmacies
1. District hospital authorities need to provide regular support and supervision to HC on eye care services. It is recommended that eye care service provision be integrated into the supervision plan of all district hospitals.
2. District hospitals must increase budgets and allocate adequate resources for eye care services. In addition to supporting Ophthalmic Technicians (OTs) with financial resources for support and supervision to HC, each district hospital must also acquire adequate equipment and allocate enough rooms / space for eye care services.
3. District Pharmacies should ensure consistent supplies of eye medication, materials and glasses at district pharmacies, and avoid long waiting periods and stockouts at HC level.

Recommendations for the Ministry of Health
1. Support secondary and tertiary health facilities to effectively support eye health services that are implemented by primary health centres.
2. Increase the budget for eye care services in Rwanda. Although the recent commitments and investements into eye health services by the GoR are commendable, the rising demand for services will need to be complemented by adequate supply of resources. It is recommended that the annual budget for health in Rwanda also reflect a meaningful contribution towards eye health. Closely related to this it is highly recommended that PEC indicators be included in the Performance Based Financing (PBF) system for Health Services.
3. Ensure that HC are equipped with the relevant tools and record books for reporting
purposes; utilise existing data capture personnel at HC levels to provide technical support and reporting on PEC data; disaggregate all data by age and gender; consider developing a regularly updated database of the trained PEC nurses (alumni) that will help track the movements of PEC nurses in and out of HCs.

4. Monitor PEC commitments at various implementation levels in Rwanda. The evaluation team are aware that decision-makers are often overloaded with competing demands and face multiple issues that need their attention simultaneously.

5. It is important that the MoH commit more to this area, investing resources towards research for eye health, and translating the research results into policy and action. Limited information is available about eye health from a health systems strengthening approach. Evidence of integration of eye health into primary health care is currently weak, particularly when applying a health systems framework. A realignment of eye health in the primary health care agenda will require context-specific planning and a holistic approach, with careful attention to each of the health system components and to the public health system as a whole.

6. The MoH should continue to foster collaboration and partnerships on the provision of eye health services in Rwanda. It is anticipated that the MoH will ensure there no duplication of services, facilitate the pooling of resources and ensure the continued provision of high quality services in Rwanda. Some of the key stakeholders include other government agencies, private sector and civil society organisations.
1. Introduction

Contextual Analysis

The World Health Organization (WHO) notes that Sub-Saharan Africa has continued to experience severe shortages of human resources for health, from primary through to tertiary level. Recent emphasis has been placed on strengthening health systems and improving the delivery of cost-effective interventions through the provision of primary health care.\(^1\) This has meant focusing on the first level contact of individuals, families and communities with the national health systems, bringing health care as close as possible to where people live and work, constituting the first element of a continuing health care process\(^2\). One area affected by the human resource crisis has been the provision of adequate eye services. According to the IAPB, the WHO estimates that in Africa, around 9% of adults aged over 50 are blind. As a region, in relative terms to the size of the respective population, Africa has proportionately 73% more blind and visually impaired people than any other region. 80% of these are due to causes that are either preventable or curable. Some data suggest that people living in regions affected by violent conflict are more likely to be blind than those living in unaffected regions.\(^3\)

A great interest in providing primary eye care (PEC) through integration into primary health care has been developed. PEC is a broad concept, encompassing the prevention of potentially blinding eye diseases and includes the identification, with treatment or referral, of individuals with treatable causes of blindness, and the diagnosis and treatment of common eye diseases.\(^4\) Integrating PEC into the work of primary health workers has the potential to improve access to eye care, particularly in rural areas where the availability and accessibility of eye care services is limited. It can be argued that the provision of PEC services makes a remarkable contribution towards universal health coverage, which is defined by the WHO as “ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services”. This means all people should enjoy access to the best quality health care without risk of impoverishment.

The delivery of eye health services is still in its infancy stages, though growing, in Rwanda. Currently very little data exists on the likely prevalence of blindness in Rwanda.\(^5\) Notable efforts only began around 2006 when the Ministry of Health conducted a Rapid Assessment of Avoidable Blindness (RAAB) survey in the Western Province, aimed at understanding how much blindness and vision loss there was in the country. The survey showed 82% of all cases of bilateral blindness in Rwanda are treatable or preventable.\(^6\)

---

About Vision for a Nation and the GPAF Grant
Vision for a Nation Foundation (VFANF) is an international non-governmental organisation (INGO) that has the mission of making vision assessments and affordable glasses available to everyone through sustainable, nationwide programmes in countries where there are no or limited Primary Eye Care (PEC) services. In Rwanda, VFANF works in collaboration with the Government of Rwanda (GoR) to create universal access to eye care services. Between September 2012 and October 2013, VFANF implemented a £243,857 grant from the Global Poverty Action Fund (GPAF), which aimed at introducing PEC services in 450 Rwandan Health Centres by training 900 Health Centre (HC) nurses and establishing a supply chain for eyeglasses through the Ministry of Health’s (MoH) Medical Procurement and Production Division (MPPD). The nationwide programme was aimed at ultimately helping to improve vision for 33,000 people by provision of Primary Eye Care services at 450 HCs across Rwanda. Lessons from Phase 1 (2009-2011) had shown that existing nurses are best placed to provide PEC services at HC level, and that the existing networks of Community Health Workers (CHWs) are best placed to raise awareness of eye care and promote the benefits of vision assessments in their communities.

Evaluation Purpose and Objectives

Purpose of the Evaluation
The purpose of this independent Final Evaluation was to provide information on whether the objectives of the VFANF programme have been achieved by collecting quantitative and qualitative information on the objectively verifiable indicators in the log frame. The evaluation was also guided by two key questions specified by Coffey International on independent evaluations for GPAF grantees: (1) What has happened because of DFID funding that wouldn’t have otherwise happened? and (2) To what extent does the use of funding represent good value for money?

Objectives of the Evaluation
The specific objectives for this particular evaluation were to:

a. Assess programme relevance: the programme’s significance with respect to specific needs and its relevance to country poverty reduction priorities;

b. Assess programme effectiveness: assessment of how far the intended outputs and results were achieved in relation to targets set in the original logical framework;

c. Assess programme efficiency: assessment of how far funding, personnel, regulatory, administrative, time, and other resources and procedures contributed to or hindered the achievement of results; to what extent the funding represented good value for money;

d. Assess programme outcomes and emerging impact: consider the broader economic, social, and political consequences of the programme;

e. Assess programme sustainability: potential for the continuation of the impact achieved and of the delivery mechanisms, following the withdrawal of external support. Impact of DFID funding on the programme, and

f. Draw lessons learnt and provide recommendations for future programme design and implementation.
2. Evaluation Methodology

2.1 General Approach to the Evaluation

The evaluators followed the guidelines developed by Coffey International, based on an assessment framework that clearly shows how evaluation findings are linked to evidence and to ensure that data has been verified through the end of programme evaluation process. A combination of methods were utilised to explore ‘why’ and ‘how’ the programme would have affected the quantitative aspect of the types and scale of changes that were observed. The process was aimed at ensuring the production of a substantial report that: (a) answered all the elements of the Terms of Reference; (b) provided rigorous and transparent evidence on the basis of which conclusions and assessments were made, and (c) supplemented VFANF’s own data with independent research.7

2.2 Sampling and Selection of Respondents

A stratified random sampling scheme was used to select the health staff trained and eye care patients who were supported through the programme by the end of October 2013. Respondents were purposefully stratified by province, concentrating on the Eastern, Kigali and Northern provinces of Rwanda. The selection of the three provinces out of five was influenced by a number of factors such as: (a) the number of health staff trained by June 2013 and who had a large proportion of patients supported by September 2013; (b) representation of urban versus rural setting; and (c) a deliberate sampling of the Northern Province where CHW training was conducted in Musanze and a radio campaign piloted in Gicumbi and Musanze.

The final sample selection for the evaluation focused on: 9 districts of Rwanda in Kigali City (Gasabo, Kicukiro and Nyarugenge); Eastern Province (Kayonza, Ngoma and Rwamagana); and Northern Province (Gakenke, Musanze and Rulindo). See Table 1 below.

<table>
<thead>
<tr>
<th>Province</th>
<th>Patients</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>70</td>
<td>19</td>
</tr>
<tr>
<td>Kigali</td>
<td>52</td>
<td>26</td>
</tr>
<tr>
<td>Northern</td>
<td>92</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>214</strong></td>
<td><strong>67</strong></td>
</tr>
</tbody>
</table>

Table 1: No. of nurses and patients participating in the survey

The evaluation attracted the participation of 67 trained nurses from 45 HCs across the 3 provinces. Of the 67 respondents, 50.7% were from rural based HCs and 49.3% from urban HCs. The majority of the nurse respondents, 85.1% (n=57/67) were from public HCs and the rest, 14.9% (n=10/67) were from subsidised HCs. The 214 patients who participated in the survey had received eye care services from a sample of 38 HCs. 71.5% of the patients (n=153)

7 Guidance from Coffey International, Independent Final Evaluations (*formerly referred to as Independent Progress Reviews) - overview for GPAF grantees
were from rural settings and 28.5% (n=61) were from urban settings. A larger proportion of the respondents, 91.6% (n=196) had been attended to at public HCs while the rest, 8.4% (n=18) had been to subsidised HCs.

**Sex of Respondents**

<table>
<thead>
<tr>
<th>Category</th>
<th>Female Frequency</th>
<th>% of Total</th>
<th>Male Frequency</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>41</td>
<td>61%</td>
<td>26</td>
<td>39%</td>
</tr>
<tr>
<td>Patients</td>
<td>119</td>
<td>56%</td>
<td>95</td>
<td>44%</td>
</tr>
</tbody>
</table>

Table 2: Sex of Survey respondents

**Respondents by Age (Patients)**

From the sample of respondents who participated in patients’ survey, 57% were above the age of 50. The distribution of the participants is a reflection of how eye diseases become an increasing concern as people age. No significant differences were noted between the age distribution of male and female respondents across the different age ranges. See Figure 1 below.

![Figure 1: Proportion of Respondents by Age](image)

**Nurses by qualifications and length of service at HCs**

About 70% (n=47/67) of the trained nurses had served as qualified nurses for at least 5 years, with 27% (n=18/67) of them having served for more than 10 years. As shown in Figure 2 below, 84% (N=56/67) of the nurse respondents had A2 level qualifications and 16% (n=11/67) up to A1 level. The programme was aimed at primary health nurses, most of who had never received any training on treating eye health disease treatment before. From our sample, only 33% of the nurses had stayed at their current HC for at least 5 years, reflecting the uncertainties faced by HCs due to the constant movement of health staff from and between HCs in Rwanda.
2.3 Evaluation Tools, Instruments and Research Team

An in-depth desk study was conducted and the initial findings were used to inform the overall evaluation process and the development of the evaluation tools. The list of documents reviewed is listed in Annex 1.2. Specific evaluation tools, both quantitative and qualitative in nature, were developed in consultation with VFANF for the different respondent groups. The final list of tools, which were utilised for this evaluation, is in Table 3 below, showing the number of respondents who participated in the administration of the tools.

<table>
<thead>
<tr>
<th>Evaluation Tools</th>
<th>Respondents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEC Nurses Survey Questionnaire</td>
<td>The Health Staff Survey was administered with trained PEC nurses from the selected 9 districts.</td>
<td>67</td>
</tr>
<tr>
<td>Evaluation Workshop Guide</td>
<td>PEC nurses and district Ophthalmic Clinical Officers participated in evaluation workshops conducted in Kigali, Rwamagana and Musanze.</td>
<td>46</td>
</tr>
<tr>
<td>Patients Survey Questionnaire</td>
<td>Beneficiaries/patients participated in an individual survey.</td>
<td>214</td>
</tr>
<tr>
<td>FGD Guide for trained CHW</td>
<td>Trained community health workers attended a focus group discussion (FGD) at Gasiza Health Centre in Musanze District.</td>
<td>43</td>
</tr>
<tr>
<td>Key Informant Interview Guide</td>
<td>Key stakeholder representatives from: the MoH; District Hospital Staff; VFANF Programme and Admin Staff; Training Team Members; Ophthalmic Advisor/Technicians; Training Module Developer; and Partners.</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 3: Evaluation tools and Respondents

The evaluation team, consisting of 1 team leader and 5 research assistants, participated in a two-day training and orientation activity on the purpose and background of the evaluation, content of the data collection tools and on how to administer the data collection tools. The
training also included a half-day pretesting activity of the evaluation tools with a sample of 10 nurses and 10 patients in Kigali before finalisation and printing. The patients’ evaluation instruments were also translated into Kinyarwanda for ease of administration.

2.4 Field Work and Data Collection

Fieldwork was conducted in the 9 districts of Kigali City, Eastern and Northern provinces between 26th of November and 6th of December 2013. Some extra days were committed to follow up meetings with VFANF staff and other key informants between 9th and 20th of December 2013.

The following activities were done as part of the data collection process:

a. Quantitative Survey: 2 structured questionnaires were administered for nurses and for patients. First, a Health Staff questionnaire was administered with 67 PEC nurses from 45 health centres. Second, a Patients’ Survey questionnaire was administered to 214 patients who had accessed eye care services from 38 HCs in the three provinces.

b. Evaluation Workshops for PEC nurses and district Ophthalmic Technicians (OTs): 3 evaluation workshops were conducted for 41 PEC nurses and 5 OTs in Kigali, Rwamagana and Musanze. The workshops, which were conducted over half a day each, utilised different participatory methodologies, such as Community Score Cards and the Most Significant Change Story technique, to gather relevant information and participants’ perceptions of the programme’s relevance, efficiency, effectiveness, sustainability and emerging impacts.

c. Community Conversation with Community Health Workers: A community meeting was held at Gasiza HC (Musanze District) with 43 CHWs, 58% of whom were women. All the 43 participants had received eye care training from VFANF in October 2013. A semi-structured discussion guide was used to gather information about the CHWs’ perceptions on the utility of the training that they had received.

d. Key informant interviews: Up to 30 purposively selected key informants were engaged, based on their particular knowledge of the programme’s activities. The final list of key informants included staff from VFANF, representatives from the MoH, Ophthalmic Advisor and Technicians, the training team, partners and district health officials.

e. Collection of Most Significant Change (MSC) Stories: A collection of 15 significant change stories was used to explore the changes and positive experiences as related by those who benefitted from the implementation of this service.

During the fieldwork, the evaluation team members consistently checked on the progress and quality of data collection processes. Particular attention was given to the sources, authenticity, relevance, appropriateness and accuracy of the data collected.

Standard professional ethics were followed, with each of the research instruments prefaced with key ethical statements that sought respondents’ consent to or decline participation in the evaluation process.
2.5 Data Analysis and Report Writing

Following the desk review, fieldwork and observations, data and key findings were analysed and synthesised into a draft report that was presented to VFANF staff. Quantitative data for individual questionnaires (nurses and patients) were coded and entered into Excel documents before being transferred to Statistical Package for Social Scientists (SPSS) programme for analysis.

Qualitative information was analysed using a content analysis four-step approach, as follows:

- Responses from the key informant interviews were summarised according to the emerging categories;
- Key and repeating concepts were identified in statements from documentation, interviewees and observable evidence;
- The MSC stories were analysed and are used in this report to provide first hand evidence of impact attributable to the programme, and
- Impact statements were drawn from the first two steps.

