# Evaluation of the Pacific Regional Blindness Prevention Programme

Prepared for Ministry of Foreign Affairs and Trade, Australian Agency for International Development and Fred Hollows Foundation New Zealand

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# Evaluation of the Pacific Regional Blindness Prevention Programme

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# 1. Executive Summary

## 1.1 Background

Fred Hollows Foundation New Zealand (FHFNZ) has been working to prevent and reduce avoidable blindness and vision impairment in the Pacific since 2002. In 2008, the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and the Australian Agency for International Development (AusAID) entered into a tripartite agreement with FHFNZ to further support and scale-up blindness prevention in the Pacific.

MFAT and AusAID provided a three year grant of NZD17, 411,143 to FHFNZ to implement the Pacific Regional Blindness Prevention Programme (PRBPP) from January 2009 to December 2011. The PRBPP provides training and workforce support to develop community eye health workers, eye nurses, and ophthalmologists in the Pacific region. The training and related support are offered out of Suva, Fiji, which serves Pacific Island Countries (the Pacific Eye Institute), Madang, Papua New Guinea and Timor-Leste. The Programme also provides clinical services and leadership in eye health, including through the development of standards, community awareness and education, and advocacy and research.

## 1.2 Evaluation of the PRBPP

MFAT and AusAID commissioned an independent evaluation of support to the PRBPP. The purpose of the evaluation was to provide an overall assessment of the PRBPP across the three Programme sites (Fiji, PNG and Timor-Leste) and its five key objectives were:

1. To assess the ***relevance*** of PRBPP
2. To assess the ***effectiveness*** of PRBPP
3. To assess the ***efficiency*** of PRBPP
4. To assess the ***sustainability*** of PRBPP
5. To identify the ***lessons learnt and make recommendations***.

The review was undertaken between August and October 2011. A range of data sources were drawn on to address the evaluation's objectives and associated questions.

1. **Desk Review:** Litmus reviewed relevant documents provided by MFAT, AusAID, FHFNZ, and independently sourced by the evaluators.

2. **Stakeholder interviews:** Litmus conducted 79 consultations involving 93 stakeholders. Country visits were undertaken in Fiji, PNG, Timor-Leste, Solomon Islands and Vanuatu. Face-to-face individual interviews, paired interviews and focus groups were undertaken with national stakeholders, FHFNZ staff, MFAT and AusAID, and graduates and students

## 1.3 Evaluation Conclusions

**Relevance**

- Despite limited regional and national data, there is evidence that the Programme is focusing on the primary causes of blindness and visual impairment in the Pacific region and Timor-Leste.
- Most stakeholders consider that the Programme's curricula has been appropriately tailored to technology and clinic settings, and that it is responding to the needs, structures and gaps of the eye health workforce in the region.
- The programme has developed good delivery mechanisms to meet country eye health priorities, particularly the Pacific Eye Institute. Clinical services provided by the PRBPP are agreed to be meeting a need in the countries served by the PRBPP.
- Systematic analysis of and response to the gender based inequalities that impact eye health prevention and care and workforce development is weak in some aspects of the Programme.
- Given the shortage of eye care specialists in the Pacific and Timor, increasing this human resource capacity by training local people is highly relevant, particularly training and development for a range of eye care personnel, i.e., specialist doctors, nurses and community health workers.
- FHFNZ is the only programme in the Pacific region undertaking systematic eye health workforce development. Ongoing strengthening of coordination with other organisations providing eye care treatment could enhance outcomes.

**Effectiveness (outputs and outcomes)**

- The PRBPP has made a significant impact on building the human resource capacity for eye health and has delivered quality eye health services accessed by increasing numbers of people.
- There is evidence that the PRBPP training courses are relevant to the Pacific context and overall, the PRBPP is responsive to country needs and contexts.
- There was strong achievement on support to mid-level eye health workers and the mechanism is a strength of the Programme.
- Graduate retention in the public health service has been high in the short term. The majority of graduates who completed a PRBPP course in 2009-–2010 are still working in eye care clinical practice in their home country or province 12 months after course completion.
- The PRBPP is considered to be well managed and the PEI and Madang training institutions are well regarded. Stakeholders believed that graduates are providing high-quality eye health services through the PEI and the Eye Clinic at Modilon Hospital.
- Weak health systems and infrastructures, a reliance on expatriate personnel in senior roles in Timor-Leste and Madang, doctor and nurse shortages in the region; and an uneven ability for graduates to conduct rural outreach and link with primary care services are challenges to Programme effectiveness.

**Efficiency**

- Overall, the PRBPP delivery and management has been conducted in an efficient manner and has achieved desired Programme outputs and outcomes.
- FHFNZ policies and procedures appear sound and stakeholders generally consider it to be an efficient organisation.
- The PRBPP delivery model offers efficiencies, including its mechanism for specialised training delivery to participants from widely dispersed Pacific countries (PEI) and rural regions (PNG and Timor-Leste) and enabling PRBPP staff and students to treat and operate on an increased number of patients.
- The evaluation did not find any evidence that FHFNZ could have significantly reduced Programme delivery costs and it is unlikely that more or better outputs and outcomes could have been achieved with the same resource.
- Without the PRBPP funding, eye care human resource capacity in the region would be significantly reduced. In addition, far fewer people in Fiji, PNG, Timor-Leste and the Pacific region would have received eye care and treatment. Given this, and the lack of comparable training opportunities (in terms of scale and tailored curricula), the Programme is providing value for money for eye health human resource development

**Sustainability**

- The PEI, PNG and Timor-Leste Programmes show different levels of institutional maturation. Across the three Programme sites there is localised evidence of country ownership of benefits.
- Overall, the current three-year Programme has not been established long enough to achieve local ownership, particularly in PNG and Timor-Leste. There is potential for local sustainability of PEI, with the appropriate planning and support.
- Expatriates currently make up most PRBPP leadership and senior professional staff in PNG and Timor-Leste, and the Programme faces challenges in recruiting local staff for these positions.
- Sustainability is closely linked to the degree to which the PRBPP is integrated in Pacific Island Countries' health infrastructure. Many facilitators and barriers to Programme sustainability thus lie within the degree to which the Programme can integrate into country systems.
- Any significant change in FHFNZ governance and structure, as a result of decreased PRBPP resources, represents a risk for ongoing Programme sustainability.

## 1.4 Lessons Learnt and Recommendations

Based on the findings of the evaluation, the reviewers make the following key recommendations:

1. Consider ways to strengthen the integration of PRBPP eye health training and service into primary health to increase relevance to country health delivery contexts.
2. Explore and expand online delivery options so that health personnel can combine study and work as appropriate.
3. Continue the strong research into Pacific eye health and consider a population- based eye health survey in PNG.

4. Consider undertaking a gender audit of the PRBPP to inform the development of a strategy that would respond to gender disparities in eye health, and eye health programming, and address gender- related issues of professional workforce development.
5. Develop a formal workforce support model for doctors as well as nurse graduates.
6. Design a model of workforce support that responds to the increasing numbers of graduates across PEI, PNG and Timor-Leste (particularly those working in remote and/or isolated locations).
7. Continue to support PacEYES as a regional organisation working with PIC government partners.
8. Increase and improve engagement with MOHs and country primary and tertiary health systems.
9. Continue to advocate for professional association membership and other formal recognition for nurses.
10. Consider recruiting an education specialist to provide regional curriculum and education oversight in the same model as the Medical Director provides clinical oversight.
11. Seek ways to address the current disconnect between UPNG and PRBPP training in DWU.
12. Increase advocacy and coordination with the PNG MOH.
13. Continue to seek ways to strengthen partnership working with PIC MOHs to avoid vertical delivery of eye health training programming and service provision.
14. Seek to harmonise data collection and management with country MOH systems
15. Continue to build local human resource capacity for both clinical and management roles.
16. Explore ways to strengthen PRBPP links with other regional health mechanisms in the Pacific.
17. Commit to a sustainability plan for PEI.
18. Continue to develop and strengthen comprehensive strategies to localise teaching roles.

# 2. Evaluation of the Pacific Regional Blindness Prevention Programme

## 2.1 Background

The Pacific Regional Blindness Prevention Programme (PRBPP) was initiated by the New Zealand Aid Programme in 2002. In 2009, the World Health Organization (WHO) and International Agency for the Prevention of Blindness (IAPB) launched an initiative to eliminate avoidable blindness by 2020 (Vision 2020). The Avoidable Blindness Initiative was announced by the Australian Government in 2008 and was a key component of the *Development for All Strategy*.

WHO estimates that, within the Pacific and Timor-Leste, there are around 80,000 people who are blind and a further 243,000 who are vision impaired. Furthermore, over 80 per cent of all vision impairment is preventable. The social and economic impact of blindness and vision impairment is significant and could grow to USD110 billion globally by 2020 if not addressed.

Fred Hollows Foundation New Zealand (FHFNZ) took up this global challenge in the Pacific and has been working in the region since 2002. Pacific countries had lacked eye care programmes and systems as well as human resources, and depended heavily on specialist visiting teams to provide eye care. With such poor access to services, avoidable blindness and low vision were reducing economic productivity and educational opportunities in these countries.

The Pacific Regional Blindness Prevention Programme (PRBPP) provides training and workforce support to develop community eye health workers, eye nurses and ophthalmologists in the Pacific region. The training and related support are provided from training institutions (for academic learning) and clinical services (for practical learning). The PRBPP also provides clinical services and leadership in eye health, including through the development of standards, community awareness and education, and advocacy and research.

The regional Programme is implemented through three sites.

1. **Fiji.** The Pacific Eye Institute (PEI), located in Suva, is the largest training centre in the Programme and services the Pacific Islands region. The PEI relocated to Fiji from Solomon Islands in 2006–07.

2. **Papua New Guinea (PNG).** The Programme is implemented from Madang in partnership with Divine Word University (DWU) and Modilon Hospital. The first intake of students was in 2007.

3. **Timor-Leste.** The Programme is implemented from Dili, and the first intake of students was in 2007.

The New Zealand Aid Programme, through the Ministry of Foreign Affairs and Trade (MFAT), has supported the work of FHFNZ since 2002. During a New Zealand Aid Programme-commissioned independent evaluation in the Pacific in early 2008, MFAT and the Australian Agency for International Development (AusAID) commenced discussions on

cooperation arrangements in support of FHFNZ. A tripartite arrangement between FHFNZ, MFAT and AusAID was subsequently entered into to provide further support for blindness prevention in the Pacific. New Zealand takes the lead for development partners.

The tripartite arrangement represented a scaling up of the existing FHFNZ Programme. The scale-up supports an increase in the number of students trained and a more comprehensive support package (including in-country workforce coordinators in the three main countries).

The PRBPP was designed as a three-year Programme from 1 January 2009 to 31 December 2011. The cost of the Programme is NZD17,411,143. MFAT contributes one-third (NZD5.6 million) and AusAID contributes two-thirds (NZD11.2 million). The three-year grant was intended to fund Programmes to strengthen the capacity and capability of the training institutions in Timor-Leste and PNG, build and staff a surgical and training facility in Suva, and enhance workforce support to graduates across the region.

The overall goal of the PRBPP is to:

> *Prevent and reduce avoidable blindness and vision impairment in the Pacific by increasing people's access to quality eye care services provided by appropriately trained eye care personnel.*

PRBPP has four key objectives:

1. strengthening sustainable training institutes
2. strengthening eye health training service facilities
3. developing appropriately trained eye health personnel in numbers commensurate with country eye health human resource (HR) plans
4. supporting eye health graduates and ensuring they are retained within the public health sector to provide accessible, effective and sustainable eye health care.