2.6 Limitations of the Evaluation Process

While we fully appreciate the support received in the delivery of this assignment, the evaluation presented some limitations. Below, we highlight some of the limitations related to this evaluation study:

a. The evaluation survey was a rapid assessment, attracting the participation of a sample of nurses and patients who were conveniently located in 9 of Rwanda’s 30 districts and in 3 provinces. As a consequence, our data may have been limited in its representation of the rest of the other districts that could have presented different perceptions to the delivery of the service in their respective districts and provinces.

b. No specific baseline study based on the DFID log frame indicators was conducted at the beginning of this programme. This would have been useful to compare specific indicators at the start and at the end of this project. The evaluators, however, noted that a national baseline study was conducted in 2012 on the general status of eye care at HCs in Rwanda. It is envisaged that the findings of that baseline will be of use in the future.

c. Another limitation of this evaluation related to the close timing of the implementation of programme activities to the end of programme evaluation. While the evaluation has generated some exciting and fundamental findings, the time lag between the start to end of the programme was narrow and therefore any claims of its potential impact were limited.
3. Evaluation Results and Analysis

3.1 Assessing Programme Relevance
Programme relevance was defined as the extent to which the programme’s interventions were suited to the priorities and challenges of the target group, partners and funders.

3.1.1 Relevance to the achievement of the MDGs
According to the WHO, recent studies have confirmed the existence of a large burden of uncorrected refractive errors, although the interventions required are significantly cost effective, and have an important impact on economic development and quality of life.8 VFANF’s eye care programme in Rwanda was developed to contribute to achieving seven of the eight Millennium Development Goals (MDGs), in particular MDG 1 (eradicating extreme poverty and hunger) and MDG 2 (universal primary education). However, very little evidence was available to demonstrate the extent to which the programme has contributed to MDG 2 so far. It appears as if the programme has targeted more older patients than young people. The strategy also successfully incorporated the three core strategies of VISION 2020: 1) Human Resource Development; 2) Infrastructure Development; 3) Disease Control – all of which contribute to reducing conditions of marginalisation and poverty. More specifically, the ultimate impact of this programme was to see a reduction in number of Rwandans living below the poverty line and in extreme poverty; increase in the number of children completing primary education; and improvement in literacy rates. In order to achieve this, VFANF has successfully collaborated with the MoH and has aligned the programme’s objectives to Rwanda’s national strategic plans.

Working within this framework and alongside the WHO’s Vision 2020 initiative for the elimination of avoidable blindness, the programme was strategically aligned to the global efforts of the Global Action Plan (GAP) for the Prevention of Avoidable Blindness and Visual Impairment of 2014-2019. Building upon the ‘Vision 2020’ and the 2009-2013 Action Plans, the 66th World Health Assembly of May 2013 unanimously approved the GAP for the Prevention of Avoidable Blindness and Visual Impairment 2014-2019: “Towards Universal Eye Health”. Consistent with the strategic priorities of the GAP, VFANF has supported some of the core elements necessary to achieve universal eye health in Rwanda, namely: (a) Comprehensive eye care services such as promotion, prevention to rehabilitation and care; (b) Eye health integration into health systems, especially by contributing to three of the six WHO building blocks of a health system: service delivery, human resources, and information; (c) Access for everyone, including the women, girls and poor people from rural areas; and (d) ensuring that point of care payment does not prevent access by enabling poor people to access services and eyeglasses at very low cost and where appropriate, making free eye care services available for the poorest including provision of glasses free of charge.9

---

3.1.2 Alignment with the intended objectives of GPAF

The grant to VFANF grant was received from the Global Poverty Action Fund (GPAF). The Fund, previously called the Poverty Impact Fund, was introduced by DFID in 2010 with the aim of supporting poverty reduction programmes focused on service delivery working towards the most off-track MDGs. The programme was clearly consistent with GPAF’s mandate and was relevant to the needs of poor and vulnerable people in Rwanda. VFANF went into a strategic partnership with the GoR to introduce PEC into primary health care by training HC nurses and subsequently establishing eye care service provision in 473 health centres, including 5 health posts across the 30 districts of Rwanda. The initiative has encouraged eye health promotion activities at community level; introduced the provision of vision assessments/case detection and diagnosis of eye problems; administered initial treatment; provided low cost eyeglasses; and referred individuals who need sight-restoring procedures such as surgery or other complications to district health facilities.

3.1.3 Relevance to the National Priorities of Rwanda: A Nation “Striding Towards Universal Eye Health”

The nationwide eye programme funded by GPAF was considered fully aligned with the national health system of Rwanda. Based on the review of documents and key informant interviews conducted during this evaluation, we concluded that the programme is considered to be appropriately responding to the strategic priorities of the GoR. Rwanda’s efforts to increase investment in eye health have been recognised by the International Agency for the Prevention of Blindness (IAPB), the agency responsible for leading an alliance of civil society organisations, corporates and professional bodies in promoting eye health through advocacy, knowledge and partnerships. The IAPB celebrated the development of the Third Health Sector Strategic Plan in 2012 by Rwanda’s Ministry of Health and its partners. With the motto ‘Universal Coverage’, the plan provides for greater integration and collaboration across the health system. Rwanda allocated 18.8% of its budget in 2011 to the health sector and community-based poverty programmes (including savings and credit) for the rural poor. An improving economy means more Rwandans are capable of contributing premiums to the community-based health insurance scheme, which allows individuals to access comprehensive, subsidised and preventive care. The review of health care ‘packages’ for different levels has been a great milestone and saw the development of eye care treatment protocols, adoption of eye indicators in the Health Management Information System (HMIS) and more eye health consumables added to the national procurement system. A central eye fund was established and workforce issues were also reviewed to support the health system. Based on such foundations, it is plausible to conclude that the introduction of primary eye care services by VFANF was timely and of extremely high relevance to Rwanda. A positive policy environment for the provision of eye health services has been set in place. Further commitment by the GoR, with the active role played by VFANF, was demonstrated when eye medications were also added to Rwanda’s list of essential drug packages in 2012. Anti-allergy eye drops, for instance, have now been included in the essential drug list of the MoH and made available to district pharmacies and HCs as part of their stock.

“I can’t even over-emphasise the importance of PEC because that’s key to all we will be doing in the near future and in the long term” (Dr John Nkurikiye, MoH Technical Adviser on Eye Health)
3.1.4 Appropriateness to the needs/requirements of the Target Audience

The programme design was found to be highly suitable for addressing some of the key challenges faced by a high proportion of people in Rwanda. Based on a review of the programme reports and anecdotal evidence, it can be said that the programme has been of greater benefit to people from rural settings, and by implication, people from poor backgrounds. As in other countries, poor people often experience limited access to eye health services and end up settling on alternative methods such as the use of traditional medicine, self-medication or developing other coping strategies. For the maximum utilisation of services, even the poorest people could benefit from eye care services through the community-based scheme, the mituelle. The health insurance scheme - an initiative by the Ministries of Health, Local Government and Agriculture - helps to address the financial burden of Rwanda’s poorest citizens by ensuring that those who need health care services can access them for free. Besides the routine registration fees for all patients at HCs, all vision assessments were made available free of charge through this programme. The purchase price of all eyeglasses was set at Rwandan Francs (RwF) 1,000, considered as fair and affordable for most beneficiaries during Phase 1. In some instances, eyeglasses were offered to some people classified as the poorest (Category 1 and/or 2) at no charge.

Evidence from programme documents and the evaluation findings indicated that the programme was increasingly benefitting those that have needed the service most:

a. 67% (n=143/214) of the patient respondents had attained primary level qualifications and a smaller proportion (29%, n=63/214) had attained secondary qualifications. Only 4% (n=8/67) had attained more than secondary qualifications. By implication, the programme has benefited people with low literacy levels, who could probably fit within the category of the poor.

b. It was pleasing to note that the programme has so far enabled people, including women and girls, to access eye health services at primary health level. Of the 32,509 beneficiaries reached since the beginning of the programme, 57% (n=18,537) were women and girls. In the world over, increasing evidence has shown that women are affected by blindness and visual impairment to a much greater degree than men.10

Notwithstanding the positive achievements recorded in the above paragraph, the evaluation team observed that the 60% achievement of female patients could have been more spontaneous than calculated. No clear strategy is in place to ensure increased reach to women and girls. It appeared that the determination of gender balance in programme reach was limited to those who had voluntarily accessed the service, rather than having interventions that have gender specific strategies in place.

---

10 Community Eye Health Journal, Gender and Eye Health, Vol. 22 No. 70 2009. Published online 01 June, 2009
Although the evaluators found sufficient evidence to demonstrate that the service was benefiting the poor, no clear information was available of how ‘the poorest’ and/or those ‘most at need’ were being deliberately targeted. Some of the findings from the survey showed that:

a. Only 1 of 5 patients (22%) who participated in this survey were unemployed. The rest were either in self employment/small enterprises/casual workers (47%), in-school/students (8%), or formally employed (24.3%).

b. A very small section of the patient survey respondents (2.3%, n=5/214) considered themselves to have disabilities. According to the draft end of programme report produced by VFANF, no specific indicators were set on the number of disabled beneficiaries reached by the programme. Hence, no disaggregation based on disability was done and no records were kept. It is recommended that future reporting capture disability status for the people reached.

c. It was also noted that routine programme reporting does not disaggregate beneficiaries by setting, e.g. rural or urban. It might be helpful for VFANF to consider such kind of disaggregation in order to track the extent to which the service is of benefit to those who need it most, particularly from rural areas.

Additionally, the evaluation team also explored the extent to which the development of the service has been responsive to the needs of the target population, in particular people with eye health problems. The general impression from the evaluation findings highlighted the need to involve more beneficiaries in the development and feedback mechanisms of the programme. Several opportunities for better engagement are available, though under utilised. For instance:

a. CHWs were identified as key partners who could link the community to their local HCs.

b. For some HCs, feedback on the quality of services is inferred from an analysis of the demand for services at the HC. For instance, an increase in the number of people coming to access PEC services at a point is interpreted to mean that the service is satisfactory.

c. Most HCs in Rwanda have suggestion boxes. However, little evidence of the utility and utilisation of suggestion boxes to inform the design of the programme, or provide feedback on PEC services, was available from the sampled HCs.

d. In very few cases, some health staff at HCs would ask clients to provide verbal feedback on the services.

Unfortunately, most of the processes for feedback, or the comments received, were not documented and hence their potential to help improve the services were limited.

“We have no particular mechanisms for feedback in place. However, we believe that there is a positive demand and impact of the service through the increased demand for services from community members.”

Head of HC, Gikondo, Kigali City
3.1.5 Relevance of programme strategies to address the needs of the target beneficiaries

The evaluation team identified and assessed six main strategies that were employed by the programme to achieve its main objective. The key strategies were: (i) Training of primary health workers to become PEC nurses at HCs; (ii) Equipping HCs with PEC kits, supplies and materials; (iii) Vision assessments at HCs; (iv) Provision of low cost eye glasses; (v) Referral of complicated cases to district hospitals; and (vi) Awareness raising campaigns through the development of Information, Education and Communication (IEC) materials, a pilot radio programme and the training of CHWs in specified districts. Overall, these strategies were deemed appropriate for addressing eye health challenges within the Rwandan context, specifically: (i) the absence of trained personnel for eye care services at primary health services in Rwanda; (ii) prohibitive costs of eye treatment for poor and marginalised people, especially from rural areas; and (iii) long distances and transport costs to travel to district hospitals where only a few eye specialists were available. These, among other factors, often caused barriers for vulnerable groups such as the poor, persons with disabilities and women/girls, from accessing affordable and timely eye health services in Rwanda.

When asked to identify the most effective strategies implemented by the programme, 70% of the respondents (both nurses and patients) considered the training of PEC nurses as the most effective of them all. This was followed by the provision of vision assessments (66%). More effort is needed to raise awareness about the availability of the service, as demonstrated by a lower proportion of respondents confirming the effectiveness of the strategy. See Figure 3 below for details.

78.5% of the patient respondents felt that the PEC services were reaching the most vulnerable beneficiaries in the community, especially the poorest, women and girls.

![Figure 3: Analysis of the effectiveness of the strategies employed](image-url)
Training of Primary Health Workers to become PEC nurses at HCs

A total of 986 nurses were trained from 473 HCs in Rwanda, exceeding the target by 86 nurses (10%) and by 23 HCs (5.1%). The training of primary health workers was identified as one of the single most effective strategies by 96% (n=64/67) of the nurses who participated in the survey. Only 16% (n=11/67) had received some form of training on eye health before, both formal and informal. The training was found to have been very effective and beneficial to the nurses who were trained. About half of the trained nurses (53%) found the training very beneficial to them at an individual level, with the other 47% believing that the training was moderately beneficial to them. The main reasons for having a fairly large proportion of nurses reporting that they found the training ‘somehow beneficial’ was related to the limited duration allocated to the training. Generally, respondents felt that the training and practice duration could have been longer than 3 days theory plus 1 day for practice. In addition, they indicated that they had not clearly understood the extent to which the training was meant to be basic and only meant to enable them to provide basic PEC services at the HC. In one evaluation workshop, some respondents proposed that they should now be upgraded to become Ophthalmological Technicians, a proposal that is rather far-fetched given the level of skills and knowledge gained to date.

Equipping HCs with PEC kits, supplies and materials

VFANF committed approximately 18% of DFID’s financial investment to the provision of basic HC supplies, kits and training material necessary to initiate PEC services at HCs. A total of HCs were equipped with complete vision assessment materials and eyeglasses. The PEC kit contained: a Pin Hole; a torch with batteries; string (40cm); rope (3m); 2 Near Vision Charts (N8); 2 Far Vision Charts as well as posters and record forms. In addition, each HC was allocated Reading Glasses of different powers: +1.50DS (5 Pairs); +2.00DS (5 Pairs); +2.50DS (5 Pairs); +3.00DS (5 Pairs) and Adjustable Glasses (5 Pairs). The strategy to provide these kits was commendable since diagnostic tools and supplies such as these seldom appear on the standard instrument lists at primary HCs. Having these provisions meant that trained nurses had the opportunity to immediately apply the knowledge and skills gained from the training.

Vision Assessments at Health Centres

There is sufficient evidence to confirm that majority of the trained nurses were able to introduce eye care services at the HCs within a week after the training. Approximately 32,509 people had received vision assessments by the end of October 2013, 57% (n=18,537) of whom were women. The heads of HCs who participated in the evaluation as key informants confirmed their commitment to PEC service provision at their HCs. Pleasingly, 68% of the nurse survey respondents confirmed that their HCs had dedicated one specific day to eye care services. Another 15% had committed two specific days per week. The remaining 16% were still providing services any day of the week.

“The trained PEC nurse at this HC loves eyes and she does it everyday!”

Head of HC, Kigali City, Kigali
Despite the head of HCs’ interest in PEC services, the evaluation findings revealed that the levels of managerial supervision at HCs were uneven. Efforts to sensitise heads of HCs about PEC through the already existing structures within the MoH were considered weak. About 4 in every 5 heads of HCs interviewed during this evaluation reported that they had little confidence to manage, support and supervise trained PECs. Sensitising heads of HCs through meetings and possibly brief training sessions could have enhanced the managerial support mechanisms within the programme. Studies have shown that effective support and supervision, in addition to training, is more likely to lead to better outcomes than training alone.11

Referral of complicated cases to district hospitals
According to the Community Eye Health Journal of 1998, about 15–20% of patients seen/detected by the PEC worker will need medical / optical / surgical interventions in a secondary eye care centre (cataract, refractive errors in children, squints, trauma and corneal ulcers).12 The findings from the first year of implementing PEC services in Rwanda have shown that up to 19% (n=6,284/32,509) of the cases attended to at HCs were referred to district hospitals.