## 2.2 Evaluation of the PRBPP

The purpose of the evaluation is to provide an overall assessment of the PRBPP across the three Programme sites (Fiji, PNG and Timor-Leste), to determine the extent to which the Programme has been effectively and efficiently managed, to assess the short- and medium-term outcomes achieved by PRBPP and to assess and provide options on sustainability of activities into the future.

The evaluation findings will also be used:

- to inform FHFNZ over whether any changes are required to enhance Programme management
- to inform MFAT and AusAID in terms of their future relationship with FHFNZ, recognising the evaluation findings are only one source of information that will be used to determine future relationship and decisions on funding support.

The evaluation focuses on the period **1 January 2009 to 31 July 2011**. It had five key objectives, to:

6. assess the ***relevance*** of PRBPP

7. assess the ***effectiveness*** of PRBPP
8. assess the ***efficiency*** of PRBPP
9. assess the ***sustainability*** of PRBPP
10. identify ***lessons learnt and make recommendations***.

A set of detailed evaluation questions was answered to inform the evaluation objectives.

## 2.3 Methodology

The evaluation was undertaken between August and October 2011 and drew on a range of data sources. Please refer to Appendix 7 for the detailed Evaluation Plan. The data sources are described below.

### 1. Desk Review

Documentation provided by MFAT, AusAID, FHFNZ, and independently sourced by the evaluators was reviewed. A full list of reviewed documents is included in Appendix 5.

### 2. Stakeholder interviews

Country visits were undertaken in Fiji, PNG, Timor-Leste, Solomon Islands and Vanuatu. Face-to-face individual interviews, paired interviews and focus groups were undertaken with national stakeholders, FHFNZ country staff, MFAT and AusAID posts, and graduates and students. In Fiji, PNG and Solomon Islands discussions were undertaken mainly in English. In Timor-Leste, discussions were undertaken in English and Tetum (via a local translator). In Vanuatu, discussions were undertaken mainly in Bislama.

In addition, face-to-face and telephone interviews were undertaken with MFAT, AusAID and FHFNZ staff in New Zealand and Australia. Discussion guides used in focus groups and interviews are included in Appendix 7.

A total of 79 consultations were undertaken involving 93 stakeholders.

**Table 1: Stakeholders consulted**

| STAKEHOLDERS | | Number of interviews |
|---|---|---|
| MFAT | Development Manager for the Pacific Regional Agencies (Wellington)<br>Tertiary Education Manager (Wellington) | 2 interviews |
| AusAID | Health Advisor, AusAID (Canberra)<br>Regional Programme Manager, AusAID (Canberra)<br>Regional Counsellor, AusAID (Suva) | 3 interviews |
| FHFNZ | International Programme Director, FHFNZ (Auckland)<br>Medical Director, FHFNZ (Rotorua) | 2 interviews |
| Regional stakeholders | Pacific Open Learning Health Net, WHO (Suva)<br>CEO, Disability Forum (Suva)<br>Strengthening Specialised Clinical Services in the Pacific (Suva)<br>CEO, Pasifika Medical Association (Auckland) | 4 interviews |
| Fiji stakeholders | National stakeholders:<br>National Advisor to Non-Communicable Diseases, Ministry of Health (Suva)<br>Head Medical Sciences Department, College of Medicine, Nursing and Health Sciences, FSM/FNU, (Suva)<br>Deputy Secretary Hospital Services, Ministry of Health | 2 interviews |
| | FHFNZ:<br>Director, PEI (Suva)<br>Associate Director, PEI (Suva)<br>General Manager, PEI (Suva)<br>Education Manager, PEI (Suva)<br>Nurse Manager, PEI (Suva)<br>Workforce Support Coordinator (based in Australia) | 6 interviews |
| | MFAT:<br>Deputy Program Coordinator Social and Vulnerability (Suva) | 1 interview |
| | AusAID:<br>Acting Senior Programme Manager (Suva) | 1 interview |
| | Graduate (Suva) | 1 interview |
| | Students (Kiribati, Solomon Islands, Fiji, Tonga) | 1 focus group (5 students) |
| Papua New Guinea stakeholders | National stakeholders:<br>Deputy Secretary of Health, Ministry of Health (Port Moresby)<br>Chief Ophthalmologist, Port Moresby Hospital (Port Moresby)<br>Deputy Dean, School of Medicine and Health Services, University of Papua New Guinea (Port Moresby)<br>CEO, Modilon Hospital (Madang)<br>Dean, Divine Word University (Madang)<br>Vice President (Academic), Divine Word University (Madang) | 6 interviews |
| | FHFNZ:<br>Country Manager (Madang)<br>Education Manager (Madang)<br>Ophthalmologist (Madang)<br>Visiting Consultants (2) (Madang) | 5 interviews |
| | MFAT:<br>First Secretary Development (Port Moresby) | 1 interview |
| | Graduates (Madang) | 1 paired interview |
| | Students (Madang) | 1 focus group (8 students) |
| Timor-Leste | National stakeholders: | 11 interviews |

| STAKEHOLDERS | | Number of interviews |
|---|---|---|
| stakeholders | Director, Human Resources, Ministry of Health (Dili)<br>Non-Communicable Diseases Unit, Ministry of Health (Dili)<br>Academic Director, Institute Nasional Science (Dili)<br>Eye Care Nurse, Hospital Nasional (Dili)<br>Ophthalmologist, Hospital Nasional (Dili)<br>Manager, Centro Saude Clinic (Dili)<br>Manager, Fo Naroman (Dili)<br>Hospital Director (Maubisse)<br>Hospital Administrator, Maubisse Referral Hospital (Maubisse)<br>Chief, National Institute for Health Science (Dili)<br>Royal Australian College of Surgeons (Dili) | |
| | FHFNZ:<br>Country Manager, Consultant (Dili)<br>Education Manager (Dili)<br>Workforce Development Manager (Dili)<br>Visiting consultant (Dili) | 4 interviews |
| | MFAT:<br>New Zealand Aid Programme Manager (Dili) | 1 interview |
| | AusAID:<br>Second Secretary, AusAID (Dili) | 1 paired interview |
| | Graduates (Dili and Maubisse) | 3 interviews |
| Solomon Islands stakeholders | National stakeholders:<br>Undersecretary Health Care, Ministry of Health and Medical Services (Honiara)<br>National Eye Programme Training Coordinator, Ministry of Health and Medical Services (Honiara)<br>National Trachoma Programme Coordinator, Ministry of Health and Medical Services (Honiara)<br>Former National Referral Hospital Superintendent (Honiara) | 5 interviews |
| | MFAT:<br>Development Counsellor (Honiara)<br>Development Programme Administrator (Honiara) | 1 paired interview |
| | AusAID:<br>Health Advisor (Honiara) | 1 interview |
| | Graduates (Honiara) | 7 interviews |
| Vanuatu stakeholders | National stakeholders:<br>Director General of Health, Government of Vanuatu Ministry of Health (Port Vila)<br>Director, Pacific Eye Institute (Port Vila)<br>Medical Superintendent, Vila Central Hospital (Port Vila)<br>Acting Medical Superintendent, Vila Central Hospital (Port Vila)<br>Hospital Manager, Vila Central Hospital (Port Vila)<br>Nurse Aid Coordinator, Government of Ministry of Health (Port Vila) | 6 interviews |
| | MFAT:<br>Development Counsellor (Port Vila) | 1 interview |
| | AusAID:<br>First Secretary Health and Education (Port Vila) | 1 interview |
| **TOTAL** | | **79** |

### 3. Graduate and student survey

Sixty-four students and graduates completed a self-completion survey on their satisfaction with the training they received from 2009 to 2011 and its relevance to their clinical setting. Surveys were completed during in-country visits in Fiji, PNG, Timor-Leste, Solomon Islands and Vanuatu. The surveys from Timor-Leste were received at a later date. A copy of the self-completion survey is in Appendix 7 and the data collected are included in Appendix 8.

The survey was in English in Fiji, Papua New Guinea, Solomon Islands and Vanuatu. It was translated to Tetum for Timor-Leste students and graduates.

A 58 per cent response rate was achieved.

## 2.4 Limitations

In considering the findings of this evaluation, the following limitations are acknowledged.

- Stakeholders interviewed were purposefully selected to best inform the evaluation objectives. Due to time, resources and travel constraints it was not possible to interview all organisations and individuals who have a stake in the PRBPP.
- Some stakeholders were not available during the country visits (that is, they were out of the country or attending outreach). Despite multiple attempts by the evaluators to undertake follow-up interviews, they were unavailable to be scheduled.
- Interviews were mainly undertaken with stakeholders in Fiji, PNG, Timor-Leste, Solomon Islands and Vanuatu. Interviews with stakeholders from other Pacific Island countries (PICs) and territories were limited to people studying at the PEI in Fiji.
- With the exception of Timor-Leste, where a visit outside the main centre to Maubisse was undertaken, most interviews were conducted in main centres – Suva, Madang, Honiara and Port Vila.

Having noted these limitations, the evaluators are confident that this report accurately represents the views of stakeholders and survey respondents who contributed to the evaluation.

This review was independent and does not represent the views of MFAT and AusAID.

# 3. Relevance of PRBPP

This section addresses ***Evaluation Objective 1: To assess the ongoing relevance of the PRBPP in Timor-Leste, PNG and the Pacific region***. It includes:

- the extent to which the PRBPP remains relevant to country priorities
- the extent to which the programme has focused on the highest priority issues in the broader context of eye health
- an assessment of other donor and government activities being implemented to strengthen eye health in Timor-Leste, PNG and the Pacific region, and whether there is effective coordination between PRBPP and these other activities.

## 3.1 Relevance of PRBPP to country priorities

According Fred Hollows Foundation New Zealand, The WHO estimates that, within the Pacific and Timor-Leste, there are around 80,000 people who are blind and a further 243,000 people who are vision impaired. Approximately 70 per cent of avoidable blindness in the Pacific is caused by cataracts, and there is global evidence to suggest that restoring sight through cataract surgery helps to eradicate poverty and that blindness is a barrier to development (Kuper, 2010).

The region faces significant issues that impact on eye health, such as the rising prevalence of non-communicable diseases (NCDs), particularly diabetes, the persistence and rise of some infectious diseases, as well as systemic health care delivery challenges, such as low ratios of medical professionals to population, low per capita government health spending, weak infrastructure and dispersed populations (PEI, 2010c: 4).

National eye health planning is weak in the region and few countries have up-to-date and agreed National Eye Health Plans. The challenges of national health planning are compounded by the lack of national and regional information. Population-based data are inadequate to sufficiently monitor need, guide service priorities and workforce requirements.

There is some detail of national need available. In Timor-Leste, a 2005 Eye Health Survey (designed and implemented by FHFNZ and another partner, the International Centre for Eyecare Education, for the Ministry of Health (MOH)) determined that around 47,000 people over the age of 40 are vision impaired and cataract and refractive error caused 90 per cent of vision impairment. This study found that those most likely to be vision impaired were among more vulnerable groups, including older, illiterate, not in paid employment and living in a rural area, highlighting the link between eye health outcomes and poverty.

In PNG, a study found that 29.2 per cent of patients over the age of 50 were visually impaired and 8.9 per cent had functional blindness. This equates to an estimated 146,000 people with visual impairment and 44,000 bilaterally blind people (Garap et al, 2006). However, national, provincial and community level eye health needs are complex, rapidly changing and largely under-documented in the region. In PNG, the evaluation found evidence that PRBPP's identification of and response to changing patterns of disease, persistence or resurgence of eye conditions associated with infectious and communicable

diseases, as well as emerging health trends such as diabetes and hypertension, was limited by both lack of nationwide data and institutional capacity. Rising patient numbers at the Madang Clinic constrain staff ability to undertake outreach visits, and eye nurse graduates have mixed capacity to undertake outreach from their provincial facilities, limiting the conditions treated largely to those who seek care or who are referred by other (non-specialist) personnel.