Awareness raising campaigns of PEC services: IEC materials, training of CHWs and a Pilot radio programme in specified districts of Rwanda
Awareness levels about the availability of PEC services are increasing in Rwanda, though slowly. There is still a need to raise awareness about the services, especially amongst the poorest communities in rural areas. Part of the reason why only 4 of 10 PEC nurses (40.3%, n=27/67) felt that the service was reaching the most desired beneficiaries, especially the poorest, women and girls was attributed to limited knowledge about the service at the community level.

Respondents were asked how they had known about the availability of PEC services at their local HCs. 56% (n=120/214) of the patients mentioned health providers as their source of information. The other sources of information included: Family and Friends (31%, n=66/214); Community Outreach (19%, n=40/214); Radio (13%, n=28/67); IEC Materials (6%, n=13/214); and TV (4%=4/214).

In Figure 4 below, the actual sources of information that had provided eye care information were paralleled with the patients’ preferred sources of information. Health workers and community outreach workers were cited as the most preferred sources of information by 39% and 26% of the patients, respectively.

---

Further analysis revealed the different trends for people gathering information about PEC services, based on their settings. The findings, as shown in Table 4 below, revealed that urban based people had more access to information about the availability of PEC services from health providers (69%, n=42/69) compared to rural based people (51%, n=78/153). On the other hand, family/friends and community outreach workers also made a significant contribution with regards to information dissemination for rural patients.

### Table 4: Source of Information by Setting

<table>
<thead>
<tr>
<th>Setting &amp; Source of Information</th>
<th>Health Providers</th>
<th>Family &amp; Friends</th>
<th>Community Outreach</th>
<th>Radio</th>
<th>IEC Materials</th>
<th>TV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>69%</td>
<td>25%</td>
<td>10%</td>
<td>11%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Rural</td>
<td>51%</td>
<td>33%</td>
<td>22%</td>
<td>14%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Media and Communication Resources / IEC Materials**

An investment of 19% of the DFID budget was allocated to the development of communication and media materials. Part of this budget was spent on the radio programme, CHW training materials; as well as developing IEC/ publicity materials; which were then used by health workers to raise awareness at community level. Almost 1 in every 2 nurses (48%, n=32/67) confirmed that they publicised eye care services using IEC materials, in addition to community outreach services (24%, n=16/67). To date, only 6% (n=13/214) of the patients reported that they had first heard news about PEC services at their HCs through IEC materials. A slightly higher percentage of respondents (26%, n=55/214) confirmed that they had seen eye health posters or display signs about the availability of PEC services at their HCs in the last 12 months. Given that the roll out of IEC materials had just started towards the end of the programme, the evaluators considered measuring the impact of this activity as rather too early. No statistically significant difference was found between the people who had seen IEC materials in rural settings (24%, n=38/153) compared to those in urban settings (27%, n=17/61).
CHW Training and Interventions at Community level in Musanze

An important element of PEC service provision in Rwanda was the training of CHWs, which was a pilot scheme implemented towards the end of the project. CHWs are known for helping people to access and utilise primary health facilities since they are familiar with the people and their local conditions.13 With funding from DFID, VFANF conducted a Master of Trainers’ Workshop at Ruhengeri District Hospital with the District In-Charge for CHWs; District OT, Supervisor at District Hospital Level, and the Medical Director. This was followed by a one day Trainer of Trainers’ (TOT) workshop for 42 participants from 14 HCs. The TOT participants were, in turn, tasked to train CHWs in their catchment areas. Of the 1296 CHWs who had been trained in October 2013, 33% (n=432) were maternal health promoters.

Given the limited time between the training of CHWs in October 2013 and the time for this evaluation in December 2013, the impact in Musanze District is already evident. An assessment of the CHW pilot and non-pilot intervention districts revealed a marked difference between the number of people accessing and utilising eye care services in Musanze District compared to the rest of the districts across Rwanda.

A comparison of PEC data in Quarter 3 (July–September) and Quarter 4 (Quarter 4) showed that the number of people who received vision assessments had more than doubled from 965 to 2018, accounting for a 109% increase within a space of 3 months. This achievement was remarkable, also reflecting a 240% increase from the first quarter where the number of people assessed between January and March was 593. The number of people assessed in Quarter 4 was also 3.4 times more than the number of people assessed in the first quarter, that is 593 for the first quarter. Similarly, the number of referrals from Musanze district HCs to the District Hospital also increased from 126 patients in Quarter 3 to 249 in patients Quarter 4 in Musanze, i.e. a 98% increase.

The evaluation team visited Gasiza HC in Musanze District and met 43 trained CHWs, of which 58% (n=25) were female. The CHWs expressed great understanding, satisfaction and commitment to their ‘new role’ as local ‘PEC champions and ambassadors’ at community level. If anything, they requested for more time to be allocated to the training since they felt that one day was inadequate for an in-depth understanding of PEC issues. Overall, CHW training was considered relevant, cost effective, replicable and also sustainable.

“We work hand in hand with the community health workers. These are the people who are very close to the community and help us to mobilise those who need treatment to come to HC. So when they come many, we know that people are aware of the service at this HC.”

(PEC Nurse, Mukarange, Eastern Province).

Pilot Radio Programme
To increase awareness on the services, a radio campaign was launched with community radios in Huye (Southern Province), Nyagatare (Eastern Province), as well as Gicumbi and Musanze districts (Northern Province). From a sample of 214 patients, 13% (n=28) had first heard about the availability of PEC services at their HC over the radio. The distribution per district was as follows: Musanze (n=12), Gakenke (n=8), Kicukiro (n=3), Rulindo (n=2), Kayonza (n=2) and Ngoma (n=1).

A follow up question revealed that out of the 92 people who had heard about PEC services over the radio 12 months preceding this evaluation, 60% were from the Northern Province. Some 37% (n=70) were from the Eastern Province and 21% (n=52%) from Kigali City.

Overall, the following issues were noted during this evaluation in relation to awareness raising campaigns:

a. Evidence from the clinical campaign conducted during the training sessions showed that community people respond positively to awareness raising activities. In some instances, HCs have made use of faith settings, schools and community events such as Umuganda. However, the programme would benefit from being able to track community knowledge, attitude and practices associated with eye care services.

b. A documentary was produced to share the positive experiences of people who have been supported through this programme. Given that most of the HCs in Rwanda have TV and video sets in their consultation/waiting rooms, there is an opportunity to show documentaries such as this and other eye care media from around the world.

c. There is need to develop and disseminate simple and clear eye health messages at community level. The evaluators were informed through the key informant interviews and evaluation workshops that in some instances, patients have left HCs dissatisfied when they felt that their ‘expectations were unmet.’ This was especially true when patients came expecting to receive eyeglasses but were not offered these. The main cause for such ‘expectations’ were attributed to the mixed messages that people had received about what the service could or could not offer them.

“Because of scarcity of trained personnel, access to primary eye care had been limited before the VFANF programme. While everything else starts at primary level in Rwanda, there was no eye care programmes available”  
(Dr John Nkurikiye, MoH Technical Adviser on Eye Health)
3.2 Assesing Programme Efficiency

Efficiency measures the optimal utilisation of resources in order to achieve the desired results vis-à-vis the quality of outputs and programme delivery. Overall, the evaluators determined the design and implementation of the programme to have been largely attentive to the efficient use of resources so as to optimise the results achieved compared to the required level of inputs. As expected of DFID’s grantees, VFANF’s budget and expenditure has also demonstrated good value for money, particularly the amount of financial resources expended compared to the results achieved.

3.2.1 Adherence to Agreed Budgets and Activity Schedule

An analysis of the programme budgets and financial reporting revealed that to a large extent, VFANF was able to deliver activities on budget against agreed plans. Considering the results achieved, the evaluators have concluded that there was a sound association between the budget allocation and the achievement of the results confirmed by this evaluation. The revised agreed contribution from DFID to the total programme was £243,857.07. As a new programme, some internal adjustments had to be made to the programme budget during implementation. VFANF used some of their unrestricted funds to meet the demand for additional costs, such as training materials, wooden boxes and eye drops required for training purposes, which had not been foreseen at the beginning of the programme. VFANF were aware that such adjustments would have been inevitable, and considered this as a learning process for future budgeting processes. An annual audit of VFANF’s accounts was conducted in March 2013. Overall, the evaluators have concluded that VFANF is a transparent organisation that observes clear accounting procedures and have successfully complied with the requirements of the grant.

A key learning for VFANF is the importance of recognising the compulsion for more rigour and attention to detail when planning and costing for a programme. In addition, for a new programme as this, it would have been ideal to include a contingency budget that would cover unexpected expenses during the course of the programme.

Although the programme was largely on track with its expenditure against the agreed budget and deliverables, the original time-scale had to shift due to several factors. First, it was observed that the planning of the programme targets was partly affected by some over-ambitious setting of milestones on the part of VFANF. Subsequently, this has had secondary effects on the delivery of all the programmed outputs.\(^\text{14}\) Second, the challenges were also attributed to the materialisation of some of the risks hitherto identified at the onset of the programme, as explained in the next paragraph.

The start date for programme implementation was delayed due to the protracted NGO registration process required by VFANF to work in Rwanda. The delays were considered justifiable, especially as VFANF had limited scope to influence the speed of the registration process, which was at the discretion of the Office of the Directorate General of Immigration and

\(^{14}\) This was confirmed in the Feedback from TrippleLine Consulting’s Annual Review Process of GPAF-INN-0010: Vision for a Nation: Rwanda – Phase 2. Dated 28th June 2013.
Emigration. In addition, VFANF realised that the original plan and timetable for programme implementation were optimistic and had not realistically estimated the time it would take to develop and test the training curriculum. Finally, the original District HC nurse training schedule of holding it in one district per week without interruption was also realised to be optimistic and possibly compromising the quality of training delivered. Accordingly, the training schedule was reduced to an average of three weeks / district per month, with the extra week used for planning. Due to these delays, VFANF had to seek a ‘no cost’ extension to complete the planned training activities by end of October 2013.

The evaluators acknowledge VFANF’s capacity and competence to manage and address programme-related risks in a timely manner. Nevertheless, VFANF should also take this as an opportunity to draw important lessons from these challenges. Most importantly, there is a need to be more realistic in setting programme targets and in scheduling programme activities. In addition, programme budgeting processes should be conducted more rigorously and actual expenses closely monitored to ensure that potential variances on specific line items are identified early and where possible, avoided.

3.2.2 Good Value for Money: Efficiency, Economy and Effectiveness

Efficiency: In terms of efficiency, VFANF has successfully match-funded programme activities with resources from different sources, hence optimising on the results of their efforts in efficient ways. The GPAF contribution of £243,857.07 accounted for 29% of VFANF’s total programme budget of £828,490.37. As shown in Table 5 below, the biggest proportion of DFID’s funding was committed to programme activities. The allocation of funds was done taking into consideration the maximum financial resources, which were available from DFID when the programme proposal was developed. Subsequently, VFANF made a deliberate decision to allocate the full GPAF budget towards direct programme costs related to the programme (see Table 5 below).

<table>
<thead>
<tr>
<th>Budget Line</th>
<th>Amount Spent</th>
<th>% Of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of Nurses</td>
<td>£135,905.80</td>
<td>56%</td>
</tr>
<tr>
<td>CHW Training</td>
<td>£5,683.77</td>
<td>2%</td>
</tr>
<tr>
<td>Training of teachers at nursing schools</td>
<td>£9,652.31</td>
<td>4%</td>
</tr>
<tr>
<td>HC Supplies, Kits &amp; Training Materials</td>
<td>£46,625.15</td>
<td>19%</td>
</tr>
<tr>
<td>Communication and Education Media</td>
<td>£45,990.04</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>£243,857.37</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 5: Proportion of Budget by Line Item

A review of the programme budget and financial reports showed a very clear segregation and reporting of specific budget line items to their respective funders.
Economy and Effectiveness: The evaluation confirmed that VFANF has done its best to buy and employ inputs at an optimum value-for-money price as demonstrated by their policies and practices described below. Some of the positive practices that demonstrated good value for money included: (a) obtaining 3 quotes for all products and services procured, in accordance with their Finance Policy; (b) recruiting an experienced and capable team of local staff in Rwanda who were compensated according to local norms; and (c) sourcing products and services locally wherever possible, including training tool boxes, training materials and reading glasses. Such efforts are praiseworthy. With support from the MoH, import duty on reading glasses was waived, while adjustable glasses, as registered medical devices, were already on the list of duty free items in Rwanda. In that case, the programme needed to consider custom clearance and handling costs only, which was a responsibility allocated to the MPPD who would clear the items and take them straight to their warehouse. The adjustable eyeglasses, which were used by the programme, were manufactured by Adlens Ltd, a UK-based technology company certified to manufacture eyeglasses under ISO 9001’s Quality Management System (ISO 13485). To increase on the economy and cost effectiveness of the programme activities, other significant costs such as administrative costs, human resources, capital expenditures, as well as M&E, were allocated to other funding sources.

Good Value for Money was also demonstrated by VFANF’s human resource utilisation strategy. For the review period, VFANF were able to allocate all staff costs to other sources, and none to DFID. Six staff, i.e. the Programme Manager, Programme and Logistics Officer and 4 Ophthalmic Technicians, worked directly under the GPAF programme. An M&E Manager was recruited towards the end of the programme in October 2013. Although considered a little belated by the evaluation team, the recruitment of M&E personnel was a noble move to ensure close monitoring of programme progress and the documentation of the results and lessons learnt. It is recommended that more resources be invested into the M&E unit, as there is already an increased demand for quality assurance and quality checks for this programme. By financing the staff costs with funding from other donors and unrestricted funds, VFANF has had more flexibility to ensure the DFID funds were fully committed to cover programme expenses, particularly training, programme material, travel and communication expenses.

VFANF’s personnel, including trustees, management and international staff representatives, as well as logistics and office administration teams, have made valuable contributions to the programme. Although the scope of the evaluation did not allow space for the evaluators to determine the proportion of time and contributions made by the support personnel mentioned above, there is adequate evidence that they invested substantial amounts of time in supporting and supervising the programme. We strongly encourage VFANF to begin considering full cost recovery approaches, as they cannot simply rely on resourcing programme personnel through unrestricted funding. In order to achieve this, VFANF would benefit from regular computations, costing and analysis of their staff time allocation and contributions when delivering programme’s of a similar nature.
3.3 Assessing Programme Effectiveness

A programme can be considered to be effective if the planned activities are implemented as planned, if the results are achieved, and have contributed to the expected outcomes. In this section, we assessed the achievement of the three outcome and output indicators set in the programme log frame. The evaluators observed that the programme plan evolved within the year and any such changes to the original log frame targets were timely communicated with, and approved by, the GPAF Grant Administrator. Overall, VFANF demonstrated a positive learning attitude through their transparent and openness to learn from any constraints that could have affected the effective delivery of the programme.

Also important to note, it must be emphasised that solely judging programme effectiveness on the basis of the numbers set in the log frame would be an understatement of the positive achievements made by the VFANF. Overall, it was especially significant to report that within one year, VFANF has collaborated with the government to establish a fully operational initiative that offers primary eye care services in 473 HCs from the 30 districts of Rwanda, including 5 Health Posts and 3 Prison HCs.

3.3.1 Progress towards the achievement of programme Outcomes and Outputs

The VFANF programme benefitted 32,509 beneficiaries by the end of October 2013, 57% of whom were women and girls. The programme reports accounted for only adults aged 18 and above; implying that the total reach could have been much higher than those currently reported. From the evaluators’ perspective, the overall programme target to reach 425,000 beneficiaries within one year was rather optimistic and considerably ambitious for a limited period of one year.