***Human resource development and clinical service priorities***

For many PICs, eye care provision is restricted to visiting specialist teams, and, overall, there are inadequate numbers of eye health professionals and clinic facilities to prevent and treat the main causes of eye disease in the Pacific; cataracts, diabetic retinopathy, corneal blindness due to trauma and eye infections, and uncorrected refractive error (PEI, 2010c: 5).

WHO guidelines recommend that countries achieve a ratio of one trained functional refractionist per 100,000 population by 2010 and 1:50,000 by 2020.[1] The number of trained eye health workers in PICs and Timor-Leste falls far below these recommended ratios. The PRBPP is therefore highly relevant to meeting this region-wide priority. Overall, the Programme is responding to the needs, structure and gaps of the eye health workforce in the region. More eye health specialists are required at all levels of national health systems and the Programme supports the training and development of a range of eye care personnel.

Given the service delivery context of the countries served by the Programme, mid-level workers are a critical bridge between community and tertiary health services. There are no government or international partner initiatives comparable to the PRBPP providing support for training mid-level eye care workers at the same scale or with similar rigor and focus. In some countries, visiting surgical teams provide informal on-the-job up-skilling opportunities for local nurses, but these visits are short (typically two weeks) and there is no explicit training curriculum. Few opportunities are available for nurses in the region who want to specialise in eye care, with the exception of Timor-Leste, where some nurses have received professional training at institutes in India and Nepal. The only regional training opportunity for doctors wanting to specialise in ophthalmology is through the University of Papua New Guinea (UPNG), and as this university does not currently have teaching staff to educate ophthalmologists, they receive their theoretical training in Fiji.

Eye health services are currently inadequate in the Pacific, PNG and Timor-Leste. All country stakeholders agreed that the PRBPP training and clinical provision was highly relevant to their countries' needs and priorities. By expanding eye health screening, PRBPP staff and students are reducing the burden of later stages of disease. Ophthalmologists consulted in the evaluation noted that some of the diseases treated in the Pacific are no longer familiar in non-developing country contexts due to a range of factors, including access to adequate primary health care.

Increasing rural eye care service delivery is especially relevant to responding to Pacific eye health priorities. Stakeholders in PNG identified this as a particular priority, and it was a significant driver for the introduction of the Certificate in Eye Care course in 2011 in Madang (not funded by PRBPP). The evaluation found evidence of support to graduates in advocating with hospital management to link primary eye care services with rural health outreach programmes that are undertaken routinely by provincial and district health

[1] WHO http://www.vision2020.org/main.cfm?type=WIBREFRACTIVEERR (last accessed 8 December 2011).

facilities. This advocacy, however, is not systematic, and it has not yet resulted in secure resources or formal arrangements to integrate and institutionalise primary eye care outreach services.

PEI is also expanding access to eye care to provincial hospitals in the Pacific. The PRBPP training programmes are designed specifically for Pacific disease and health delivery contexts, and there is clear evidence that curricula have been tailored to local settings and are reviewed regularly (FHFNZ, 2009; FHFNZ, 2010). Training includes contextual modules, which target generic regional needs, such as patient data collection, clinic management and specific modules in community eye care and health promotion, which address integration into primary care.

Despite the prevalence of avoidable blindness in the Pacific and Timor-Leste, eye health does not feature prominently in national health agendas. The majority of stakeholders concurred that eye health should be an important priority for national health budgets, but pointed out that competing health priorities placed pressure on resources. High levels of maternal and child morbidity, the burden of other infectious diseases, HIV & AIDS and growing rates of NCDs were cited as more urgent priorities for Pacific health.

The Programme's practical response to gender-based inequalities across a range of aspects is limited. FHFNZ has a Gender Equality and Development Policy (May, 2011i) that recognises the gendered barriers to blindness prevention and treatment, women's disproportionate access to information and decision-making ability and the mobility constraints that disadvantage women more than men in eye care access. The policy also notes that blindness prevalence among women accounts for nearly two-thirds of the world's blind population and that women in developing countries are much less likely to receive cataract surgery than men.

The policy outlines FHFNZ's commitment to gender mainstreaming across a range of programme areas, but the review did not see evidence in practice. Across all Programme sites, efforts to identify, measure or specifically respond to gender inequalities that impact the Programme were largely absent in planning documents, workforce support reports and accounts of decision-making, planning and Programme implementation. Stakeholders reported, for example, that a notable proportion of eye trauma is a result of gender-based violence, however, there is no evidence to suggest this has been incorporated in the Programme's eye health promotion work.

Data from training programmes are sex disaggregated, but data from clinical and surgical services are not consistently available, can be challenging to collect and are not always disaggregated (also see FHFNZ 2010 Annual Report 125). There was no indication that strategies to respond to recognised gender inequalities, which may not be reflected in available quantitative data, such as barriers to accessing the clinical and surgical services, have been developed. While the Programme has been successful in ensuring women are trained, response to the multiple gender-based constraints, such as undertaking rural outreach or effectively negotiating and advocating for resources with hospital administration, was less evident.

## 3.2 Programme focus on the highest priority eye health issues

As outlined in the previous section, the evidence base for determining eye disease burden is limited in the region. Health information systems throughout the region do not

systematically collect and/or report on eye health data. Graduates of FHFNZ programmes are engaged in data collection and there is evidence from Programme annual reports that these data are being used to monitor levels of service and enhance Programme responsiveness.

The increase in NCDs, in particular, diabetes, was highlighted by stakeholders as a high priority in eye health. In 2009, a new PEI Diabetes Eye Clinic opened in the Colonial War Memorial Hospital (CWMH) in Suva (jointly funded by the PRBPP and the World Diabetes Foundation). During 2009, the Programme developed new training courses to meet this eye health need. The first student intake into the Postgraduate Certificate in Diabetes Eye Care (PGCDEC) was in 2010, while the Postgraduate Diploma in the Medical Management of Vitreo-Retinal Disease (PGDMVD) was first delivered in 2011. The Diabetes Eye Clinic has provided the clinical setting for PGCDEC and PGDMVD learning, and programme reports indicate that this has significantly expanded clinical eye care for diabetic in-patients (in CWMH) and out-patients in Fiji.

Other eye health issues raised by stakeholders included: uncorrected refractive errors; cataract; trachoma; chronic diseases (glaucoma and diabetic retinopathy); nutrition disorders (vitamin A); trauma and injury (for example, lime burns). The picture of the ways in which these issues are prioritised in each country is fragmented; for example, there is less emphasis on diabetic retinopathy in PNG, but Programme stakeholders have identified that diabetes prevalence is rising in certain areas of the country.

## 3.3 Coordination with other donor and government activities

Across the Pacific region, PNG and Timor-Leste, there are several donor, country, volunteer and government activities to strengthen eye care.

Other eye care organisations working in the region include: Foresight, Marine Reach, the Christian Blind Mission (CBM), ICEE, Lions Club, Callan Services, PNG Eye Care and visiting Australian, New Zealand, American and other nationality specialist teams. These organisations provide eye care treatment, refraction and spectacle supply and cataract surgery, some on short (typically two week) country visits. Visiting teams often work with local eye nurses and doctors and these visits were generally considered by national stakeholders to offer up-skilling opportunities, particularly for nurses.

There is evidence that PEI is seeking to coordinate with visiting teams by circulating a comprehensive list of all participating visiting teams to the region and encouraging visiting teams to remain in communication with PEI. In PNG, there are fewer visiting teams, due in part to security issues. The Madang Programme does not explicitly coordinate with all other visiting surgical teams in PNG, but FHFNZ successfully established a national coordinating committee that collaborated to develop the National Eye Health Plan. The Timor-Leste Programme made good progress in providing coordination of these providers (the Royal Australian College of Surgeons (RACS), in particular) and national partners note an improved level of coordination in the past 12 months with the appointment of the new Country Manager.

There are two key organisations providing support to eye health in Solomon Islands; FHFNZ provides human resource development via the PRBPP and Foresight provides infrastructure and technology resources. Solomon Island stakeholders felt that coordination

between the organisations was lacking, citing an example of mismatch between equipment trained on at the PEI and equipment supplied to Solomon Islands clinic by Foresight.

## 3.4 Conclusion

Despite limitations in regional and national data, there is evidence that the Programme is focusing on the primary causes of blindness and visual impairment in the Pacific region and Timor-Leste. Stakeholders agree that the curricula has been tailored appropriately to technology and health facility settings, and that it is largely responding to the needs, structures and gaps of the eye health workforce in the region.

The programme has developed good delivery mechanisms to meet country eye health priorities, particularly the PEI. Clinical services provided by the PRBPP are agreed to be meeting a need in the countries served by the PRBPP, but analysis of and response to the gender-based inequalities that impact on eye health care in Programme sites is weak.

Given the shortage of eye care workers in the Pacific and Timor, increasing this human resource capacity by training local people is highly relevant. Furthermore, eye health specialists are required at all levels of national health systems, and the Programme supports training and development of a range of eye care personnel.

FHFNZ has a unique offer in that it is the only programme in the Pacific region and Timor undertaking systematic eye health workforce development. There are, however, several other organisations providing eye care treatment, mostly through visiting specialist teams, and overall coordination with these could be much stronger.

# 4. Effectiveness of PRBPP

This section addresses ***Evaluation Objective 2: To assess the effectiveness of the PRBPP***. It includes:

- the extent to which the goal and outcomes of the PRBPP are clearly defined and feasible
- the extent to which progress has been made towards the achievement of Programme outputs, outcomes and goals
- the extent to which PRBPP activities are sufficiently integrated into primary care services and other clinical settings/training
- the extent to which the Monitoring and Evaluation Framework is fit for purpose, i.e. whether it has provided appropriate and robust information on outputs and contribution towards outcomes and impact
- factors that support and constrain the achievement of outputs and outcomes and how these are being addressed by FHFNZ.

## 4.1 PRBPP goal and outcomes

Phase 2 of the PRBPP represents a continuation of Phase 1 of the Programme, in partnership with the New Zealand Agency for International Development (NZAID) (now MFAT) from 2002–08. The development of Phase 2 also built on existing FHFNZ work in PNG and Timor (2002–08). Phase 2 programme design drew on findings and recommendations from the PRBPP Phase 1 evaluation (Hughes, 2007) to broaden the Programme's geographic focus to include Timor and PNG (FHFNZ, 2011: 2).

The PRBPP has a clearly defined goal of "Avoidable blindness and vision impairment is prevented and reduced in the Pacific by increasing people's access to quality eye care services provided by appropriately trained eye care personnel".

The PRBPP has five defined outcomes (the first two outcomes relate to the PEI and Madang training institutions only), which appear in the Programme Proposal and Activity Annual Progress Reports.

1. Well qualified Pacific eye care personnel will be employed within the PEI and Madang training institutions and delivering relevant eye care training courses.
2. PEI and Madang training institutions will be well managed and independently governed, working in close association with their partner universities, and highly regarded in the Pacific community.
3. Pacific eye care personnel will staff eye care training clinics in Suva, Madang and Dili (with possible satellite campuses in other centres) which will provide an excellent eye care training clinical environment and high quality comprehensive service for patients.
4. Eye nurses and eye doctors will be undertaking training in sufficient numbers to create a significant impact on the eye health human resource needs in the Pacific.

5. Qualified eye nurses and eyes doctors are retained in the public sector and providing a quality health service which is used by an ever increasing number of people in the community.

The Programme also has four stated objectives:

1. strengthening sustainable training institutes
2. strengthening eye health training service facilities
3. appropriately training eye health personnel in numbers commensurate with country eye health human resource plans, to meet eye health needs in each Pacific country
4. supporting eye health graduates and ensuring they are retained within the public health sector to provide accessible, effective and sustainable eye health services to meet eye health needs in each Pacific country.

Programme documentation involving stakeholders and staff focuses on the Programme goal and objectives and, to a much lesser extent, on outcomes. Progress reporting to donors and other stakeholders focuses on progress made against objectives rather than outcomes. When communicating with the (New Zealand) public, FHFNZ focuses on the intended impact of the Programme, that is, restoring sight, as Programme objectives such as workforce development may be considered less salient.

The achievement of the intended goal, outcomes and objectives as outlined in the Tripartite Agreement refers to the 2009 -2011 period. However, the overall goal and the outcomes reflect an implicit longer term view, and the feasibility of and actual progress toward their achievement varies across the Programme countries and sites. The intended goal, outcomes and objectives are less feasible for PNG and Timor-Leste training institutions, which face systemic impediments, including weak national health systems, nurse and doctor shortages in Timor-Leste, among others.

## 4.2 Progress towards achievement of Programme outputs and outcomes

The evaluation focused on progress towards the achievement of PRBPP outputs and outcomes from 1 January 2009 to 31 July 2011.

### *Programme outputs*

#### Course overview

The PRBPP offered seven qualifications for eye care technicians, nurses and doctors from 2009–11.

Three qualifications for doctors were offered through the PEI in Fiji.

- A one-year Postgraduate Diploma in Ophthalmology (DO), which produces an eye doctor competent in diagnosing and treating leading causes of blindness and impaired vision.

- A three-year Master of Medicine in Ophthalmology (MMed), which produces an eye care professional who is an authority on ophthalmic knowledge and practice pertaining to surgical and medical care of individuals, as well as an authority on population-based eye care.
- A Postgraduate Diploma in the Medical Management of Vitreo-retinal and Diabetes Eye Care (PGDMVD).

Four qualifications for mid-level workers (nurses and eye care technicians) were offered across the three training centres.

- A Certificate in Eye Care (CEC) offered in the PEI, PNG and Timor-Leste. This is a six-month certificate in PEI, a 10-week course in PNG and a one-year certificate in Timor-Leste. It produces an eye care worker with limited but specific competencies in eye care. (The CEC is not funded by the PRBPP in PNG.)
- A six-month Postgraduate Certificate in Diabetes Eye Care (PGCDEC) offered in the PEI. It produces an eye care worker who can examine the eye to identify signs of diabetes eye disease, grade level of retinopathy and refer for treatment.
- A one-year Postgraduate Diploma in Eye Care (PGDEC) offered in the PEI and PNG. It produces an eye care worker with a wide range of competencies, including essential eye care, operating theatre, refraction, management and health promotion.
- A Masters in Community Eye Care (MCEC) offered extramurally through a partnership with the Pacific Open Health Learning Network, an initiative of WHO.

There is a high completion and pass rate for students who enrolled in PRBPP courses over the 2009–11 period. Two students deferred commencement of their courses.

Criteria for recruitment of students varied across all sites. Applicants to the Diploma and Certificate training in PEI are assessed on three main areas: eye care personnel needs of the applicants' country and/or community, MOH or clinic support of the applicant after graduation and the applicants' personal characteristics, determined through references and, where possible, interviews. The PEI courses were oversubscribed in 2011.

In PNG, the support of the applicant's supervisor or hospital Chief Executive Officer is required. A decision that insufficient mathematics levels were hampering the training prompted FHFNZ to add a Grade 12 maths requirement for 2011 applicants.

In Timor-Leste, the Institute of Health Sciences chooses who is selected for the eye care training. Nurses were selected in the first intake, but a critical nursing shortage impacted the government's willingness to release nurses for extended training. The second intake of students was selected from among high-school leavers who trained as Eye Care Technicians.

**Total number of students 2009–11**

A total of **114** eye care technicians, nurses and doctors completed a PRBPP qualification in 2009 and 2010 or are attending a PRBPP qualification in 2011. A break down of the numbers is as follows:

- **66** have completed their study and a further **46** are studying across the three sites
- **14** doctors and **98** certificate or mid-level workers have completed their study or are currently studying across the three sites

- **62** have completed or are currently studying at the PEI and **35** and **15** have completed or are currently studying at the PNG and Timor-Leste training centres, respectively.

**Table 2: FHFNZ students by training centre, qualification and year**

| | Completed 2009 | Completed 2010 | Students 2011 | Total |
|---|---|---|---|---|
| **PEI (Fiji)** | | | | |
| PGCEC | 1 | – | 3 | 4 |
| PGCDEC | – | 6 | 7 | 13 |
| PGDEC | 8 | 12 | 10 | 30 |
| DO | – | 6 | 4 | 10 |
| MMed | 1 | – | 3 | 4 |
| MCEC | | | 1 | 1 |
| PGDMVD | | | 2 | 2 |
| **PNG** | | | | |
| CEC | – | – | 10 | 10 |
| PGDEC | 7 | 10 | 8 | 25 |
| **Timor-Leste** | | | | |
| CEC | – | 15 | – | 15 |
| **TOTAL** | **17** | **49** | **48** | **114** |

**Analysis by gender**

The majority of students who completed training in 2009–10 or are currently studying in 2011 were women **(**over 71**%).** Women also participated more across all qualification levels:

- **11** women and **4** men participated in qualifications for doctors
- **70** women and **28** men participated in qualifications for mid-level workers.

**Analysis by country and province**

Students from **11** countries have participated in the PRBPP from 2009–11. There has also been participation by students in most provinces in Fiji, PNG and Timor-Leste.

- The PEI in Fiji has selected students from 11 countries. The greatest numbers of students came from Fiji (25 students) and Solomon Islands (13 students).
- The PNG training centre has trained students from a diverse range of provinces. Some of the provinces that do **not** have FHFNZ-trained eye care personnel are the National Capital District Province (Port Moresby), Central Province and the Autonomous Region of Bougainville.
- The Timor-Leste training centre has drawn students from a range of provinces.

**Table 3: PRBPP students by country and region**

| PEI (Fiji) | | PNG | | Timor-Leste | |
|---|---|---|---|---|---|
| **Country** | **Number** | **Province** | **Number** | **Province** | **Number** |
| Fiji | 27 | Madang | 5 | Liquica/Maubara | 4 |
| Solomon Islands | 13 | West New Britain | 5 | Manatuto/M. Villa | 4 |
| Tonga | 6 | East New Britain | 4 | Viqueque/Autocarbau | 4 |
| Vanuatu | 4 | Morobe | 3 | Aileu/Aileu Villa | 3 |
| Kiribati | 3 | Chimbu | 2 | | |
| Cook Islands | 2 | East Sepik | 2 | | |
| PNG | 2 | Eastern Highlands | 2 | | |
| Samoa | 2 | Milne Bay | 2 | | |
| Tokelau | 2 | New Ireland | 2 | | |
| Nauru | 1 | Sandaun | 2 | | |
| Timor-Leste | 1 | Western Highlands | 2 | | |
| | | Enga | 1 | | |
| | | Gulf | 1 | | |
| | | Oro | 1 | | |
| | | Southern Highlands | 1 | | |
| **TOTAL** | **63** | | **35** | | **15** |

## *Programme outcomes*

### Outcomes Framework

An Outcomes Framework was developed by the evaluators as a tool to describe the PRBPP outcomes and goal and included and approved in the Evaluation Plan. The outcomes were surfaced and compiled from documentation examined in the Desk Review and initial stakeholder interviews, and the Outcomes Framework was validated in all field visits by FHFNZ staff and other stakeholders. The framework incorporates the PRBPP's documented goal and outcomes and includes the results of an outcome mapping exercise undertaken by FHFNZ in 2010.[2]

Reading from the outside towards the inside of the circle, the Outcomes Framework includes the following.

### Short-term outcomes

- Well qualified Pacific eye care personnel employed in PEI and Madang training institutes
- PEI and Madang training institutes well managed and independently governed
- PEI and Madang training institutes worked in close association with their partner universities
- PEI, Madang and Dili provided with excellent clinical environments for training

[2] The Outcomes Framework was developed solely for the purposes of the evaluation and has not been formally accepted by FHFNZ.

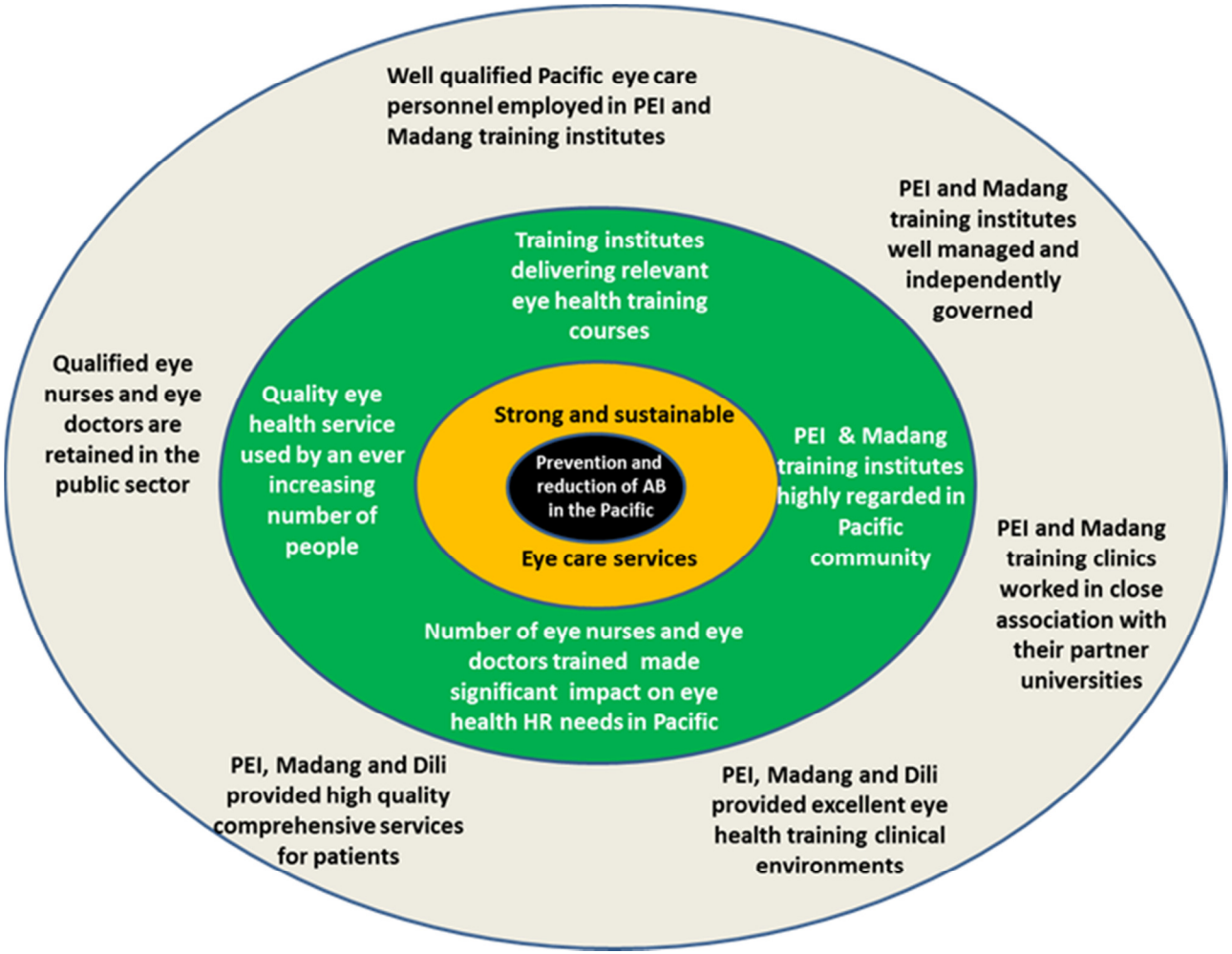
- PEI, Madang and Dili provided comprehensive, high quality services for patients
- Qualified eye nurses and eye doctors are retained in the public service.