**Outcome 1: 33,000 people will have improved vision from Primary Eye Care services provided.**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achieved</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Indicator 1: Number of people aged 8 years and above who have a 3-line improvement (the number of additional lines the beneficiary is able to read on a vision chart) through the provision of glasses.</td>
<td>33,000</td>
<td>5,961</td>
<td>18%</td>
</tr>
<tr>
<td>Outcome Indicator 2: Number of people aged 8 years and above who have had further treatment having been referred to a District Hospital.</td>
<td>3,000</td>
<td>1,420</td>
<td>47%</td>
</tr>
</tbody>
</table>

Table 6: Indicators for the Programme Outcome

As shown in Table 6 above, the target to reach 33,000 people who have a 3-line improvement through the provision of glasses recorded an 18% (n=5,961) achievement. Based on the assessment of the programme, the evaluators concluded that although the achievement of this outcome was considerably below target by 82%, the work done was no mean feat. It is plausible
to argue that the achievement of such a high target would have required a much longer time than was set. Due to the delayed start of the training, the achievement of this outcome has only started to be realised. Most significant was the assurance from 69% (n=46/67) of the health staff who reported that they had begun to see increased numbers of clients attending PEC services at their HCs.

In addition to accessing services at HC level, it was noted that more people who required specialist services were utilising eye health services at district level after being referred. According to key informants interviewed during this evaluation, district health experts were now attending to ‘necessary and appropriate cases. According to the programme records, a total of 1,420 referrals were treated at district level across Rwanda. Given the lack of a clear reporting mechanism on the referral pathways, the evaluators assume that the 47% achievement (based on a target of 3000 referrals) is a gross under-reporting of the real figures supported at district level. In particular, it was noted that HC records indicated 6,284 patients having been referred to district hospitals, yet only 1,420 (23%) are reported through the VFANF recording system.

It is necessary to ensure that appropriate reporting and feedback mechanism on referrals are in place to avoid the risk of under-reporting, which the evaluation team believe is happening. While the number of “walk-in” clients for eye care has been drastically reduced, the evaluators believe that the number of eye care cases that are treated are still high. To a great extent, HC staff are dealing with eye care problems that can be addressed at primary health care, hence reducing the burden of hosting ‘petty eye care’ issues at district hospitals. However, as noted from a sample of 5 district hospitals, i.e. Bugesera, Kibagabaga, Musanze, and Rwamagana, the increased awareness about eye care services at community level have also led to an increase in the demand for eye care services at HCs. Subsequently, the number of referrals to District Hospitals are also likely to increase. We recommend VFANF to collaborate with the Ministry of Health to conduct an analysis of the trends to and establish the possible effects of increased awareness about the availability of eye care services at the different health system level in Rwanda.

Moreover, the patients’ survey revealed that of the 34 cases that had been referred to district hospitals for further treatment, 88% (n=30) had proceeded to district hospitals and accessed the services. Two of the four patients who had not gone to the district hospital had just been attended to at HC and were yet to go. The other two reported that they had not gone to the district hospital due to distance/transport costs.

Confidence levels with district health facility services among primary health care staff were fairly high, with 66% (n=44/67) of the survey nurses confirming that they were confident to refer patients to district hospitals. Of the 30 patients who were attended to at district level, 60%, n=18/30 were satisfied with the district health services.
A key challenge identified by PEC nurses was the lack of feedback from district hospitals, with 57% (n=38/67) of the survey nurses stating that they never got feedback from their district hospitals. Only 9% (n=6/67) confirmed that they always got feedback and another 34% (n=23/67) stated that they sometimes got feedback. As shown in Figure 5 below, patients’ satisfaction levels with eye care services at HCs (78%) were high, compared to 60% with district hospitals. While 4% of the respondents reported dissatisfaction with services at HCs, a larger number, 13%, were dissatisfied with district hospitals. No further investigations were done to understand why satisfaction levels were lower at district hospitals compared to HCs.

![Figure 5: Satisfaction Levels with Eye Health services](image)

Some issues that were identified with regards to referral services include:

a. Some patients who are referred to district hospitals fail to proceed to the district hospital due to factors such as distance, transport and cost of services. It may be necessary to conduct ongoing operational research to identify potential barriers that hinder patients from accessing district level eye health care services.

b. As the number of referrals increase, there is a greater risk of overstretching district OTs with extra work. This, in the long run, could negatively affect and/or compromise the quality of eye care services at district level.

c. Feedback mechanisms between district hospitals and HCs on eye health are generally weak. One respondent highlighted that: “No mechanism is in place for feedback. We only give them back if they call to ask us. Otherwise we give feedback in the case of emergencies only.” (District Health Staff, Eastern Province).
Output 1: 450 Health Centres will have the capacity to provide primary eye care services.

The introduction of eye care services followed the successful in-service PEC training that had been rolled out to cover 473 HCs in Rwanda by October 2013, thus exceeding the target of 450 by 5%. The capacity development at HCs was done through training of primary health care staff and provision of start up kits at HCs.

The evaluators confirmed that the training followed the PEC curriculum developed by a core team of eye care specialists in Rwanda and was approved by the MoH. The first TOT workshop involved a core group of 4 Master trainers from VFANF who carried out further training in the 30 districts of Rwanda and trained 986 nurses (477 male and 509 female).

The survey results showed that PEC services were run to a very high standard at HCs in Rwanda, leading to an overwhelming proportion of patients (83%, n=178/214) expressing greater satisfaction with PEC services from their HCs.

As shown in Figure 6 above, staff attitude at HCs was rated to have been exceptionally satisfactory, with more than 9 of 10 respondents (95%) reporting satisfaction. With average satisfaction levels of 82% to 86%, the results revealed that a slightly lower proportion of patients (71%) were satisfied with the availability of medication and other supplies at HCs. Key informant discussions also highlighted the unavailability of rooms dedicated for eye care services at HCs as one critical challenge that needs to be attended to.
Support and Supervision of PEC Nurses

Management and supervision levels of PEC services varied from one HC to another. Ideally, eye health issues should be discussed bi-weekly at HCs. The evaluation survey found out that 78% (n=52/67) of the nurses had discussed eye health issues with the management at their HCs. A concerning small proportion of 18% (n=12/67), had last discussed eye care services between 1 to 3 months prior to the evaluation. 4.5% (n=3/67) reported that they rarely talk about eye care services with their management.

“For me, I have not received any information on eye treatment and so there is nothing that I can supervise on. To make matters worse, we have never had a supportive supervision visit from VFANF or the district hospital. So we just hope they are doing a good job” (Head of HC, Rulindo District, Northern Province).

Approximately 7 out of 10 heads of HCs felt that VFANF should have also trained them at the same time as the PEC nurses. They emphasised that heads of HCs stay longer at HCs compared to the rest of the HC staff, and that they also required the right skills to support and supervise PEC staff.

“As heads of HCs, we were supposed to be trained on PEC as well. In case of absenteeism or emergency we would have been available to help solve issues with confidence – but without that we are usually helpless.”

(Head of HC, Nyamirama)

The key roles played by site supervisors included: Checking Practice and Observing Consultations (n=22); and Discussing Roles and Responsibilities (n=17).

![Figure 7: Support and supervision from heads of HCs](image-url)
However, some respondents (n=10) reported that their supervisors did nothing on PEC. Further analysis revealed that those who reported non-action from their heads of HC were likely to report that they had not spoken about eye health care services with their supervisors for at least a month before this evaluation (see Figure 7 above).

Seeking for Support
The survey participants were also asked who they consulted if they faced any challenges related to PEC. Out of 59 respondents, only 15% (n=9/59) said that they would consult the heads of their HC if they needed help on eye health issues. A greater proportion of nurses (42%, n=25/59) would consult with their colleagues/fellow PEC nurses followed by district health staff/OTs (27%, n=16/59).

Although 69% of the nurses confirmed having had further contacts with VFANF staff or representatives since the training, it was rather surprising that only 14% (n=8/59) of the PEC nurses would have considered consulting them if they faced challenges. An explanation provided for this lack of contact was the packed agenda that VFANF staff had in the first year of the programme, having had to spend at least 29 weeks of the year in training throughout the 30 districts of Rwanda.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achievement</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of nurses who have successfully completed the Primary Eye Care training</td>
<td>900</td>
<td>986</td>
<td>110%</td>
</tr>
<tr>
<td>Of which % were female</td>
<td>63%</td>
<td>52% (n=509)</td>
<td></td>
</tr>
<tr>
<td>Number of Health Centres with complete vision assessment materials and eyeglasses</td>
<td>900</td>
<td>986</td>
<td>110%</td>
</tr>
</tbody>
</table>

Table 7: indicator for Output 1

Close to 100% of the respondents (n=64/67) confirmed that two people were trained from their HCs by VFANF and only 4% (n=3/67) had one person trained at their HCs. The target for 900 nurses who completed PEC training was exceeded by 10%, thereby training an additional 86 PEC nurses to the planned 900. Successful completion of the PEC training was defined as a “nurse who has fully participated in the 3-day training session and deemed by the instructor to have fully understood what he or she has been taught.”\(^\text{15}\) The increase in the number of staff trained was necessitated by the corresponding increase in the number of HCs supported by the programme.

The total number of HCs, which were equipped with materials and eyeglasses, was 986. It was noted that in addition to the conventional HCs, this number included five health posts with staff

\(^{15}\) VFANF (2013) Revised Logframe GPAF-INN-2010 to DFID
trained and equipped purposively due to the distance and served population, as well as three Prison HCs.

To understand satisfaction levels with PEC training, participants were asked to rate different elements of the training. On average, 56% (n=38/67) of the respondents were largely satisfied with the overall training process. As seen in Figure 8 below, high levels of satisfaction were reported on the Training Content, Logistics & Admin, as well as Facilitation. However, satisfaction levels with the training duration were lower, with only 16% largely satisfied, 61% moderately and 22% dissatisfied. In a consistent manner, the limited duration allocated to the training meant that the likelihood to meet participants' expectations was also limited. In this instance, only 43% were largely satisfied.

“In the past, people used know that eyes were only treated at Kabgayi Hospital. If they did not have money to go there they would stay at their homes and continue suffering. But now we are nearer to them and can provide them with good services here at the HC”
Dative Mukamurangwa, PEC Nurse, Nyacyonga HC, Gasabo – MSC Story.

Figure 8: Satisfaction levels with the Delivery of PEC Training

Lack of consistency on recruitment and selection processes for the training participants at different HCs was apparent during this evaluation. Although essential criteria and minimum skills for trainees were set and developed by the Technical Working Group, compliance rates at HC levels were mixed. Some heads of HCs stated that they had not received the criteria at all. Others said they had received the information about the training at short notice. Due to short notices about the training, it was noted that not all the people who were trained were necessarily the most ideal people for the training. In some instances, heads of HCs reported that they

“84% of the nurses who were trained on eye care through this initiative had never received any training, either formal or informal, on eye health before the VFANF Training.

“We were informed about the training on that very morning of the training by telephone and had to send the nurses who were nearest and available. One had just finished night duty, which was not ideal. Given enough time, we would have selected those involved in consultation”
(Head of HC, Eastern Province)
only got information about the training by telephone 24 hours prior to the training. In one instance, one nurse was invited to the training after having spent the night on duty. In this case, the selection processes were challenged. In some HCs, staff were selected following participatory group discussions and in others, selection was based on their HC rota schedules for training. In some instances, selection was based on one’s key areas of responsibility, such as selecting those who worked in the consultation room, being the first point of contact with patients. One example of good practice was picked up from one HC in Kigali City:

“For us it was fine. We received invitation letters after a sensitisation meeting where all Heads of HCs were informed about the training. So we prepared and selected the persons involved in routine consultation activities at our HC”

(Head of HC, Gikondo, Kigali City).

Some other training-related challenges identified during this evaluation included:

a. Limited number of trained personnel per HC: The maximum number of people trained was limited to only 2 people per HC. Given the high HC staff turnover in Rwanda, sustaining the momentum at HCs is compromised. It was disturbing to learn that 28% of the nurse survey participants reported that at least one of the nurses trained at their HCs had already transferred or left their job since the training.

b. No follow up support was provided by VFAN immediately after the training. Due to a heavy workplan to deliver training across the 30 districts, VFANF was unable to immediately provide support, supervision, and refresher courses after the training.

Training Material Packs produced and provided to Health Centres

63% of the nurses (n=42/67) agreed that the training manuals/materials provided to them were of reasonably good quality. Some of the respondents felt that although the training materials were of good quality, they had faced some challenges with interpreting some of the content, mostly due to language barriers, since they were mostly in English. Some of the respondents stated that the materials did not fully address all the key eye care issues that they met during their delivery of services. Despite these less positive sentiments, only 6% (n=4/67) of the PEC nurses reported that they could not identify or treat some simple eye diseases.

Output 2: Vision assessments provided to people aged 8 years and above.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achieved</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision assessments provided to people aged 8 years and above.</td>
<td>425,000</td>
<td>32,509</td>
<td>8%</td>
</tr>
<tr>
<td>Of which % were female</td>
<td>52%</td>
<td>57% (n=18,537)</td>
<td></td>
</tr>
<tr>
<td>Number of Health Centres with complete vision assessment materials and eyeglasses</td>
<td>450</td>
<td>473</td>
<td>105%</td>
</tr>
</tbody>
</table>

Table 8: Indicators for Output 2
It appeared as though the targeting of 425,000 vision assessments within the first year of the programme was over ambitious and unrealistic. A significant amount had to be done in the first year before the full roll out of vision assessments, including the full registration process for VFANF in Rwanda, provision of training across the 30 districts as well as provision of start up kits, including glasses at HC level. However, the demand for eye care services is evident. More than 80% of the patients who participated in the survey had visited the HC specifically for eye care services. Almost 2 in every 5 patients (n=78/214) had visited the HC for eye care services at least twice a year.

Some limitations to the achievement of this output were however noted. Most critical is the staff shortage in terms of nurses who are trained to deliver PEC services. Two trained staff at an HC was considered largely inadequate, resulting in them facing high workloads compared to non-PEC nurses. In some instances, PEC services were reported as a lesser priority than other services. It was learnt that PEC staff were often summoned to attend to other health management issues that seemed more urgent than eye care issues.

“One of the challenges at district and HC level is that eye care is never considered as an emergency.”

(District OCO, Eastern Province).

**Equipping Health Centres with complete vision assessment materials and eyeglasses**

All the HCs participating in this programme (n=473) were equipped with vision assessment materials and eyeglasses. The achievement of this output indicator exceeded the target by 5%, owing to both increased numbers of HCs as well as expanding the service to a few health posts. By October 2013, a total of 27,984 eye glasses had been delivered to HCs across Rwanda, of which 84% (n=23,432) were reading glasses and 17% (4,552) were adjustables.

An area of concern identified during the evaluation was that almost every 6th nurse survey respondent reported stock-outs of medication and / or glasses at their HC, i.e. 61% (n=41/67). It must, however, be noted that the challenge of stock-outs was particularly greater during the first few months of programme implementation.

![Stockout of Medication and Glasses at HCs](image)

*Figure 9: Stock-out challenges at rural and urban HCs*
As shown in Figure 9 above, stock-outs were more likely to happen in rural settings (35%) compared to urban settings (25%). In addition, more stock-outs were reported for medication (37%) compared to eyeglasses (23%). The pie chart in Figure 10 below shows that slightly more than half of the HCs who experienced stock-outs (54%, n=22/41) received their supplies within a month; 36% (n=4/41) between 1-3 months; while 10% (4/41) after more than 3 months. Possibly due to distance and travel frequencies, more HCs in urban settings (59%) reported shorter waiting periods of less than a month, compared to HCs in rural settings (50%). None of the urban HCs waited for more than 3 months, unlike 17% of the rural HCs.

Output 3: 30,000 pairs of eyeglasses delivered to HCs.

33,530 glasses were purchased and 27,984 eye glasses were delivered to HCs across Rwanda, of which 84% (n=23,432) were reading glasses and 17% (4,552) were adjustables. This total number of eye glasses included the glasses delivered to HCs by VFAN in the training tool kits and during the practice sessions, and by the MPPD via District Pharmacies.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Achieved</th>
<th>% Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of reading eyeglasses delivered to HCs</td>
<td>20,000</td>
<td>23,432</td>
<td>117%</td>
</tr>
<tr>
<td>Number of adjustable eyeglasses delivered to HCs</td>
<td>10,000</td>
<td>4,552</td>
<td>46%</td>
</tr>
<tr>
<td>Total number of glasses</td>
<td>30,000</td>
<td>27,984</td>
<td>93%</td>
</tr>
</tbody>
</table>

Table 9: Indicators for Output 3

The programme statistics revealed that about 17% of all eye care patients require reading glasses and the program has delivered on that accordingly. It is important to also note that through this programme, it was learnt that there is greater need for reading glasses compared to distance/adjustable glasses.
From the evaluation survey sample, about 7 out of 10 patients (n=151/214) had received eyeglasses after vision assessments. The majority (91%, n=137/151) had received reading glasses; 7% (n=11) received adjustable glasses and 2% (n=3/151) had received both adjustable and reading glasses. Almost 7 of 10 respondents (68%, n=103/151) of the recipients of eyeglasses were largely satisfied with the quality of eyeglasses that they had received. However, the evaluators also learnt that almost 1 in every 4 respondents (23%, n=34/151) were moderately satisfied and another 9% (n=14/151) were less satisfied. See Figure 11 below.

Further analysis of satisfaction levels based on type of glasses revealed that patients receiving reading glasses were more likely to be satisfied with the quality of glasses than those who receive adjustable glasses. 72% (n=98/137) of those who received reading glasses were largely satisfied, compared to those who received adjustable glasses (36%, n=4/11) and both (33%, n=1/3). The breakdown of the satisfaction levels, disaggregated by the type of glasses, is shown in Table 11 below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>To a less extent</th>
<th>Moderately</th>
<th>To a large extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustable</td>
<td>45%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Both</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Reading</td>
<td>7%</td>
<td>22%</td>
<td>72%</td>
</tr>
</tbody>
</table>

Table 10: Satisfaction levels with glasses by type

Approximately one in every two PEC nurses (51%) believed that the equipment / tools provided to their HCs, such as eyeglasses, were appropriate and usable. Some key informants and evaluation workshop participants described the design of the adjustable glasses as less than satisfactory.

“Reading glasses were better preferred by our clients. In some cases we have had clients refuse adjustable glasses, mainly because of their design which is not very nice looking and they are uncomfortable”
(Head of HC, Busengo HC)
3.3.2 Monitoring and Evaluation Processes

Regular and systematic supervision, together with responsive M&E systems should ideally be incorporated in national health care systems. The evaluators confirm that VFANF has made incredible attempts to develop necessary M&E systems fit for the purpose and developed to support the delivery of eye care activities in Rwanda. The commitment to M&E by VFANF is praiseworthy. A new M&E Manager was recruited towards the end of this programme and is now in place at VFANF. There is evidence that efforts to improve on the monitoring tools and instruments are already in motion.

Tracking and Monitoring Programme Outputs

A major M&E achievement has been the addition of the key indicators for PEC in the MoH's HMIS at both HC and district hospital level. A programme-specific output monitoring system has been set up in each district where nurses have been trained in PEC. The District OTs based at district hospitals keep in contact with the HCs (where nurses have been trained in PEC) and receive monthly updates on service uptake figures, number of people treated, number and type of glasses dispensed, the number of referrals made to the district hospital, etc. These figures are compiled in each district and forwarded to VFANF every month. Despite the minimal delays experienced by district hospitals in receiving HC reports, the data collection and collation process has worked fairly well. This initiative has led to the collection of a standard set of eye health data across Rwanda.

M&E Support and Supervision Services from District Health Centre Staff

The plan for district OTs to provide a total of 4 monitoring visits to each HC over the 3-month period following the completion of training were not successful. The plan was to ensure that nurses were well-supported and procedures followed correctly after training, i.e. vision assessments, record keeping, dispensing eyeglasses, stock control and cash control. However, this plan did not fully materialise due to several reasons. The findings from this evaluation indicated that the supervisory role of the OTs in the first year of the programme was seldom fulfilled. A survey among a sample of ophthalmic nurses conducted during the evaluation revealed that they felt less equipped to fulfill the supervisory role, and in most cases there was only one eye specialist in an entire district. Amongst other things, OTs were found to have had limited skills, capacities and time to provide supportive supervision services to the trained HCs. Although a modest monthly budget was available from VFANF to support their communication expenses, no budget was set aside for travel/support visits to the HCs. In addition, district OTs are often deprived by their own supervisors of the opportunities and space to actively participate in support visits to HCs.

Measuring of Changes/Impact Study on PEC Services

A baseline study to determine data on infrastructure, human resources and disease control services related to eye health in all the HCs was conducted by VFANF Rwanda in 2012. Unfortunately, it was noted that the key research questions for the baseline study were broader than the specific indicators relevant to the GPAF Programme. No programme-specific baseline study was conducted at the inception of the GPAF programme. In such instances, determining
the achievement of outcome level indicators without a baseline study that was aligned to the programme poses a major challenge. The non-alignment of the baseline indicators to the programme indicators made associating the evaluation findings to the baseline findings challenging. We strongly recommend that specific baseline studies be conducted for particular programmes. It is also envisaged that a baseline study that is well aligned to particular programme indicators provide a strong basis for future impact studies.

Response to the Annual Review Process by DFID
During this independent final evaluation, we also assessed the extent to which VFANF was able to act upon the feedback on the Annual Review Process (ARP). The ARP process is DFID’s principle management tool by which grantees are held to account and to ensure they are working towards their stated objectives. Having read the feedback from Triple Line Consulting/Crown Agents, contracted by DFID to review all GPAF progress reports, we confirm that VFANF has satisfactorily addressed comments and made necessary adjustments, in particular by reporting age-specific data.

M&E Challenges and Outstanding Issues
Notwithstanding the positive efforts by VFANF, we would like to bring to attention some key M&E issues that were identified during the evaluation process:

a. No M&E Plan was available: Although VFANF has kept an up-to-date record of programme data, no overall M&E Plan was developed for this programme. Focus has, therefore, been on specific tools, rather than an overall oversight of the programme’s M&E system.

b. Record books: Most of the record books distributed to HCs for reporting purposes had run out by the time of the evaluation. An unspecified proportion of HCs had not made extra copies as they were expected to and no replacements were available. This finding underscores the risk of losing some data, as HCs were not uniformly using a standard set of recording documents.

c. Patients’ Contact Details: In several cases, heads of HCs agreed that it would have been ideal if they had the clients’ contact details for follow up and support services. Interestingly, follow up in villages especially where CHW were more active, was seen to be easier than in urban areas.

d. Double Counting of Patients: While the HC records captured data on new and repeat patients, the VFANF reporting template did not. In that case, there is a greater risk for double reporting on the same client who might have visited the same HC over consecutive months.

e. Age and Gender Disaggregation: Following the ARP feedback, VFANF has started to collect data relating to clients’ ages. However, the evaluation team found that the age ranges that are being used by VFANF (0–16 years; 17–39 years; and above 40 years) are not directly aligned to the MoH age ranges (0–11 months; 1–4 years; 5–14 years; 15–24 years; 25–34 years; 35–49 years; and 50+ years). It is recommended that the reporting formats be aligned in the future, both for ease of reporting and for comparison with national statistics. Alternatively, VFANF may want to consider the three age groups used by the WHO: 0-14 years, 15-49 years and 50 years and older, to determine the
prevalence of visual impairment and blindness.\textsuperscript{16} Although the reporting form provided by VFANF to the HCs captures sex-disaggregated data, the data are not correspondingly disaggregated by age. It is ideal that data analysts be able to determine age and sex, rather than just one or the other.

d. \textit{Reporting to District Hospitals}: Specific report submission date deadlines to district HCs have been largely observed, albeit reporting delays from HC to district level have also been experienced. This has been partly due to the manual nature of reporting. Although the majority of HCs are equipped with functional ICT personnel and services, such as computers and internet connectivity, insufficient evidence was available to show the utilisation of these facilities to improve eye related health information collection and use. PEC nurses and district OTs stated that PEC data were still being collected, collated and delivered manually to the District Ophthalmic Services department. More than 7 of 10 nurses felt that the manual reporting process could be improved if reports could be submitted in soft copy to the district hospitals by email, even if it meant posting the original copies of the report at a later stage.

e. \textit{Contents of the Reporting Template}: The reporting template could be improved by adding a section on challenges faced at HC level and stock level records. This would be useful for district OTs to identify potential support needs at HCs in a timely manner.

f. \textit{Database for Alumni}: Although the trainers maintained the list of names and contact numbers for the trained nurses, there is no active and up-to-date database that is in place to track staff transfers and movements.

3.4 Asssessing Emerging Impact and Outcomes

In this section, we assess the emerging impact that the GPAF funding has brought to the people of Rwanda through the VFANF programme. However, it must be noted that both the evaluators and VFANF were aware that since the programme has been implemented for only one year, any claims of impact should be made with caution. Although it is too early to determine the overall impact of the programme, we found sufficient evidence to suggest that the programme will have a lasting impact on equitable poverty reduction and the empowerment of all Rwandan citizens. Acknowledging the limitation of measuring impact after only a year of the inception of the programme, the evaluation team concentrated on ascertaining the differences and changes resulting from programme activity. At individual and community levels, evidence of some positive and measurable impacts on productivity, education, employment and quality of life for beneficiaries are beginning to emerge. Ultimately, the final long-term results are more than likely to help improve the quality of life for more Rwandans, as they will be actively participating in decisions that affect them at local and national level.

3.4.1 Programme Beneficiaries

The programme has directly benefitted:

a. Health staff at primary health centres through training. 69% of the nurses surveyed reported that the training had raised their confidence in providing eye health services to patients at primary care level.

b. Of the patients who presented themselves with eye care problems at HCs across Rwanda, 60% were women. 84% (n=180/214) of the patients and 66% (n=44/67) of the nurses believed that the introduction of PEC services at health centres was beginning to make a difference in the lives of people in their community.

c. CHWs who were trained on eye health in Musanze District; and

d. Teachers at the 8 Nursing Training Schools in Rwanda.

At the same time, the programme has started to benefit the wider Rwandan community, especially through awareness raising campaigns.

3.4.2 The difference made by GPAF funding

In this section, we assess the difference that GPAF funding has made to the programme’s delivery of results that provide value for money, which would not otherwise have been achieved. Based on our review of programme documents, interviews and collection of Most Significant Change stories, positive results were emerging, as substantiated below.

a. *Increased awareness about the accessibility and availability of affordable PEC services at local health centres:* The trained CHW and health staff members have played an important role in raising awareness and challenge myths and misconceptions about eye health issues in the community. Patients often delay accessing treatment due to the association of eye problems to witchcraft as well as preferences for self-medication and traditional remedies, thereby exacerbating conditions and even causing blindness. Due to increased awareness about the availability of PEC services at local HCs, more people have begun to access eye care services within the proximity of their homes. The introduction of PEC services at HC level has brought eye care services closer to the community. 65% (n=138/214) patients agreed that the programme had begun to make a positive impact in their lives. From the evaluation survey it was found that 80% (n=172/214) respondents lived within 5km from the nearest HC. Only 1 person (0.5%) lived more than 15km away. Some individuals who participated in this evaluation reported improved eyesight as a result of this intervention. The MSC stories confirmed that some people’s sight had improved and others read books and/or their bibles. Others had their eye sight fully improved and had gone back to productive work. In a significant change story from Rwamagana, Evariste, a PEC Nurse shared the testimony of a 52-year old man by the name of Bukuru. According to the story, Bukuru had almost lost his sight until he was given glasses. As a result of improved sight, he went back to his self-employed role as a cobbler and continued to generate income for his family.

"After conducting vision assessments for a man at our centre, we gave him eyeglasses. After some time he came back to report that he could now see. Now he can help his family to read the bible. Even more exciting, he has since brought 6 other people to our HC for eye treatment which is our pride."

Rose Tuyishime, PEC Nurse, Bushoka HC, Gakenke.
b. **Enhanced capacity of individual HC staff to identify and manage eye care challenges at primary health centres:** The provision of training opportunities to 986 nurses (52% female) and the supply of eye care materials, equipment and medication to 473 HCs (including 5 Health Posts and 3 Prison HCs) in Rwanda has resulted in some notable differences at both individual and HC level. First, the trained nurses reported improved knowledge and skills to address eye care challenges at local HCs. About 8 out of every 10 (79%) reported that they have been able to fully practice and apply what they had learnt from the training.

“We now the community has increased confidence in me as a PEC nurse. In the past, they could not believe that at the health centre, you could get eye care services. They now treat me like an eye doctor”

(Tuvindingwe Denyse, Murambi HC, Rulindo District).

c. **Increased accessibility and utilisation of affordable nationwide eye care services at primary health care centres:** Before the introduction of PEC at HCs in Rwanda, diagnosis and treatment of eye health challenges was limited to a few individuals who could afford to access secondary, tertiary and private facilities. However, the introduction of PEC services though this initiative has led to an increase in the utilisation of eye care services at local levels, within their proximity. More than 80% of the cases are now being treated at HC level, saving the clients the time and money to go to district hospitals.

“For a primary eye care programme to be effective, it must have close liaison with secondary and tertiary levels of health care, and a proper and adequate back up referral system.”

Key Informant, Musanze District, Northern Province

d. **Reduction in the number of walk-in patients with minor eye problems at district hospitals and the development of a stronger referral pathways between HCs and the district hospitals:** While the number of unexpected walk-in patients has decreased at district hospitals, the evaluators also verified and confirmed that district hospitals have also witnessed a marked increase in the number of referrals for cases that could not be dealt with at HC level. According to one Head of a HC, District OTs were now concentrating on 'real issues for their level'. Laurence Nikuze, a PEC Nurse from Gikondo HC, shared a significant change story of a 70 year old woman whom they referred to the district hospital. After treatment, the woman came back to the HC to appreciate the work done for her by the PEC nurses. Her eyesight had completely improved and she has been referring a lot more people from the community to the HC.

“Nurses who have been trained at HC level are now able to identify and deal with treatable cases at HC level. They now refer only the cases that need to come to us.”

(District OT, Bugesera, Eastern Province)

e. **The strengthening of a conducive policy environment for primary eye care services in Rwanda:** At national level, PEC services have become recognised as a key health issue that needs to be attended to. According to Dr Ciku Mathenge, the support from the
Rwanda MoH has led to greater confidence to say that every citizen has access to an eye check even at the lowest level of the health system, the local health centre. The enabling environment in Rwanda has made it possible that additionally refractive errors could be corrected at that level and affordable glasses made available too. To demonstrate the supportive nature of the MoH, some of the following actions have been noted: releasing nurses for PEC training, asking health centres to allocate dedicated day/s for eye care; and ensuring that relevant eye medicines are included in the essential drug list for health centres. It was pleasing to note that the basic eye medicines that are needed by the population of Rwanda have been included in the official list of approved drugs. To date, the national health system can stock and sell them. Both reading glasses and adjustable glasses have also been registered, approved and included in the official list. Collaboration with other supportive partners such as the Fred Hollows Foundation have also been encouraged. The Director General reaffirmed the GoR’s commitment to eye health programmes, as long as they are aligned to the Ministry of Health’s priorities. Some of these priorities relate to: (i) increasing the efficiency and productivity of the existing infrastructure and resources; (ii) developing human resources – all categories (ophthalmologists, clinical support staff, administrative support staff, professional management); and (iii) developing infrastructure and resources for eye care that would enhance the uptake of eye care services to desired levels.