**Medium-term outcomes**

- Training institutes delivering relevant eye health training courses
- Number of eye nurses and eye doctors trained made significant impact on eye health HR needs in the Pacific
- Quality eye health service which is used by an ever increasing number of people
- PEI and Madang training institutes highly regarded in the Pacific community.

- **Long-term outcomes** are an eye care service which is strong and sustainable.
- The **ultimate outcome** is the prevention and reduction of avoidable blindness in the Pacific and Timor-Leste.

Figure 1: Outcomes Framework for PRBPP



**Short-term Outcome 1: Well qualified Pacific eye care personnel will be employed within the PEI and Madang training institutions**

There has been good progress against this outcome at the PEI where the Director, Associate Director and General Manager are Pacific nationals. These personnel are widely respected by regional and national stakeholders, are considered to be providing good leadership in the eye care sector and working to a high professional standard. There is still a reliance on expatriates to supplement specialist staff numbers. Recently, the PEI sought to recruit a Pacific optometrist as Education Manager, but could not find suitably qualified individuals. There remains a reliance on visiting lecturers from Australia and New Zealand.

There has been limited progress against this outcome in the Madang site. The three most senior staff, the Country Manager, Education Manager and Ophthalmologist are expatriates, and there is a reliance on visiting consultants to provide training and workforce support. The three expatriate staff are returning to Australia at the end of 2011, and the recently appointed new Country Manager is also an expatriate. There are two national (PNG) staff members who work in non-clinical/administrative roles in the Eye Clinic and two PGDEC nurse graduates working in the clinic. The Operating Theatre module of the 2011 PGDEC course was delivered by past graduates. FHFNZ is currently working DWU to build academic expertise for eye care training within the university, including funding one of two new positions. Country Office staff and DWU have developed a strategy to nationalise training and intend that training will be undertaken by Pacific people with no requirement for visiting lecturers by 2018.

In Timor-Leste, senior staff (Country Manager, Programme Manager, Education Manager and the newly appointed General Manager of the National Eye Centre) are expatriate staff (New Zealand, Indonesian and Australian), the Workforce Development Manager and all supporting staff (including managers of outreach, health promotion) are Timorese nationals.

**Short-term Outcome 2: PEI and Madang training institutions well managed and independently governed**

***Management of training institutions***

There has been positive feedback from regional and national stakeholders on the management of the PRBPP both at a regional and training institution level. The General Manager of the PEI has extensive management experience working for the Fiji health system, and her management skills are rated highly by regional and national stakeholders. The outgoing PNG Country Manager had previously worked as a volunteer for DWU and has also worked in a monitoring and evaluation role in Australia. Regional and national stakeholders consider regional and country managers to be professional and responsive. Stakeholders also believe the Programme has good quality assurance systems and processes.

*Governance*

While the three training institutions have autonomy for managing day-to day budgets, the regional office based in Auckland provides Programme governance (strategic planning, monitoring and evaluation, and quality assurance), project budgets and recruitment of expatriate staff.

Some Fiji national stakeholders consider that the PEI is at a stage of maturation and has the capacity and leadership to govern on its own, without the involvement of FHFNZ. The new National Eye Centre in Timor-Leste has established a management committee that includes the FHFNZ Country Manager as a member. This committee will provide oversight for the new National Eye Centre.

**Short-term Outcome 3: PEI and Madang training clinics worked in close association with their partner universities**

The PEI has a close working relationship with the Fiji School of Medicine, which confers the qualifications. The PNG training Programme has a collaborative working relationship with DWU in Madang, which confers its qualifications and provides teaching leadership and vocational support to students. Some stakeholders noted the PRBPP in Madang had no active collaboration with UPNG (as the principal national university and other provider of medical training) and that this needed to be addressed.

The Timor-Leste Programme has not yet established a partnership with the University of Timor-Leste (which now delivers all pre-service health training in the country). FHFNZ ran the Diploma in Eye Care course through the Institute of Health Sciences, which has undergone restructuring and is now renamed the National Institute of Health. The Programme has begun discussions to determine training delivery options in 2013 following the IHS restructure.

**Short-term Outcome 4: Excellent eye health training clinical environments provided**

Overall, stakeholders agree that PRBPP training clinics offer a high quality teaching and learning environment. The physical organisation of training environments ranges from split sites (Timor-Leste) and same site (PEI and PNG). Staff and students at PEI noted that the new building has enhanced the seamless quality of training and found it a big improvement from the previous split site. It has also had an impact on efficiency as there is no longer travel time between sites (please see Section 5 on Efficiency for further discussion).

**Short-term Outcome 5: PEI, Madang and Dili provided high quality comprehensive services for patients**

There is good evidence that PRBPP clinics in PEI, PNG and Timor-Leste provide high-quality eye care services. Stakeholders agreed that the clinics are well managed and delivering appropriate and quality eye care. PEI, with its Diabetes Eye Clinic, outreach visits and larger surgical team, including visiting specialists, offers the most comprehensive services. There is an emerging indication that PEI has become the medical provider of choice for patients in Suva. All PRBPP eye clinics (including mobile outreach clinics) were well respected by stakeholders.

**Short-term Outcome 6: Qualified eye nurses and eye doctors are retained in the public sector**

All 66 students who completed a PRBPP course in 2009–10 commenced or returned to eye care clinical practice in their home country or province.

The majority of graduates are still working in eye care clinical practice in their home country or province 12 months after course completion. Figures are as follows:

- **33** of the **34** *PEI* graduates remain in eye care clinical practice after 12 months

- **14** of the **17** *PNG* graduates remain in eye care clinical practice following training. One was considered by the Country Manager to perhaps not be so committed to eye health; another is pursuing a career in midwifery; the third has been deployed to other hospital duties

- **14** of the **15** *Timor-Leste* graduates remain in eye care clinical practice after 12 months (one has since trained in acupuncture).

While it is not possible to say whether graduates will remain in eye care in the medium to long term, those from the PEI and PNG training centres appear to be committed to a career in eye care, driven by the contributions they are making to restoring sight and the overall benefits they are bringing to communities.

By contrast, some Timor-Leste graduates had a desire to pursue other health-related career options in future (for example, pharmacology and midwifery) and indicated they did not plan to remain in eye care. For many Timor-Leste graduates, eye care was not their first or second choice for training, and most are school leavers for whom working as an eye care technician is their first job. Some noted they found the work under-stimulating, driven by the lack of patients requiring consultations and their status in the clinical hierarchy.

**Applying skills and knowledge in eye care to clinical practice**

Overall, most graduates consider they are applying the skills and knowledge in eye care gained in the course to their clinical practice.

- The majority of graduates (96%) rate the *relevance of the PRBPP training to their country's needs* as very good/good.

- All graduates rate the training as having *increased their knowledge and skills* in eye care as very good/good.

- The majority of graduates (92%) rate their ability to *apply the training they received to clinical practice* as very good/good.

However, there are some graduates who are not applying their skills and knowledge to clinical practice and these include those in provincial and/or district settings. The following health system elements were identified as necessary for graduates to apply their skills and knowledge: greater support by health facility management, appropriate equipment, consistent supplies of consumables and appropriate infrastructure. Poor achievement of these elements formed barriers to accomplishing this outcome in PNG, Timor-Leste, Solomon Islands and Vanuatu. FHFNZ workforce support and Country Managers are working hard to support graduates facing these systemic issues.

Eye care nurses, in particular, noted the increased confidence that the training had afforded them. The mix of theoretical and clinical skills, and support from the Programme workforce development, was regarded as highly valuable in enabling patient treatment and knowledge of appropriate referral. Those who are working in team settings or based in an eye clinic are considered to be more effective and satisfied by Country Managers.

**Supporting the workforce**

There is strong achievement overall in the area of support to graduate mid-level eye health workers in the Programme sites and Pacific Islands. In PNG, graduates have three formal

interactions with the Programme annually. They are visited by the Country Manager who supports administrative relationships within the health facilities, and by the Workforce Support Manager, who performs technical assessments and supports problem solving and clinical mentoring. The nurses also convene annually for a graduate workshop, which is designed to strengthen the network and provide refresher skills training. An occasional newsletter for graduates is also circulated.

Other sites operate on similar mechanisms. In Timor-Leste, an assessment of workforce support was undertaken in 2011 to identify additional training, equipment, consumable needs and constraints to graduates' eye service provision. An agreement was subsequently made with the Timor-Leste MOH on the scope of ongoing provision of material and technical support to Eye Care Workers. This will include further development of the Eye Care Workers Association, which is in the early stages of planning.

There is consensus across all sites that resources for workforce support will need to be amplified in the near term as the number of trained workers continues to grow. The current model of one-on-one support is considered valuable and best practice, but viable only due to the current relatively small size of the workforce. A support scheme that enables similar *in situ* support to individual eye care workers across the region will need to be designed.

***Medium-term Outcomes***

**Medium-term Outcome 1: Training institutions delivering relevant eye health training courses**

All three training sites have made solid progress against this outcome and worked hard to ensure curricula are relevant to the Pacific context. There is a demonstrated responsiveness to country needs and contexts. Internal curriculum reviews in PNG and PEI were undertaken to fine-tune modules to better meet student and local needs. The training curriculum in Timor-Leste is also being modified and adjusted in response to reforms in the MOH.

**Medium-term Outcome 2: PEI and Madang training institutes highly regarded in the Pacific community**

PEI is widely regarded across the region as a centre of excellence in the Pacific. Stakeholders in all PRBPP countries consistently regarded PEI highly.

The operation in Madang is also well regarded but is not as well recognised. As it is a smaller program in a bigger country, and not located in the national capital, some PNG stakeholders, and those outside of the country, did not have the same understanding of its work.

**Medium-term Outcome 3: Eye nurses and eye doctors trained in sufficient numbers to create a significant impact on eye health human resource needs in the Pacific**

There is evidence of progress towards the achievement of this outcome in some areas. Figures for training targets were compiled from Programme planning documents.

**Table 4: PRBPP trainees against targets**[3]

| Country | Eye Doctors | | | | Eye nurses | | | |
|---|---|---|---|---|---|---|---|---|
| | Ideal number | Actual number 2008 | Target training number 2011 | Actual training number 2011 | Ideal number | Actual number 2008 | Target training number 2011 | Actual training number 2011 |
| Cook Islands | - | - | - | 1 | 2 | 1 | - | 1 |
| Fiji | 9 | 4 | 1 | 8 | 35.2 | 9 | 8 | 18 |
| Kiribati | 2 | - | 1 | 1 | 4 | - | 1 | 2 |
| PNG | 60 | 10 | 14 | 2 | 240 | 39 | 58 | |
| Samoa | 2 | - | 1 | | 7.2 | 2 | 2 | 2 |
| Solomon Islands | 5 | 1 | - | 3 | 20.8 | 15 | 2 | 10 |
| Timor-Leste | 10 | - | 3 | | 44 | 11 | 10 | 1 |
| Tonga | 2 | 0.5 | - | | 4.4 | 2 | 1 | 6 |
| Tuvalu | 0 | - | - | | 2 | 1 | - | |
| Vanuatu | 2 | 1 | - | | 8 | 11 | - | 4 |
| **TOTAL** | **92** | **17** | **21** | **15** | **368** | **91** | **82** | **44** |

In PNG, while there is progress being made in the training of eye care nurses, there is limited progress in relation to the training of eye doctors. Stakeholders note a desire for more national ownership, particularly including through links with University of Papua New Guinea, but administrative, leadership and relationship issues have challenged progress.

In Timor-Leste there are significant challenges in training sufficient eye nurses and eye doctors to create an impact on human resource needs. In 2008, Timor-Leste had 11 nurses in training out of estimated country need for 40 eye nurses.

The Programme set a target to train 10 eye nurses, but, due to a critical nursing shortage in the country, it had to recruit school leavers instead of nurses in its latest intake (2010). While the overall number of graduates trained exceeded this number by five graduates, the level of qualification, competencies and services they are able to provide is below the level of nurses.

Timor-Leste has a significant doctor shortage, and currently the Cuban government is funding and providing medical training for around 900 Timorese medical students. The first wave of graduate doctors will return to Timor-Leste in 2012. There are ongoing efforts to identify and attract individual practising doctors to choose to specialise in ophthalmology. Opportunities for recruiting new doctors for specialist eye care training will be limited in the short-to-medium term.

**Medium-term Outcome 4: Quality eye health service used by an ever increasing number of people**

There is evidence that the graduates of the PEI and Madang Programmes provide high-quality eye health services through the PEI and the Eye Clinic at Modilon Hospital. Stakeholders in Fiji and PNG comment on the professionalism of the operations and aspire to provide commensurate specialised and competent care. The PEI is considered to be a 'gold standard' operation across the health sector and a model of good practice that can

[3] Targets are based on population and reflect the challenges of Pacific geography

positively influence other disciplines. The clinics at both PEI and Madang are routinely filled to capacity with patients who travel significant distances to access the services.

By contrast, Timor-Leste has faced nationwide challenges with under-utilisation of eye services. Lack of demand for health services is a problem across the health sector in Timor-Leste (for example, in maternal and child health). A strong Programme response to this issue included an outreach initiative in districts and communities to identify and transport patients. The Programme utilised participatory methodologies to engage community leaders, and it is subsequently using similar processes to mobilise people for mass vision screenings and visiting surgical teams. There is evidence that these initiatives generated an increase in patients across a range of services in Timor-Leste in 2011.

***Programme long-term outcomes and ultimate outcome***

The evaluation was not intended to assess the extent to which the long-term outcome of the Programme "Strong and sustainable eye care services in the Pacific" and the ultimate Programme outcome "Avoidable blindness and vision impairment is prevented and reduced in the Pacific" were achieved. However, there is evidence of progress towards "a strong and sustainable eye care service" in Fiji, contributed mainly through the work of the PEI. There is localised evidence of initial progress towards strong and sustainable eye care services in PNG and Timor-Leste.

Given this limited progress towards achieving long-term outcomes, it is too soon in the Programme's implementation to assess its contribution to the achievement of the ultimate outcome "Avoidable blindness and vision impairment is prevented and reduced in the Pacific".

**Continuing professional development**

The majority of students and graduates surveyed by the evaluation regarded the training as having contributed to their professional development (95%). At the PEI, there is an opportunity for stair-casing skills and qualifications. Lack of recognition of specialist qualifications within the structure of PICs' public service is an impediment to professional development for graduates. In some countries, including Timor-Leste and Solomon Islands, eye care workers and eye nurses' additional qualifications have not translated to an increase in level or salary. In PNG, the PGDEC qualification was not recognised by the Medical Association Board until September 2011. In Fiji, the FHFNZ Professional Development Director is advocating for the professional recognition of eye care nurses by the Fiji Nursing Association.

## 4.3 Integration of PRBPP activities into primary care services

The delivery of primary health care is a priority in the region, particularly for rural people who are the majority of the population in the Pacific and Timor-Leste. Limited medical staff, resources and access to services characterise many Pacific health systems and the extent to which PRBPP implementation is integrated into primary care is essential to Programme effectiveness. The Programme's integration into primary care delivery mechanisms varies across the sites and by Programme activity. Overall, however, evidence of integration is limited.

The objectives of the PRBPP include developing a specialised workforce to provide clinical services in eye health. An emphasis on quality assurance has shaped this focus. Stakeholders reported internal tension amongst Programme staff regarding the specialist approach versus a more community-centred, primary care, eye health promotion approach.

Clinical services in all three Programme sites are provided out of discrete eye health facilities, two in capital cities and one in a provincial centre, and there is limited evidence of systematic integration with primary care services. Throughout the region, the ability for mid-level eye care graduates to undertake rural outreach (including for screenings and health promotion) is constrained by country health infrastructure and low resources. The Programme, through its workforce development component, primarily emphasises ensuring graduates are performing their clinical skills well in their health facility setting over ensuring systematic rural outreach for primary eye health care.

In Timor-Leste, for example, eye care workers have not been successful in linking up with district and/or community outreach services because district hospitals have not prioritised or allocated budget resources for primary eye care programs. The Programme has been working to find appropriate solutions to this, including the provision of motorbikes in select cases. There is evidence that the PEI is achieving good programming integration into primary care and outreach services for diabetes through the PEI Diabetes Eye Clinic located in CWMH.

## 4.3 Facilitators and barriers to the achievement of outputs and outcomes

Facilitators to achievement of Programme outputs and outcomes include:

- the FHFNZ brand and its credibility to operate regionally
- appropriate student recruitment (with an existing skill base commensurate with training, that is, Grade 12 maths in PNG)
- targeted workforce support for graduates that provides clinical mentoring and better integration into primary care mechanisms in health facilities
- good working relationships with Ministries of Health at national and sub-national levels.

Barriers to Programme outputs and outcomes include:

- weak health systems, infrastructures and supply chains
- reliance on expatriate professionals for teaching and management
- students who do not choose to become eye specialists but are selected by government
- nursing and doctor shortages in PNG, Timor-Leste and Vanuatu.

## 4.5 Monitoring and Evaluation Framework

PRBPP actively monitors Programme activities and outputs and, over the evaluation period, has submitted thorough, well-documented reports with clear information on Programme outputs and evidence of its contribution to desired outcomes.

Data collection includes student feedback on training modules, which is reflected in course design and revision. Academic staff assessments are undertaken through staff self-reflection, student-based evaluations and six-monthly performance reviews of all staff.

FHFNZ convenes country reflections once a year, a process that involves country offices, key partners and graduate representatives gathering to share perspectives on the year's progress and highlights and to undertake annual planning for the upcoming year. FHFNZ also holds annual regional reflection meetings with staff, representatives and all country managers. The most recent regional reflection was held in September 2011.

FHFNZ currently has two staff based in Auckland who job-share the Monitoring and Evaluation Manager role. There is an annual formal monitoring and evaluation visit to each Programme centre, which leads into the reflection process. The International Programmes Director, Information Coordinator and Medical Director conduct frequent monitoring visits to programme countries. While they are considered to be supporting the achievement of effective Programme monitoring, there is acknowledgement that their time is limited.

In 2010, FHFNZ developed a proposal for a comprehensive Monitoring and Evaluation Framework for PRBPP and FHFNZ. The purpose of the new framework was to move away from the current log-frame reporting to an approach based on outcome mapping the Programme logic (FHFNZ, August 2010: 1). This proposal was not completed and implemented, however, due to staff changes at FHFNZ.

## 4.6 Conclusions

Programme outcomes were clearly defined but ambitious in parts. Overall, however, the Programme has achieved progress against most of its outputs and outcomes.

Particular successes include: the number of training qualifications achieved, retention in the public health service and effective workforce support, development of high-quality courses and curricula, increased PRBPP-led coordination in eye care sector. PEI has a high number of Pacific staff in senior positions. Challenges to the achievement of outputs and outcomes include: weak health systems and infrastructures in-country; reliance on expatriate personnel; a shortage of doctors and nurses in the region; and an uneven ability for graduates to conduct rural outreach and link with primary care services.

The Programme has made a significant impact on building the human resource capacity for eye health during 2009–11, with all targets being met. PRBPP has achieved quality eye health services that were accessed by increasing numbers over the evaluation period.

# 5. Efficiency of PRBPP

This section answers ***Evaluation Objective 3: To assess the efficiency of the PRBPP in delivering Programme outputs and outcomes***. It includes:

- the extent to which the Programme has been efficiently delivered both in-country and in New Zealand to meet regional and country needs
- the extent to which the administration and management of the Programme has been efficient and effective, for example, organisational structure, operational procedures, policies, personnel management
- the extent to which the delegated aid arrangement facilitated Programme efficiency
- the extent to which the Programme is providing value for money
- factors that have enhanced or constrained the ongoing efficiency of Programme implementation.

## 5.1 Programme's efficiency in meeting regional and country needs

### *Governance and management of PRBPP*

The PRBPP is managed by FHFNZ from its Auckland office and constituted the largest single funding stream for FHFNZ over 2009–11. Several FHFNZ staff in Auckland manage the PRBPP (International Programmes Director, Information Officer, Monitoring and Evaluation Manager, Research and Development Director). The documentation reviewed by the evaluation indicates a well-managed organisation with clear goals and sound organisational strategy. FHFNZ regularly reviews its organisational systems. In 2009, it conducted a complete review of management and clinical systems that resulted in revised policies and procedures (FHFNZ, 2009a, Annual Report: 7).

The FHFNZ International Programmes Director oversees management of the three Programme sites in Fiji, PNG and Timor-Leste. Each of the three sites is managed by an in-country lead (Medical Director, PEI and Country Managers in PNG and Timor-Leste). Relationships between Auckland and country Programme sites appear strong and to be based on open, frequent communication. Reporting lines between Programme sites and the International Programme Director range from written monthly reports, face-to-face debriefs and periodic reports triggered by meetings. Despite this reporting structure, there is active management of all sites by Auckland, and the International Programmes Director is proactively addressing reporting anomalies. Information communication technology (ICT) difficulties were reported by Programme stakeholders in Timor-Leste and PNG as negatively affecting their connection with FHFNZ in Auckland. Timor-Leste stakeholders reported particular difficulty in accessing the FHFNZ intranet as well as English-language issues.

FHFNZ has an active data monitoring and evaluation function, supported by a part-time monitoring and evaluation manager in Auckland. PRBPP graduates are required to collect eye care data that are reported back to FHFNZ (FHFNZ, 2010e: 15). These data are used for monitoring purposes, but it is unclear how FHFNZ data collection may be operating "within and alongside existing systems" in countries (ibid) and thus they represent a risk of duplication or non-integration into respective MOH systems.

FHFNZ holds annual PRBPP country reflections in each Programme site, as well as an annual regional cross-Programme reflection held in Auckland. The reflection workshops show a commitment to an organisational learning culture and establishing common goals with Programme staff. Most Programme stakeholders (eye health professionals and Programme site staff) felt able to access support from FHFNZ in Auckland and/or the PEI when required. PEI is a significant regional hub for those PICs visited by PEI outreach. Stakeholders in Solomon Islands and Vanuatu are more likely to relate to PEI than the FHFNZ in Auckland. For stakeholders in PNG and Timor-Leste, their relationship is more with FHFNZ, with little direct contact with PEI.

### *Addressing regional, multi-country and individual country needs*

There is evidence that the PRBPP Phase 2 was carefully designed and implemented to meet identified regional and country needs. A Pacific Eye Care Personnel workshop was held in March 2009; this undertook a comprehensive situational analysis of Pacific eye care workplace environments. FHFNZ has been active in developing responsive curricula as evidenced in the development of introductory PGDEC modules to address gaps in nursing education, the development of a diabetes eye care diploma and creating progressive specialisation through the Masters Programmes. Curricula are reviewed regularly and are responsive to local context (for example, the inclusion of lime burn prevention and treatment in PNG Programme content). In addition, curricula include health promotion, community eye care and equipment maintenance (for example, slit lamp repair), all appropriate to Pacific health delivery considerations and challenges.