“No matter how much money a programme has, it only works the way it should if there is buy-in from Government.”

Dr Ciku Mathenge, Consultant Ophthalmologist and Director of Training and Research

3.5 Assess Programme Sustainability

To evaluate programme sustainability, we were concerned with an examination of the extent to which the benefits of the programme could be sustained after the funding stops. Based on the findings of this evaluation, it is likely that the approach and outcomes of this programme will be sustained, even without VFANF’s interventions. We believe that some more work has to be done to ensure that PEC services are fully integrated and supported at various levels in Rwanda. However, the reassuring reality of this effort has been the full support that the programme has received from the relevant ministries of health and education. The service is provided through existing health facilities, by government personnel. In addition, relevant policies and procedures that are supportive to the development of the service are being put in place. If anything, mobilising further resources to improve the quality and scale up the scope of PEC services should be a priority.

3.5.1 Sustainability beyond Current Funding

The evaluators gathered that one of VFANF’s strength has been its emphasis on aligning their interventions to global priorities, such as Vision2020 as well as existing government structures and systems. The initiative was neither implemented in a vacuum nor was it introduced as a
parallel intervention to government’s efforts. In an appropriate manner, VFANF provided training to nurses who were already providing primary health care at health centres and who are on the regular budget of existing institutional support, such as government departments. As a result of this programme, the MoH has made PEC services part of the standard package of health services provided at the point of delivery, rather than a short-lived ad-hoc activity. It is commendable that this intervention is aligned to universally accepted best practices and standards, hence offers greater chances for sustainability of the programme outcomes.

“For full integration, we must learn from the approach that was used for integrating Family Planning services. In Family Planning, resources were invested in training as many nurses as possible and hence they are readily available today at primary health level”

(Head of HC, Gahanga HC).

A strategic document suggesting ‘Norms and Procedures on providing Primary Eye Care’ for the Rwandan population has been developed by the Technical Working Group, of which VFANF is a part. This document has been approved by MoH, which is an important step towards full integration of PEC services in Rwanda. Among other things, the document suggests the inclusion of eye care indicators in the performance-based incentive scheme that is currently being run by the MoH in Rwanda. Evaluation respondents confirmed that the absence of eye care in Performance Based Financing (PBF) indicators is often associated with the poor prioritisation of PEC services. A statement from one of the respondents summed up what we found to be the general impression from the people of Rwanda:

“We all feel that PEC services must be included in PBF. Without this, we still feel eye care services are not fully integrated in the health system.”

(Head of HC, Nyamirama)

3.5.2 Leveraging Additional Resources
The evaluation team confirmed, with satisfaction, that VFANF has successfully mobilised additional resources by leveraging additional funding for the programme. The approved budget indicated that the programme had a diversified range of funding sources. As shown in Table 12 below, DFID’s contribution was 27% of the total budget. In addition to a 59% contribution from other sources (J Chen), VFANF was able to utilise some of their unrestricted funds (14%). It was anticipated that the funding levels for 2012/2013 were likely to remain the same for the next phase of the programme (2013/2014).

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>Amount Contributed</th>
<th>% Of Total Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFID</td>
<td>£243,857.07</td>
<td>29%</td>
</tr>
<tr>
<td>Own Contribution (Unrestricted)</td>
<td>£ 130,000</td>
<td>16%</td>
</tr>
<tr>
<td>Additional Funding - J Chen</td>
<td>£454,633.30</td>
<td>55%</td>
</tr>
<tr>
<td><strong>Total Cost of Programme</strong></td>
<td><strong>£828,490.37</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 11: Sources of Funding for the Programme
Greater integration of the implementation of the programme through the country’s existing institutions and systems was an important strategy applied by VFANF. All the nurses who were trained and are now implementing PEC services are funded through existing salary structures, mostly government funded. In accordance with the Memorandum of Understanding signed with the MoH GoR, all the eyeglasses had to be procured through the MoH’s MPPD before they could be dispensed to HCs through the district pharmacies.

At local HC level, full ownership by the heads of HCs will be an important part of sustaining the service. Confidence in the ownership of PEC services is increasing. It was interesting to note that 72% (n=154/214) of the patients believed, to a large extent, that their local HCs and their management were fully supportive of PEC provision.

With increased management support at the local level, the sustainability of services at HC level is likely to increase. From a sample of 67 PEC nurses, 21% (n=14/67) believed that the programme outcomes could survive without external funding from organisations or donors. Just above half of the respondents (52%) were modestly confident about sustainability without external support while 27% were less confident.

Ultimately more HCs should increase their support for PEC by allocating some of their budget to eye care services. At the time of the evaluation, only 7.5% (n=5/67) respondents stated that their HCs had allocated some money to eye health. No further enquiries were made to determine the level of investments made by these HCs.

VFANF has collaborated with the HCs to build up a pool of unrestricted funding from the minimal contributions of RwF1000 made by patients towards the cost of eyeglasses. We are cautious that it may be too early to establish the extent to which the payments will contribute towards the sustainability of the programme, although the efforts were considered noble.

It was reassuring to find 82% (n=176/214) of the patients willing to pay for future eye care treatment to cover costs. 80% of those who were willing to pay for their eye care expenses in the future were from rural settings and 85% were from urban settings.

### 3.5.3 Integrating Training of PEC at Nursing Schools

The allocation of a proportion of the programme budget to training nursing school teachers was yet another positive step taken towards sustaining PEC services in Rwanda. The evaluators noted, with satisfaction, that PEC has been included as part of the basic curricula taught in all the nurse training schools of Rwanda. This means that all nurse graduates will leave their training institutions with the skills and knowledge to provide eye care services by the time they are deployed to their respective HCs. This action recognises that relying on continuous in-service training is costly and unsustainable. As a result, a training workshop for trainers in nursing and midwifery training institutions was planned involving 4 members of staff from each of the 7 nursing schools in Rwanda. These trainers would then deliver pre-service training in PEC.

> “The training received at this workshop was declared adequate to allow training in PEC to commence in nursing schools in Rwanda. Enough fulltime teachers were part of the workshop participants and they would be involved in day to day training activities as shown here”

(Dr Ciku Mathenge, Workshop Report of PEC Training for Trainers in Nursing and Midwifery Training Institutions, August 2013)
to their students in the nursing and midwifery schools.

The evaluators interviewed two staff members from Nyagatare School of Nursing and from Byumba School of Nursing and Midwives. Both were trained and equipped with the skills to pass on PEC knowledge to the nursing students at their schools. The case of Byumba School of Nursing and Midwives was phenomenal:

“After the workshop, we took a resolution to integrate PEC in our curriculum and to have a specific course of PEC. For our school, this knowledge is incorporated under two courses: Sensory Pathologies and Specialties Nursing Care procedures. First, 56 third-year nursing and midwives students participated in a 2-day workshop. In the 2nd cohort, 85 students of 3rd years in academic year 2013-2014 have been taught in primary eye care in preparation for their clinical practice in referral hospital. However, we have some challenges: (i) insufficient didactic material during the demonstration and practice; as well as (ii) the absence of special classroom design for the practice in primary eye care skills. We still need more support as we intend to increase PEC awareness in Gicumbi District through our 3rd year students’ clinical practice in community and health centers.”

3.5.4 Engaging with other Actors
Increased collaboration between organisations focusing on eye health and other issues as well as other departments such as health promotion, social and environmental services, nutrition or other sectors can facilitate better ways of gathering and utilising resources. For the period under review, VFANF has successfully focused on collaborating with the MoH to introduce primary eye care services at HCs. As part of the Technical Working Group, programme management and staff have invested adequate time on building relationships with key decision makers on eye health policy development so as to achieve incremental improvements.

To sustain PEC services, it is indispensable to have in place appropriate secondary eye care services to deal with referred cases from the primary level. A critical observation from this evaluation is the need for capital investments towards enhancing the support and supervisory roles of the district OTs. The development of this programme has already established that OTs are a desirable cadre for the support, and identified M&E of primary eye care activities as part of their role descriptions, which in turn, will be an integral part of comprehensive health care.

A general scarcity of active players participating in the provision of eye health services in Rwanda was observed. Only 13% of the nurses stated that their HCs had worked with other partners besides VFANF to complement other existing activities. From our perspective, a limited number of key players in the field of eye health could potentially defer the scaling up of quality of PEC services in Rwanda.

It is expedient that VFANF, in collaboration with the MoH, intensifies their efforts to actively identify, develop and/or strengthen strategic relationships with other partners and funders who are willing to support the eye health agenda in Rwanda. Some potential local partners were identified by the survey participants – see Figure 12.
Several partners, potential and existing, were identified and can contribute towards the achievement of the programme’s reach and impact:

a. Academic/Research Institutions and Civil Society Organisations
b. Media organisations, including local radio stations and TVs. A key example of media is the Urunana Development Communication, a specialised organisation in Behavior Change Communication using radio and interpersonal communication.
c. The Ministry of Education which is responsible for Nurses Training Schools in Rwanda.
d. Private Sector, including private health institutions and local businesses.
e. Schools, particularly teachers and children for awareness raising activities.
f. The National Army of Rwanda who are known for supporting eye health activities during the “Army Week Medical Outreach Services” period.
4. Conclusions and Recommendations

4.1 Conclusions and Findings
The evaluation findings have generated some useful information about the current state of eye care services in Rwanda. The conclusions presented here are a synthesis of the answers to the evaluation questions presented in the Terms of Reference.

4.1.1 Programme Relevance
The implementation of the VFANF programme has demonstrated great relevance to the needs of the people of Rwanda, particularly those most excluded from accessing vital services. The approach has been regarded relevant, particularly the genuine engagement and cooperation between government and an NGO that presents greater opportunities for programme priorities to be aligned to government and other international priorities.

Findings and Lessons Learnt
1. To maximise the relevance and effectiveness of development interventions such as primary eye care services, the programme aims, strategies and implementation efforts must be consistent and aligned to the relevant Ministry’s strategy for the area under focus.
2. Realistic expectations about which aspect of eye care services can most appropriately be learnt and provided by primary health workers must be identified and understood by all those involved in PEC programmes. It is particularly important for PEC nurses who receive in-service training to understand that the training does not necessarily entail an easy route to professional upgrade to become ophthalmological technicians.
3. Following the initial training of primary health staff on PEC service provision, adequate time and resources should be set aside for ongoing support, supervision and refresher courses for the alumni.
4. Prevention of childhood blindness is one of the major components in the ‘Vision 2020. VFANF will need to increase community awareness on the need to act on prevention of blindness in the early stages of childhood by seeking services from the nearest health centre as soon as possible and to make vision rehabilitation possible, where necessary.
5. For wider reach and effective implementation of eye care services and establishing a significant impact in the lives of poor and marginalised people, particularly for women and girls, programmes and programmes must: (i) Ensure that poor people, especially women and girls, are meaningfully involved in community consultation and decision-making processes; (ii) Actively seek to identify and address key barriers and challenges faced by poor people, particularly women and girls, when designing and delivering eye care services; and (iii) Disaggregate data by sex (and age) when conducting research and to track results.
4.1.2 Programme Efficiency

The evaluation has concluded that VFANF has had the necessary organisational structure and the capacity to deliver and implement high level programmes in an efficient and accountable manner. The review of programme documents revealed that in consistent ways, VFANF has satisfactorily delivered on timely progress and expenditure reporting in compliance with the policies and guidelines stipulated in the DFID grant contract. In addition, the programme provides a good example of the value added by the pooling of resources for greater impact and in relation to the inputs that are invested into the work.

Findings and Lessons Learnt

1. By all means possible, programme budgets and disbursement forecasts must reflect realistic estimates aligned to the planned activities and the organisation’s existing capacity, especially during a programme’s early years.
2. Bearing in mind the uncertainties associated with a new programme budget, as well as the incremental financial and non-financial costs associated with enhanced supervision and restructuring new initiatives, a programme needs to ensure that a contingency budget is agreed with the funder and is in place right from the start.
3. The acceptability, utilisation and/or non-use of eyeglasses can be associated with cosmetic perceptions, visual comfort and appearance. It was, therefore, learnt that good quality, attractive and comfortable spectacles are essential to avoid waste from non-use.

4.1.3 Programme Effectiveness

Although the programme has not met some of its targets, such as number of vision assessments or people accessing glasses, the overall performance has been judged as consistently effective and considered to have produced positive results. The numerical targeting was considered overly ambitious, yet the progressive achievements made within one year are considered to have been remarkably outstanding. However, increased focus on support, supervision and M&E were identified to be weak and need urgent attention.

Findings and Lessons Learnt

1. Heads of HCs are better placed to provide leadership when implementing PEC services within their facilities, with support from district ophthalmic technicians. It is, therefore, important for a programme to invest resources into getting them on board through sensitisation, and where possible, training them along with the PEC nurses.
2. Supportive supervision is probably less effective when the supervisors, such as heads of HCs, do not have the technical skills that juniors health staff are expected to have gained.
3. Health initiatives that work within existing structures and institutions, such as relevant government ministries or departments, are effective in strengthening the communities and patients that they serve, rather than creating “silos” of effort.
4. Primary health care nurses are often faced by a large, demanding and growing list of conditions to be managed. Introducing and adding PEC services to the nurses’ already existing duties can lead to work overload and consequently compromise the quality of eye health services. If services produce poor-quality results in patients, this in turn, may lead to detrimental outcomes and further undermine the goodwill that has been built in the development of this service.
4.1.4 Programme Outcomes and Emerging Impact

The results emerging from the first year of implementing PEC services seem to point to significant gains at individual, community, district and national levels. Among other things, the emerging impacts identified through this evaluation included the following lessons:

Findings and Lessons Learnt

1. The impact of the provision of PEC services can only be as strong as the primary-health environment within which they are formed and delivered. An important aspect of a supportive environment that will lead to positive results is to ensure that trained staff are properly supported at HC level.
2. Dispensing eye glasses, in addition to providing refraction, may improve the sustainability of a refractive error service and increase uptake by patients. The ideal primary eye care service provision is a model that combines both these components of refractive error services at a central service point, close to where the communities live.
3. A functional referral pathway from primary levels to specialist services at secondary levels is essential for PEC services.
4. District level health cadres, such as ophthalmic technicians, must be adequately equipped so as to effectively receive and serve clients that are referred to them.

4.1.5 Programme Sustainability

Conclusions on sustainability highlight that VFANF has given priority to the performance of the initiative, and also effectively balanced it with sustainable institutional capacity building that will continue beyond the programme. While higher-level MoH offices are responsible for the overall coordination of the programme and equipment procurement, the district and local HC facilities are responsible for implementation of PEC services. As evidenced by the findings that emerged from the evaluation, the value added by this programme was demonstrated through the concrete level of strategic collaboration with the MoH to address mutually recognised problems.

Findings and Lessons Learnt

1. While the use of an organisation’s own unrestricted resources may be a good idea for a new programme, it would be more sustainable for an organisation to consider and implement full cost recovery strategies.
2. To increase the likelihood of sustainability, it is essential to maximise the use of existing institutional staff and integration into the country’s structures and processes. For instance, where it is necessary to incorporate essential operational costs for programme-related incremental expenses of government officials/staff, the programme should include measures to minimise distortions in the government’s internal incentives.
3. The approach implemented by VFANF to promote institutional development alongside government priorities is highly sustainable as the MoH will eventually take full responsibility of the implementation of the service within the existing structure and staff.
4. It is also important to develop a clear strategy for full integration, and for phasing out of a particular programme by preparing time-bound action plans for necessary capacity development, such as training.
4.2 Recommendations

4.2.1 Recommendations for VFANF

1. Provide further training, support and supervision to HC staff at primary health centres and ensure that constant numbers of personnel are in place at HCs until a time that schools of nursing are fully graduating pre-service trained PEC nurses. Based on the successes of the implementation of PEC services in one year, VFANF are encouraged to mobilise some more resources to continue providing further training and refresher courses for PEC nurses for a few years. This is particularly important since HCs are often affected by staff turnover and also given the increasing demand for the services. Resources permitting, the provision of PEC services should be extended to health posts to increase coverage, reach and impact.