FHFNZ also is active in conducting original research, such as the national eye health surveys in Fiji and Timor-Leste (2010) and prisoner eye health survey in PNG (2010). There is evidence that FHFNZ has also worked with national partners and regional organisations to advocate for and support the development of eye health national plans (FHFNZ, 2009a and 2010e). Examples include FHFNZ work with the Timor-Leste MOH to develop the 2006–2022 National Eye Health Strategy and ongoing FHFNZ support for Pacific Eye Care Society (PacEYES).

The Programme aims to collect data to monitor and respond to individual country needs on an ongoing basis. The extent to which the Programme collates data to scope regional need, and therefore a common regional (or national) response, is unclear. PRBPP activities and reporting are separated into PEI, PNG and Timor-Leste Programmes. PEI activities extend into other PICs, principally Vanuatu, Solomon Islands and Samoa on an individual country-need basis. Overall, the PRBPP is organised as three distinct Programmes that are managed by FHFNZ Auckland but that do not have a strong identity as a regional health mechanism seeking regional responses to shared regional problems. The Independent Progress Review of the Avoidable Blindness Initiative found that PRBPP had “weak links with other Pacific regional programs”, such as the Strengthening Specialised Clinical Services in the Pacific programme, Pacific Framework for the Prevention and Control of Non-Communicable Diseases and WHO (Constantine and Shaw, 2010: 29).

## 5.2 Programme administration and management

This section considers the extent to which the administration and management of PRBPP (organisational structure, operational procedures, policies and personnel) has been efficient and effective.

The FHFNZ is a mature non-governmental organisation (NGO), with a well-established organisational structure, operational policies and procedures. FHFNZ was well placed to implement and deliver the PRBPP 2009–11. The current Programme was built on the foundations of PRBPP Phase 1, 2002–2008, and Programme maturation is particularly evident in the PEI Programme site.

There was a significant expansion of Programme staff capacity over the evaluation period. The 2009 Programme report notes that it has been challenging to develop related policies and procedures in a short space of time (FHFNZ, 2009 Annual Report: 46). All PEI, Timor-Leste and PNG staff have employment contracts and performance reviews (FHFNZ 2009, Annual Report: 15, 40; FHFNZ, 2010g: 81).

The Programme has sufficient management and administration staff (such as accountancy support), to run efficiently and effectively in the three country Programmes visited by the evaluation. Staffing challenges have included difficulty in recruiting specialist personnel; PEI for example, has only one full-time optometrist but needs further optometrist supervision for PGDEC students. At present, additional optometrist support has to be contracted from overseas for short stints. The sole ophthalmologist in the PNG Programme also requires additional support; his capacity to undertake cataract surgeries has been severely restricted by the number of emergency cases (FHFNZ 2010e: 13). There have also been several key Programme personnel changes over the 2009–11 period (new International Programmes Director and Timor-Leste and PNG Country Managers in 2010). The PNG Programme faces significant change at the end of 2011 when the expatriate Country Manager, Ophthalmologist and Education Manager contracts will end. With the exception of PEI management, most PRBPP Programme management positions are filled by expatriates.

### *Staffing*

The following table outlines the 2011 PRBPP staff resource.

**Table 5: PRBPP staffing structure and numbers**[4]

| PEI (n=24) | PNG (n=26) | Timor-Leste (n=23) | FHFNZ |
|---|---|---|---|
| ▪ Director<br>▪ Associate Director<br>▪ General Manager<br>▪ Education Manager/ Optometrist (E)*<br>▪ Senior Nurse Manager<br>▪ 1 Ophthalmologist<br>▪ 1 Diabetes Eye Nurse<br>▪ 9 Nurses (OT/Eye Clinic)<br>▪ 2 Technicians<br>▪ 3 Office staff<br>▪ 3 Support staff | ▪ Country Manager (E)<br>▪ Education Manager (E)<br>▪ 3 Ophthalmic Clinicians<br>▪ Refractionist<br>▪ 6 Nurses<br>▪ Theatre<br>▪ 4 Community health workers<br>▪ Lecturer (E)<br>▪ 3 Office staff<br>▪ 3 Support staff<br>▪ Work Force Support Contractor (E) | ▪ Country Director (E)<br>▪ NEC General Manager (E)<br>▪ Programme Manager (E)<br>▪ Education Manager (E)<br>▪ Trainer<br>▪ Education Programme Assistant<br>▪ Office Manager<br>▪ HR Manager<br>▪ 1 Ophthalmologist (E) (left August 2011)<br>▪ 3 Ophthalmic Technicians<br>▪ 1 Nurse<br>▪ 1 Health Promotion Coordinator<br>▪ 2 Community service staff<br>▪ Outreach Team Leader<br>▪ Workforce Development Manager<br>▪ 1 Office staff<br>▪ 4 Support staff | ▪ International Programmes Manager<br>▪ Medical Director (p/t)*<br>▪ Professional Development Director<br>▪ Monitoring and Evaluation Manager |

**Note: (E) = Expatriate staff, p/t = part time.*

**Table 6: PRBPP staff broken down by nationality and job role**

| Total staff | PEI: 24 | PNG: 26 | Timor-Leste: 23 |
|---|---|---|---|
| Pacific | 22 | 21 | 18 |
| Expatriate | 2 | 5 | 5 |
| Clinical/Professional | 18 | 19 | 18 |
| Administrative | 6 | 7 | 5 |

[4] FHFNZ 2010e.

### *Administration and management of training and workforce support processes*

PEI applies rigorous criteria to candidates who are considered by a selection panel. The success of this process can be seen in the high completion rate. Selection mechanisms for PIC candidates (for example, from Vanuatu and Solomon Islands) are less clear. In Solomon Islands, candidates are required to do a clinical placement at the National Referral Hospital Eye Clinic in preparation for PEI training. Solomon Island students and graduates felt this had prepared them well for specialist training. In Timor-Leste, candidates are selected by the MOH and/or Institute of Health Sciences, which the evaluation found can result in a mismatch between individuals' aspirations and eye health training. This may be compounded by candidates being high school graduates rather than experienced nurses. In PNG, the Academic Committee determines selection criteria and has increased their strictness in order to select the best candidates in response to oversubscription (FHFNZ, 2010e: 73). The evaluation asked current students and graduates (n=64) about the application process: 59 (92 per cent) rated it as very good or good.

The organisation of training clinics differs across Programme sites. The new PEI building has resulted in increased teaching and learning efficiency as it brings together clinical and academic facilities. In Madang, the Eye Clinic has insufficient space for clinical services and no space to provide training. In Timor-Leste, there is a split site arrangement, with classroom learning located at the Institute of Health Sciences, clinical learning at Timor-Leste National Hospital and the FHFNZ urban health clinic staffed by the FHFNZ ophthalmologist. There is also a Spectacle Centre at the FHFNZ Programme office which belongs to Fo Naroman Timor-Leste (FNTL), a self-governing local NGO partner.

The PRBPP delivery model combines supervised clinical learning in clinic settings in Suva, Madang and Dili, with outreach both within countries and regionally (in the case of PEI). This model combines teaching and learning with clinical service provision, a powerful and efficient combination as it generates patient cases for learning, enables ongoing workforce development for less-experienced staff and provides scaled-up eye health care. This combination has allowed a significant increase in the number of people accessing eye care services in Fiji, PNG, Timor-Leste and the wider Pacific region (FHFNZ, 2010e).

A key feature of the PRBPP training is the continuing professional development (CPD) and workforce support provided to graduates. This support is managed differently for each Programme site and is more comprehensive for nurse graduates than doctors. PEI nurse graduates are supported by the FHFNZ Professional Development Director with annual visits. Graduates (nurses and doctors) also receive ongoing clinical and CPD support from PEI and FHFNZ staff via email contact and outreach visits. However, the FHFNZ Professional Development Director is based in Australia, and travel to PICs to visit an increasing number of graduates means this role will be increasingly stretched.

Graduates in PNG and Timor-Leste are supported by country Programme staff and visiting workforce development staff. Graduates' home clinic visits are central to PRBPP workforce support. In 2009, 18 out of 19 eye nurse graduates received workforce support visits in their home clinics (FHFNZ, 2009 Annual Report: 22). In 2010, all graduates (both nurses and doctors) received on-site assessment visits (FHFNZ, 2010e: 10). Individual clinic visits are more costly (and incur a heavy security cost in PNG) than bringing graduates together, but Programme stakeholders felt strongly that home clinic visits allowed a real grasp of service and clinical issues faced by graduates, along with the assessment of how graduates applied their training in the workplace. At present, workforce support is managed by expatriate staff (excluding support during PEI outreach visits).

Other regionally coordinated workforce support activities include the *Eye Care News* e-newsletter (first produced in August 2009); continuing educational materials distributed to eye health nurses; and a regional Self-Assessment Module for continuing clinical education (FHFNZ, 2009 Annual Report: 23). FHFNZ also supports PacEYES by filling the role of Secretariat and hosting the PacEYES annual general meeting at regional FHFNZ meetings. This cross-Programme management of workforce support represents an efficient way to reach graduates across the region.

Graduates returning to work in rural practice (provincial or secondary hospitals or health clinics) are potentially more isolated than centrally located clinics as they are often the sole eye health professional. Workforce support visits to rural locations are more costly in money and time than to centrally located clinics. In addition, rural nurses may face constraints to practice or to improving their eye health skills. Reasons for this include the following:

- because of a shortage of nurses they are needed for general nursing provision
- pressure on budgets and transport challenges restrict local outreach resulting in fewer patients and less clinical practice and experience for eye health nurses
- because of telecommunication challenges they are less connected to in-country and PEI colleagues for professional support.

These factors may reduce the efficiency of more rural PRBPP graduates.

The FHFNZ Auckland office provides efficiencies in overarching Programme functions, such as monitoring and evaluation (although this capacity is limited in 2011 in terms of full-time equivalent staff and augmented by the International Programme Director and the Country Managers), Programme reporting, organisation policies such as those for HR management and operational procedures, for example, financial reporting. In addition, Programme efficacy and efficiency is strengthened by having a regional Medical Director who provides senior clinical advice and leadership to country doctors who may be practising as sole ophthalmologists.

Overall, FHFNZ is considered by stakeholders to be responsive and to get things done with a focus on quality.

## 5.3 Efficiency of the delegated aid arrangement

PRBPP Phase 2 was funded under a delegated aid arrangement between the then New Zealand Agency for International Development (now MFAT), AusAID and FHFNZ. The delegated arrangement was new to Phase 2[5] and provided joint funding from NZAID and AusAID on a grant basis (New Zealand High Commission – Canberra, 2009: 3). AusAID's support was part of its Avoidable Blindness Initiative. AusAID contributions were paid into an NZAID trust fund to be managed by NZAID based on agreed Programme work plans and budget. NZAID was responsible for managing funding payments to FHFNZ and monitoring Programme reporting and audits. NZAID provided reports to AusAID and Tripartite (FHFNZ, MFAT and AusAID) meetings were held annually. Most Programme contact was between FHFNZ and MFAT but the delegated arrangement also stipulated that all parties "may consult each other on any matter of common interest arising out of the

[5] PRBPP Phase 1 and the work of FHFNZ in the Pacific had been supported by NZAID over 2002–09.

implementation of the Programme" (ibid: 5). The evaluation found that FHFNZ–AusAID contact over 2009–11 had mainly been through the annual tripartite meetings, with some direct contact as required by AusAID Programme managers.