2. Build the capacity of the heads of HCs and key personnel at district hospitals to provide effective supervision, logistics, and support to trained PEC nurses. This is important so that the existing internal supervision systems can improve on the support offered to PEC nurses. Internal management is compromised by the fact that local supervisors/heads of HCs seemed not to have a good understanding of what PEC entails. We recommend that VFANF strengthen internal support, supervision and management of the health staff trained in the provision of PEC at the health centres.

3. The pilot intervention to train and engage Community Health Workers (CHWs) in Musanze District towards the end of the project has already shown evidence of positive impact. As a result of CHW training in Musanze, the number of people receiving vision assessments increased from 965 in Quarter 3 to 2,018 in Quarter 4. Likewise, the number of people referred to the district hospital increased from 126 to 249 during the same period. We strongly recommend that this initiative be scaled up to a nationwide programme. The pilot has already demonstrated that the training of CHW workers does not only help increase awareness and uptake of eye care services, but also sustain the efforts beyond the life of the project.

4. Improve on the M&E and Data Management systems for the programme. This is particularly important since the programme is relatively new in Rwanda and will, therefore, require robust M&E systems that capture and utilise the data. Some of the key action points for consideration will include:

   a. Develop a comprehensive M&E Plan for each new programme that VFANF implements. The M&E plan should include identified data needs, standardised indicators, data collection procedures and tools, as well as the roles and responsibilities for the implementation of the M&E system. In addition, eye care indicators should be streamlined to ensure relevance to management, monitoring and evaluation needs.

   b. As much as possible, the design of each new programme must include a baseline study at its inception. The baseline indicators should be aligned to the specific programme indicators set for the programme. These will also be useful for comparison of findings at the end of that particular programme.

   c. The programme must utilise existing data capture personnel at HC levels to provide technical support and reporting on PEC data. In addition, VFANF
must work to develop (or support the development of) electronic registers at all levels, utilising existing ICT systems developed at the various facility levels.

d. All data must be disaggregated by age and gender. The evaluation findings revealed that although attempts to disaggregate data by age and/or gender, the reporting has been inconsistent for the various outputs set for this programme. We also recommend that all the age ranges be aligned to the MoH age ranges, such as 0–11 months; 1–4 years; 5–14 years; 15–24 years; 25–34 years; 35–49 years; and 50+ years. Alternatively, VFANF may consider the three age groups used by WHO to determine visual impairment and blindness prevalence, i.e. 0-14 years, 15-49 years and 50+ years.

e. Revise the contents of the reporting template at HC level to include stock updates, challenges and highlights of activities.

f. Consider developing a regularly updated database of the trained PEC nurses (alumni) that will help track the movements of PEC nurses in and out of HCs. This is particularly important given the rate of staff turnover at HCs. An appropriate plan of replacing PEC nurses who would have transferred is also important.

5. Increase VFANF’s role to influence policy and practice on eye health issues in Rwanda through modeling: Increase focus on influencing policy and practice by continuously engaging with decision makers on pertinent issues affecting the delivery of eye health in Rwanda. The process will need to start by generating adequate evidence about the priority issues and gaps in the health system that need to be addressed. Policy influence and engagement could take place at different levels, such as:

   a. HC levels: Ensure that heads of HCs regard eye health as an integral part of their work, hence providing enough space for trained PEC staff to apply what they learnt.

   b. District pharmacies to improve on the availability of supplies and reduce stock out periods. This is especially important for rural-based health centres which can experience stock outs for as long as 3 months.

   c. Nationwide: Collaborate with other strategic partners and actors to advocate for, and secure the necessary resources to scale up the provision of PEC services at HC and Health Post levels, in line with the WHO Global Action Plan 2014-19.

6. Strengthen Strategic Partnerships and Coordination Activities with other partners: It is commendable that VFANF has made a strategic decision to be part of the Technical Working Group on Eye Health in Rwanda. We encourage VFANF to identify and strengthen linkages with other like-minded organisations who may be interested in eye health issues, even if they are currently not engaged. This provides VFANF with greater opportunities to develop a common agenda with partners, to increase their reach and to widen their resource base.

7. Increase engagement with local media to raise awareness about PEC services: The utilisation of different media channels in supporting and increasing awareness about the provision of PEC services cannot be overstated. In particular, the radio has the potential
to initiate and strengthen dialogue on specific issues, swiftly spread the agenda, and channel public support. VFANF will need to develop and cultivate ongoing relationships with the media, to both raise awareness of the availability of PEC services and also to increase support for eye health in Rwanda. In working with the media, VFANF will need to ensure that media personnel and journalists have a clear understanding of issues around eye health so they can communicate them clearly and correctly. This implies that they may need to undertake training of media personnel, consisting of intensive orientation on the issue and subsequent periodic orientations/refresher courses.

8. Cultivate a Strong Documentation, Research and Learning Culture within the Organisation: Lessons from the implementation of PEC services have shown that the integration of PEC services into primary health care brings several complex dimensions. It is, therefore, necessary for VFANF to consider playing a ‘learning and modelling’ role. In this case they should aim to demonstrate and document best practices/approaches, which can be adopted or replicated by others to bring wider improvements in eye health policy and practice. It is remarkable that the GoR fully supports the introduction of PEC services in Rwanda. However, there is still a great need to demonstrate the effectiveness and impact of such efforts in Rwanda. Increased understanding of eye health issues in Rwanda will enhance the ability of policy and other decision makers, including eye-care professionals/planners, to decide upon effective models for the delivery of eye-health services from primary to tertiary levels.

9. To sustain the high level of commitment demonstrated to date, VFANF has to participate in monitoring the implementation of eye health related commitments in Rwanda at all levels. In particular, there is a greater need to positively engage heads of HCs since they often get preoccupied with other priorities or may not realise the importance of eye health issues, often resulting in them forgetting, overlooking or resisting the effective provision of PEC services at the HCs that they head. As such, VFANF would need to set aside time and resources for monitoring and supporting the commitments and ensure their implementation. Otherwise, they would also need to develop strategies for further advocacy if implementation does not take place.

10. Conduct a closer review and analysis of patients’ satisfaction levels with the quality of eye glasses provided and respond to their needs accordingly. Eye care patients in Rwanda have very limited options for getting eyeglasses in Rwanda after receiving prescription, particularly for those who live outside Kigali. It was noted that good quality glasses are either too expensive or unavailable for underserved communities. The findings from this evaluation revealed that the quality of the low cost adjustable/distance glasses purchased through this programme was regarded inferior by both patients and HC nurses, which has been a discouraging factor for their use. It is vital to ensure that acceptable quality eye glasses are made available as this is essential to avoid refusal or discontinuation of their use. We recommend that:
   a. Patients be offered a variety of spectacle frames to reflect personal and local preferences. Some people are willing to spend more on an acceptable pairs of glasses and this can provide the required income to sustain the services of PEC services in the long run. Smaller frames need to be available for children.
   b. Ensure that there is a constant supply of all the glass types and other necessary
accessories at HC level, for example, glass cases and cleaning materials.
c. In collaboration with the MoH and other partners, promote the increased availability
develop dispensing centres or shops for eye glasses, especially outside Kigali.

**Recommendations for Health Centres**

11. Improve awareness of PEC services through the utilisation of CHWs, a variety of media
and where appropriate, public educational materials. Increased ownership and
participation in raising awareness of PEC services if necessary at HC level. Given the low
coverage and penetration of existing PEC services at the start of this programme, HCs
should not only cater to those who come to the centre, but should also proactively seek
out those who are in the community. Besides the regular public information campaigns,
health staff may also need to be more creative and use media such as TV sets at their
HCs to raise awareness on eye health issues as patients await treatment. We also
suggest further exploration of different means of communication such as mass media,
community conversations/events, and outreach to schools, faith groups, informal peer
networks.

12. HC staff should strengthen linkages between service sites and the communities in which
they are located, mainly through the CHWs. Linkages could be strengthened by
sensitising and updating CHWs and volunteers to PEC issues, and by enlisted their
support. The role of CHWs has been recognised and an extensive programme to engage
them through training has been widely piloted and proved to be effective. With support
from VFANF, HC are encouraged to extensively engage CHWs, especially with regards
to awareness raising and case finding at community level.

13. Improve the recruitment and selection processes for the staff who participate in PEC
related training.

14. Aim for full integration of primary eye care services into primary health centre services:
Heads of HCs are encouraged to give value to PEC services and particularly support
PEC nurses to deliver on their work. This will include ensuring that adequate time is
allocated to the implementation, support, supervision and monitoring of PEC services. As
already stipulated by the MoH, all HCs should ensure that at least one day is set aside for
PEC services. In addition, a meaningful proportion of the HC budget should also be
allocated to the delivery of PEC services. Where possible, PEC work should be
integrated to complement other existing activities at HC level.

4.4.3 **Recommendations for District Hospitals and Pharmacies**

15. District hospital authorities need to provide regular support and supervision to HCs on
eye care services. It is recommended that eye care service provision be integrated into
the supervision plan of all district hospitals. The appropriate staff at district hospitals
should invest time to examine the validity and reliability of PEC reports received from the
HCs, and then develop and implement relevant action plans to address identified
weaknesses and gaps. Timely feedback to HC is necessary, especially relating to the
referral systems. Ultimately, all the OTs based at district hospitals should develop a clear
work plan to support PEC nurses, which is fully supervised and appraised.
16. District hospitals must increase budgets and allocate adequate resources for eye care services. In addition to supporting OTs with financial resources for support and supervision to HCs, each district hospital must also acquire adequate equipment and allocate enough rooms / space for eye care services. In liaison with the MoH, each district hospital will need to increase the number of personnel involved in eye care service provision at district level.

17. District pharmacies should ensure that there is a consistent supply of eye medication, materials and glasses at district pharmacies to avoid long waiting periods and stock-outs at HC levels. This will entail working closely with the MPPD to safeguard against prolonged waiting times to the detriment of the service at the HC level.

**4.4.4 Recommendations for the Ministry of Health**

18. Support secondary and tertiary health facilities to effectively support eye health services that are being implemented by primary health centres. In particular, district hospital staff have a crucial role to motivate and supervise the work of PEC nurses at HC levels. Amongst other things, ensure that OTs are supported to do their work effectively. This might entail working with district hospitals to include a reasonable budget for PEC services and to also allocate adequate time to support PEC services.

19. Increase the budget for eye care services in Rwanda. Although the recent commitments and investments on eye health services by the GoR are commendable, the rising demand side of services will need to be complemented by adequate supply provision. It is recommended that the annual budget for health in Rwanda also reflect a meaningful contribution to eye health. Closely related to this recommendation, we encourage that PEC indicators be included in the Performance Based Financing (PBF) system for Health Services. This was a popular request from respondents at all levels. While we submit this recommendation, we are also aware of the WHO guidelines on the application of incentive schemes in health care. The WHO recognises that financial incentives alone are not sufficient to retain and motivate staff and emphasises the crucial role equally played by non-financial incentives in improving performance and productivity.\(^\text{17}\) It is therefore important that the delivery of quality eye health services must not be wholly based on the availability or non-availability of financial incentives.

20. It is important that the MoH invest more commitment, allocation of resources towards research for eye health, and translate the research results into policy and action. Limited information is available about eye health from a health systems strengthening approach. Evidence of integration of eye health into primary health care is currently weak, particularly when applying a health systems framework. A realignment of eye health in the primary health care agenda will require context-specific planning and a holistic approach, with careful attention to each of the health system components and to the public health system as a whole.

21. Ensure that HCs are equipped with the relevant tools and record books for reporting purposes. The tools should be aligned to the national reporting systems for ease of consolidation and comparison over time. It is also recommended that HCs keep a record of patients’ contact details. In addition the tools should be clear enough to avoid double counting.

22. Monitor PEC commitments at various implementation levels in Rwanda. The roll out of this intervention at a national level is a demonstration of the commitment of the GoR to eye health. However, the evaluation team are conscious of the fact that decision-makers are often overloaded with competing demands and face multiple issues that need their attention simultaneously.

23. The MoH should continue to foster collaboration and partnerships on the provision of eye health services in Rwanda. The prevention of avoidable blindness relies on activities by many agencies working together. The MoH of Health has the primary responsibility for ensuring the provision of eye health services and for reporting to the WHO on national progress against the Global Action Plan. In coordinating these efforts, it is anticipated that the MoH will ensure that there is less duplication of services, bring together the needed resources, and ensure the continued provision of high quality services in Rwanda. With the growing interest in eye health in Rwanda, it is important for the MoH to continuously engage and coordinate the efforts from other government bodies, civil society and private actors. The following key players have been identified as potential partners to the MoH:
   a. Other government departments can play an important role in the provision of PEC services, such as representatives from the Ministries of Finance and Treasury, Ministry of Education, Disability and Social Services, as well as those responsible for Planning and Infrastructure within Rwanda.
   b. Local and international civil society organisations who have a crucial role as mobilisers and providers of resources, information, services and technical expertise in the area of eye health.
   c. Private Sector: While eye health requires a strong public health response, it is also encouraged that the views and inputs of the private sector be incorporated in the eye health interventions. Of particular interest, private health institutions, ophthalmologists and optometrists in private practice should be included in the work towards universal access.
   d. In particular, the Ministry of Education, who are now responsible for the schools of nursing, must be supported to ensure that a comprehensive package of eye health education is fully included in the curriculum. They will also work to ensure that more support is allocated to resources for training more OTs and Ophthalmologists in Rwanda.
## 5 Annexures

### 5.1 Annex 1: List of People Contacted

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdalla Uwihoreye</td>
<td>VFAN Rwanda</td>
<td>Rwanda Prog Officer</td>
</tr>
<tr>
<td>Afisa Munyana</td>
<td>Gahanga HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Aster Niragire</td>
<td>Cyabingo HC</td>
<td>Data Manager</td>
</tr>
<tr>
<td>Azades Ray Ray Karekezi</td>
<td>VFAN Rwanda</td>
<td>Junior Staff Ophthalmic Tech.</td>
</tr>
<tr>
<td>Chantal Uwanyirigira</td>
<td>Mukarange HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Chipo Nyambayiro</td>
<td>VFAN Rwanda</td>
<td>Finance &amp; Admin Manager</td>
</tr>
<tr>
<td>Denyse Umuhze</td>
<td>Gakenke HC</td>
<td>District OT</td>
</tr>
<tr>
<td>Dr Ciku Mathenge</td>
<td>Rwanda International Institute of Ophthalmology</td>
<td>Consultant Ophthalmologist</td>
</tr>
<tr>
<td>Dr John Nkurikiye</td>
<td>Dr Agarwal’s Eye Health</td>
<td>Consultant Ophtamologist</td>
</tr>
<tr>
<td>Dr Theophile Dushime</td>
<td>Ministry of Health/ Rwanda</td>
<td>Director General Clinical Services</td>
</tr>
<tr>
<td>Eliane Ndererimana</td>
<td>VFAN Rwanda</td>
<td>Rwanda Program Manager</td>
</tr>
<tr>
<td>Emmanuel Karerangabo</td>
<td>Rukira HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Emmanuel Rizinde</td>
<td>Nyamata District Hospital</td>
<td>District OT</td>
</tr>
<tr>
<td>Florence Mujawayezu</td>
<td>Ngoma District Hospital</td>
<td>District OT</td>
</tr>
<tr>
<td>Florence Uwamahoro</td>
<td>Nyamata District Hospital</td>
<td>Clinical Placement</td>
</tr>
<tr>
<td>Francois Habirayemeye</td>
<td>TWG / MoH</td>
<td>Chairperson</td>
</tr>
<tr>
<td>Jacques Nsengiyumva</td>
<td>Nyamirama HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Jeanne d’Arc Mukesomana</td>
<td>Cyabingo HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Kyamusoke Borauzima</td>
<td>Byumba Sch of Nursing &amp; Midwives</td>
<td>Academic Affairs</td>
</tr>
<tr>
<td>Leontine Myoshaka</td>
<td>Gasiza HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Marie Jose Uwisunze</td>
<td>Nyamata District Hospital</td>
<td>District OT</td>
</tr>
<tr>
<td>Massimo Presente</td>
<td>The Fred Hollows Foundation</td>
<td>Country Director</td>
</tr>
<tr>
<td>Munyana Afisa</td>
<td>Gahanga HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Nshimiyimana Ladislas</td>
<td>Musanze District Hospital</td>
<td>District OT</td>
</tr>
<tr>
<td>Nyiraneza Veneranda</td>
<td>Rwamagana District Hospital</td>
<td>District OT</td>
</tr>
<tr>
<td>Olivier Bizimana</td>
<td>VFANF Rwanda</td>
<td>M&amp;E Manager</td>
</tr>
<tr>
<td>Rose Gahire</td>
<td>VFANF Rwanda</td>
<td>Country Director</td>
</tr>
<tr>
<td>Sebastian Ford</td>
<td>VFANF</td>
<td>Project Support Manager</td>
</tr>
<tr>
<td>Seraphin Mukamuhanda</td>
<td>Kabuye HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Silvia Kana Mujiji</td>
<td>Kabusunzu HC</td>
<td>Head of HC</td>
</tr>
<tr>
<td>Sjoerd Hannema</td>
<td>VFANF</td>
<td>Executive Director</td>
</tr>
<tr>
<td>UMUHOZA Cesarie</td>
<td>Nyagatare Sch of Nursing &amp; Midwives</td>
<td>Clinical Instructor</td>
</tr>
<tr>
<td>Vedaste Ntakirutimana</td>
<td>Busengo</td>
<td>Head of HC-Deputy</td>
</tr>
<tr>
<td>Yaso Ariaratnam</td>
<td>VFANF</td>
<td>Finance Manager (UK)</td>
</tr>
</tbody>
</table>
5.2 Annex 2: List of Documents Consulted

2. Coffey International, Independent Final Evaluations (*formerly referred to as Independent Progress Reviews) - overview for GPAF grantees
5. Dr Ciku Mathenge (2013), Report of the Rwanda PEC Training workshop for Trainers in Nursing and Midwifery Training Institutions
6. GPAF Grant Annual Report, GPAF-INN-010, April 2013
7. GPAF-INN-010, Annual Review Feedback 1
15. VFANF (2013) Revised Logframe GPAF-INN-2010 to DFID
16. VFANF (2013), Masters’ TOT Training Report for CHWs in Musanze DistricT
17. VFANF Programme Proposal and log framE
18. VFANF Rwanda (2013), Vision For a Nation Foundation Baseline Survey on Primary Eye Care in Rwandan Health Centres, Survey Report
## Annex 3: Programme for Field Work, November - December 2013

<table>
<thead>
<tr>
<th>Date</th>
<th>Province/ District</th>
<th>Evaluation Methods</th>
<th>Who participates?</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 November</td>
<td>Kigali</td>
<td>Inception Meeting – Face to Face</td>
<td>Lead Consultant and Key Staff from VFANF in Rwanda to familiarize and to confirm fieldwork agenda.</td>
<td></td>
</tr>
<tr>
<td>25 November</td>
<td>Kigali</td>
<td>Training of Research Team</td>
<td>Research Assistants</td>
<td>-</td>
</tr>
<tr>
<td>26 November</td>
<td>Kigali Province Gasabo</td>
<td>Evaluation Workshop in Kigali City 0900 – 1300hrs</td>
<td>15 nurses trained, 5 each from Gasabo, Kicukiro and Nyarugenge. 3 district hospital reps, 1 from each district.</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Survey 0900 – 1100hrs</td>
<td>20 beneficiaries, from each of the 1 selected HC in Gasabo district, of which 10% were referred to a district hospital.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Staff Survey for Health Staff 1100 – 1400hrs</td>
<td>10 nurses trained by the programme from Gasabo district. Research Team to visit at least 5 Health Centres.</td>
<td>10</td>
</tr>
<tr>
<td>27 November</td>
<td>Kigali Province Kicukiro Nyarugenge</td>
<td>Patient Survey 0900 – 1100hrs and 1400 – 1600hrs</td>
<td>20 beneficiaries, from each of the 2 selected HC in Kicukiro and Nyarugenge districts, of which 10% were referred to a district hospital.</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Staff Survey for Health Staff 1100 – 1400hrs</td>
<td>20 nurses trained by the programme from Kicukiro and Nyarugenge districts. Research Team to visit at least 5 HCs per district.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key Informant Interviews</td>
<td>At least 1 key informant from each district.</td>
<td>3</td>
</tr>
<tr>
<td>28 November</td>
<td>Eastern Province Rwamagana</td>
<td>Evaluation Workshop in Rwamagana 0900–1300hrs</td>
<td>15 nurses trained, 5 each from Gatsibo, Rwamagana and Kayonza. 3 district hospital reps, 1 from each district.</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Survey 0900 – 1600hrs</td>
<td>10 beneficiaries, from each of the 2 selected HC in Rwamagana District, of which 10% were referred to a district hospital.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Staff Survey for Health Staff 0900–1600hrs</td>
<td>20 nurses trained by the programme from Rwamagana district. Research Team to visit at least 5 Health Centres in the district.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key Informant Interviews</td>
<td>At least 1 key informant per district.</td>
<td>2</td>
</tr>
<tr>
<td>29 November</td>
<td>Eastern Province Kayonza Gatsibo</td>
<td>Patient Survey 0900 – 1100hrs and 1400 – 1600hrs</td>
<td>10 beneficiaries, from each of the 4 selected HCs in Kayonza and Gatsibo, of which 10% were referred to a district hospital.</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Staff Survey</td>
<td>10 nurses trained by the programme</td>
<td>20</td>
</tr>
<tr>
<td>Date</td>
<td>Province/District</td>
<td>Evaluation Methods</td>
<td>Who participates?</td>
<td>Total Number</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>02 December</td>
<td>Northern Province</td>
<td>Evaluation Workshop in Musanze</td>
<td>15 trained participants, 5 from Musanze, Gakenge and Rulindo. 3 district hospital reps, 1 from each district.</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Musanze</td>
<td>Patient Survey</td>
<td>20 beneficiaries, from 1 selected HC in Musanze District, of which 10% were referred to a district hospital.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Staff Survey for Health Staff</td>
<td>20 nurses trained by the programme from Musanze district. Research Team to visit at least 5 Health Centres in the district.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FGD for CHW</td>
<td>15 CHW trained by the programme in Musanze District</td>
<td>15</td>
</tr>
<tr>
<td>03 December</td>
<td>Northern Province</td>
<td>Patient Survey</td>
<td>10 beneficiaries, from each of the 4 selected HCs in Gicumbi and Rulindo, of which 10% were referred to a district hospital.</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Gicumbi and Rulindo</td>
<td>Health Staff Survey for Health Staff</td>
<td>10 nurses trained by the programme from Gicumbi and 10 from Rulindo districts. Research Team to visit at least 5 Health Centres per district.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key Informant Interviews</td>
<td>At least 1 key informant from the district</td>
<td>3</td>
</tr>
<tr>
<td>04 December</td>
<td>Kigali</td>
<td>Key Informant Interviews</td>
<td>Partners and Stakeholders</td>
<td>10</td>
</tr>
<tr>
<td>06 December</td>
<td>Kigali</td>
<td>FGD and Key Informant Interviews</td>
<td>VFANF Staff</td>
<td>5+</td>
</tr>
</tbody>
</table>
5.4 Annex 4: Terms of Reference

End of Programme Independent Evaluation of DFID GPAF Programme – Consultancy
Programme Title: Nationwide primary eye care training of Health Centre nurses in Rwanda to provide vision assessments to an estimated 425,000 people and 30,000 eyeglasses to those in need.

BACKGROUND
Eyeglasses are a basic tool that enables people to work, learn and perform daily tasks. Yet in low- and middle-income countries around the world eye care services are severely limited. According to the World Health Organization (WHO) an estimated 285 million people worldwide live with visual impairment. Uncorrected refractive error is the primary cause of visual impairment globally. In sub-Saharan Africa, 95% of people who need eyeglasses don’t own a pair. In low- and middle-income countries there are two main barriers to delivering vision correction: Accessibility and Affordability. Visual impairment adversely affects a person’s employment, education and safety, and costs at least $121.4 billion per year globally in lost productivity. Yet 80% of all visual impairment can be prevented, treated or cured. Vision for a Nation (VFANF) was founded in 2008 to help address this enormous need for primary eye care services. The charity’s first nationwide programme was launched in Rwanda in 2009. The Global Poverty Action Fund (GPAF) was introduced by DFID in 2010. The Fund (previously called the Poverty Impact Fund) supports poverty reduction programmes focused on service delivery working towards the most off-track Millennium Development Goals (MDGs). VFANF received a grant of £243,857.07 in September 2012 for the National programme in Rwanda, running from 01/09/2012 to 31/10/2012.

PROGRAMME PURPOSE AND OBJECTIVES
VFANF is an innovative collaboration with the national Government of Rwanda to create universal access to eye care services in Rwanda. Two nurses in each of Rwanda’s 450 HCs will be trained to perform vision assessments, referring those with eye disease to District Hospitals and dispensing up to an estimated 30,000 pairs of low-cost eyeglasses. Thus assisting those with poor vision with literacy and employment, helping to reduce poverty (MDG 1) and enabling more children to complete primary education (MDG 2). The GPAF funding has gone directly towards the development of a curriculum (approved by the MoH), the training of the 900 nurses in the 450 HCs and related training material. In addition to this, GPAF funds have also been used in communication activities to raise awareness of the PEC services available at HCs and additional marketing activities to raise awareness of VFANF in Rwanda.

PURPOSE OF THE EVALUATION
1. Relevance – programme’s significance with respect to specific needs and its relevance to country poverty reduction priorities.
   • Efficiency – how far funding, personnel, regulatory, administrative, time, other resources and procedures contributed to or hindered the achievement of results. To what extent does funding represent good value for money?
   • Effectiveness – assessment of how far the intended outputs and results were achieved in relation to targets set in the original logical framework.
   • Impact – broader economic, social, and political consequences of the programme.
   • Sustainability – potential for the continuation of the impact achieved and of the delivery mechanisms, following the withdrawal of external support. Impact of DFID funding on the programme.
EVALUATION QUESTIONS

Relevance:

• To what extent did VFANF support achievement towards the MDGs?
• To what extent do the activities, services and results being delivered by the programme align with the intended objectives of GPAF?
• To what extent did the programme target, reach and benefit the target population? To what extent did the programme mainstream gender equality in the design and delivery of activities (and or other relevant excluded groups)?

Efficiency

• To what extent did VFANF deliver activities on time and on budget against agreed plans?
• To what extent and in what ways did the programme achieve good value for money?
• To what extent did the programme understand their cost drivers and how these relate to performance requirements?
• Were the risks properly identified and well managed?

Effectiveness

• What are the key drivers and barriers affecting the delivery of results for the programme.
• To what extent has programme used evidence to improve programming?
• To what extent does the programme represent good value for money with regards to economy and efficiency?
• To what extent has the programme put in place M&E systems that are fit for the purpose and are being used to support the delivery of activities?

Sustainability

• To what extent has the programme leveraged additional resources (financial and in-kind) from other sources? What extent has this had on the capacity of the programme to deliver their activities?
• To what extent is the programme engaging with other actors to ensure their interventions complement existing activities? In what ways has VFANF worked with others to enable them to effectively deliver the programme?
• What are the prospects for the benefits of the programme being sustained after the funding stops? Did this match the intentions?

Impact

• What was the programme’s overall impact and how did this compare with what was expected?
• What difference has GPAF funding made to the programme’s delivery of results which provide value for money that would not otherwise have been achieved?
• To what extent and how has the programme built the capacity of local actors?
• Who were the direct and indirect/wider beneficiaries of the programme? How many of these people were unintended beneficiaries?
• To what extent and how has the programme affected people in ways that were not originally intended?
METHODOLOGY
This should include:

• A desk review of programme information
• Interviews with programme managers and partners to collect information on achievements and impact and difficulties faced by the programme including the management aspects of work
• Interviews with beneficiaries (including those who might normally be excluded), to discover what impact (if any) the programme has had on their lives
• Interviews with key programme stakeholders to include questions on the degree to which programme has had the intended impact; and what could have been done differently or better, so that the lessons can be learned
• Measuring impact where possible and proportionate through comparison groups and other quantitative methods
• The selected consultant will be expected to work collaboratively with VFANF to refine their methodology and develop a detailed evaluation plan.

SKILLS & COMPETENCIES OF EVALUATOR
The Independent Evaluator should be a suitably-qualified and experienced consultant or consulting firm. The consultant profile should include:

• An evaluation specialist with a minimum of seven years’ experience in programme evaluation in an international development context
• Experience of results-based monitoring and evaluation
• Ability to manage an evaluation and research process from end-to-end, including interpreting baseline data and conducting a final evaluation
• Ability to design and plan the evaluation approaches and research methodologies, including quantitative and qualitative research methods
• Good understanding of NGO finance and audit – particularly of DFID guidelines and requirements (specialist finance qualifications not essential)
• Experience in training and/or health programmes.
• Experience developing evaluation frameworks
• Ability to present complex information in a systematic way
• Excellent writing, analytical and communication skills
• Fluency in written and spoken English
• Ability and commitment to deliver the expected results within the agreed period of time
• Experience of relevant evaluations in Rwanda preferred

DELIVERABLES

• An evaluation plan
• Present a preliminary overview of their findings to the Management team and receive comments from stakeholders before preparing the draft evaluation report.
• Submit the draft report to the Management team for written comments before finalising the report, to minimise the chance of inaccuracies and to maximise ownership of the findings
• Final report (publishable quality of less than 50 pages including annexes) to be produced in the format as defined in the GPAF Final Evaluation Guidance
• Debriefing presentation to VFANF after the evaluation report has been finalized
TIMETABLE AND APPLICATION PROCESS

There will be travel involved in the evaluation and the successful bidder will be expected to begin the work mid-November 2013, with a finalised evaluation report due by Friday 10 January 2014.

Please send applications including:

- A cover letter introducing the evaluator/s/organisation and how the skills and competencies described above are met, with concrete examples.
- A brief outline of the proposed evaluation process, including - proposed outline methodology - management arrangements
- A clear indication of availability / dates
- A 1 page budget covering all major costs, and clearly identifying daily rates charged on any consultancies.
- A CV for each member of the evaluation team (if there is more than one consultant in the bid).
- One example of a relevant previous evaluation (one each in the case of joint bids)

All applications to be submitted via email to info@vfanf.org by the 13th October 2013. For further information please contact 0786653860 on email info@vfanf.org