FHFNZ stakeholders noted that the delegated aid arrangement resulted in reporting efficiencies because it required one formal reporting stream on funded activities. There were, however, reported potential communication weaknesses between parties; for example, MFAT and AusAID Posts interviewed by the evaluation knew little about the Programme (managed from Wellington and Canberra respectively). Donor stakeholders in Fiji pointed out, in particular, that they were often not aware of PEI activities. One donor stakeholder noted that the delegated aid arrangement had resulted in a slower process for the release of funds but did not feel that this had actually delayed Programme implementation. It is important to note the significant change and restructuring in both AusAID and MFAT over 2009–11, and, in particular, the change in health and disability teams that oversaw PRBPP.

## 5.4 Value for money of the Programme

The Desk Review drew on documentation relating to the actual cost of MFAT and AusAID support to the PRBPP from 1 January 2009 to 31 December 2011.

The three-year funding arrangement allocated a total NZD17,411,143 to FHFNZ to implement and manage the PRBPP Phase 2 in Fiji, PNG and Timor-Leste. Phase 2 represented a significant scaling up of previous Programme activity. Programme resourcing was split over the three sites as outlined below.

**Table 7: Total allocated Programme funding per year[6]**

| Programme site | 2009 | 2010 | 2011 |
|---|---|---|---|
| | Allocated NZD6,177,457 | NZD6,091,426 | NZD5,142,260[7] |
| PEI | 3,666,707 | 3,961,496 | 2,622,492 |
| PNG | 1,235,300 | 1,239,755 | 1,497,290 |
| Timor-Leste | 1,275,450 | 890,175 | 1,022,478 |
| **TOTAL** | **NZD17,411,143** | | |

Value for money is defined by MFAT as "achieving the best possible development outcome over the life of an activity relative to the total cost of managing and resourcing that activity and ensuring that resources are used effectively, economically and without waste" (MFAT).

[6] Donor Funding Arrangement between NZAID and AusAID 2009-11.

[7] Including additional funds NZD559,507 as per Letter of Variation No 3.

### *Cost of Programme 2009–11*

**Table 8: Programme funding from MFAT and AusAID per year**

| Financial year | MFAT[8] | AusAID | AusAID contribution to MFAT management costs[9] | Programme cost per year |
|---|---|---|---|---|
| 2008/09 | 2,059,152 | 4,118,305 | 2.5% up to NZD77,727 | 6,177,457 |
| 2009/10 | 2,030,475 | 4,060,952 | NZD77,727 | 6,091,426 |
| 2010/11 | 1,527,584 | 3,055,169 | NZD149,235 | 5,142,260[10] |
| **TOTAL** | **NZD5.6 million** | **NZD11.2 million (AUD 9.8 million)** | **NZD304,689** | **NZD17,411,143** |

Programme activities for the period 2009–11 were broadly grouped into two main areas: **Institutional and Clinic Strengthening** and **Workforce Training and Support** as outlined below.

[8] The evaluation was not provided with MFAT's management costs.

[9] This contribution to management costs was included in the total AusAID contribution of AUD9.8 million.

[10] Including additional funds NZD559,507 as per Letter of Variation No 3.

**Table 9: Programme activities 2009–11**

| Programme Objective | Activities | Budgeted cost | Amended cost[11] |
|---|---|---|---|
| 1. Institutional strengthening | ▪ Curricula<br>▪ Teaching infrastructure<br>▪ Academic staff<br>▪ Institutional management<br>▪ Institutional reliability<br>▪ Research | NZD5,116,615 | NZD5,314,058 |
| 2. Clinic strengthening | ▪ Clinical staffing<br>▪ Clinical service management<br>▪ Equipment and infrastructure<br>▪ Health system strengthening | NZD5,052,957 | NZD5,364,157 |
| 3. Workforce training | ▪ Scholarships<br>▪ Student equipment<br>▪ Trainers | NZD2,353,735 | NZD2,353,735 |
| 4. Workplace support | ▪ Graduate support<br>▪ Community access<br>▪ Health system strengthening<br>▪ Regional representative body | NZD2,142,818 | NZD2,142,818 |
| 5. Monitoring, evaluation and learning | ▪ Annual reflection process<br>▪ MEL staff | NZD653,545 | NZD653,545 |
| 6. FHFNZ Programme management (10%) | | NZD1,531,967 | NZD1,582,831 |
| **TOTAL** | | **NZD16,851,637** | **NZD17,411,144** |

Within institutional and clinic strengthening, the bulk of Programme resources were spent on curricula, teaching infrastructure and academic and clinical staff. Within workforce training and support, the bulk of Programme resources were spent on scholarships and graduate support.

The PRBPP provides some support for clinical outreach visits in PNG, Timor-Leste and PEI (Objective 4.2 Community Access), but the level varies in each country. PNG, in particular, has experienced resourcing pressures to both conduct outreach visits and service the Madang Eye Unit, which has seen a sharp increase in patient numbers (FHFNZ, 2010e: 89). PEI outreach visits are reported to be partly funded (around 60 per cent) by PRBPP with the remainder sought from other donors (PEI email communication, 19 October 2011).

### *Outputs and outcomes*

Over 2009–11, the Programme has achieved the desired outcomes and targets for every objective in PEI and PNG and made significant progress towards achieving them in Timor-Leste in terms of relevant courses delivered, training and workforce support activities, clinical facilities upgraded and eye care provision.

[11] Following Letter of Variation No 3 additional funding of NZD559,507.

By expanding eye care service delivery, the PRBPP workforce development has resulted in an additional benefit for Pacific eye health. Early diagnosis and treatment (for diabetic retinopathy, for example) can save cost later. The majority of stakeholders emphasised the "priceless" value of sight and its impact on individuals, work and productivity, families and communities.

The PRBPP significantly increased the number of qualified eye care nurses servicing the region. This may represent a cost-efficient way to maximise eye health service capacity in the delivery context of very few ophthalmologists. The nursing workforce both refers patients to, and clinically supports, visiting ophthalmologists, making these visits more efficient.

In addition to delivering specialised qualifications, the PRBPP has also expanded the pool of Pacific specialists who can potentially undertake mentoring and future training of nurses and doctors. The PEI, in particular, has strengthened this group of Pacific specialists. FHFNZ works with MOHs to advocate efficient utilisation of PRBPP graduates in country health systems but notes its "ability to directly influence [this] varies from country to country" (FHFNZ, 2009 Annual Report: 17).

Another positive outcome of the PRBPP, and particularly the new PEI, has been the raised profile of eye health and ophthalmology as a career choice.

### *Value for money*

As outlined above in the Effectiveness section, the Programme achieved almost all its objectives in terms of the targets set out in the Agreement and surpassed most of them (with the exception of Timor-Leste). It made good progress on most of its desired outputs and outcomes. The extent of this means it is unlikely that more or better outputs and outcomes could have been achieved with the same resources.

The evaluation considered potential alternative approaches to the present PRBPP model of workforce training and support.

**Table 10: Alternative delivery models for workforce development**

| Alternative approaches | Pros | Cons |
|---|---|---|
| Satellite training hubs in PICs | ▪ No travel and subsistence costs if students remain in-country<br>▪ Part-time option to continue working while studying | ▪ Poor economies of scale for smaller countries<br>▪ Medical teaching capacity in some countries is currently limited |
| Distance learning | ▪ Already trialled in PEI course via Pacific Open Learning Health Network<br>▪ Students able to remain in-country and continue working while studying | ▪ Self-directed study more challenging<br>▪ Students potentially isolated<br>▪ Dependent on efficient ICT<br>▪ Lack of direct clinical supervision |

Stakeholders agreed that the PRBPP model of training, combined with ongoing workforce development, is unique. This, in combination with the Programme's offer of locally tailored curricula, means that the PRBPP has a high value in the absence of other comparable opportunities in the Pacific. Several stakeholders identified the PRBPP's added value as a regional structure providing specialist health training for PICs.

Programme spend has been monitored and reported in FHFNZ Annual Activity Progress Reports. Budget overspending has been due to price rises (for example, in equipment costs in Timor-Leste) (FHFNZ, 2010e: 66) or underestimated costings (for architect services for the new PEI building) (FHFNZ, 2020e: 46). Additional funds were agreed in 2011 (Letter of Variation No 3). The evaluation did not find any evidence of wasteful spending by regional or country offices. Of note is the efficient completion to time and within revised budget of the new PEI building in Suva.

The evaluation did not find any evidence that FHFNZ could have significantly reduced its Programme delivery costs over 2009–11, and it is unlikely that the same Programme outcomes could have been achieved for less money.

Key to note, however, are other Programmes and FHFNZ funding streams that impact closely on PRBPP areas. These include: Fred Hollows Foundation Australia funding of the National Eye Centre building project in Timor-Leste (2009); KOHA funding of an eye care service in West New Britain and establishment of a clinic in Madang; FHFNZ core funding (that is, non-PRBPP funding) supporting delivery of a certificate-level course aimed at lower level health personnel in PNG. Other funding streams, including World Diabetes Foundation funding have purchased clinical equipment for FHFNZ-managed clinics (FHFNZ, 2009 Annual Report: 7).

## 5.5 Facilitators and barriers to Programme implementation

Facilitators to Programme efficiency include:

- credibility and capacity of FHFNZ to operate regionally
- resourcing Human Resource capacity for the Programme (for example, following increased management capacity at PEI, the Medical Director can focus on clinician role)
- appropriate staff recruitment (effective, well-qualified people filling management roles)
- appropriate student selection (leading to high retention, high completion rates)
- active workforce support for graduates that enhances their efficiency to practise post-graduation
- investment in annual country and regional reflections to foster Programme and organisational learning
- good working relationships with partner universities (DWU and Fiji National University (FNU) and Fiji School of Medicine, Fiji School of Medicine (FSM) and IHS).

Barriers to Programme efficiency include the following.

- Effective coordination with other eye health organisations working in the region is challenging; for example, the number and origin of fly-in fly-out visiting surgical teams.
- Weak in-country health infrastructures and supply chains can mean equipment and consumables are not available.
- Small 'pool' of Pacific ophthalmologists currently means a reliance on expatriate professionals for teaching.
- Nursing shortages in PNG, Timor-Leste and across the Pacific impede Programme efficiency as they limit the number of nurses released for training and can mean that graduates do not work all, or most, of their time in eye health.

## 5.6 Conclusions

Overall, the PRBPP delivery and management has been conducted in an efficient manner and has achieved desired Programme outputs and outcomes. Over 2009–11, PRBPP has significantly increased the numbers of eye health professionals and access to eye care in Fiji, PNG, Timor-Leste and the wider Pacific region. FHFNZ policies and procedures appear sound and stakeholders generally consider it to be an efficient organisation.

The Programme delivery model allows for the following features, which are efficient and effective.

- A regional training hub at PEI is an efficient mechanism for specialised training delivery to participants from widely dispersed Pacific countries. Suva is a regional centre and this increases travel and time and cost efficiencies for students and outreach visits.
- Outreach visits are a valuable combination of clinical learning with service delivery.
- A higher number of patients are being treated and operated on by PRBPP staff and students.

The evaluation did not find any evidence that FHFNZ could have significantly reduced Programme delivery costs. Given the achievement of Programme outputs and outcomes it is unlikely that more or better outputs and outcomes could have been achieved with the same resource. Alternative approaches to workforce training and support are constrained by the size of PICs, the small 'pool' of eye specialists to teach and ICT.

Without the PRBPP funding, eye care human resource capacity in the region would be significantly reduced. In addition, far fewer people in Fiji, PNG, Timor-Leste and the Pacific region would have received eye care and treatment. Given this, and the lack of comparable training opportunities (in terms of scale and tailored curricula), the Programme is providing value for money for eye health human resource development.

# 6. Sustainability of PRBPP

This section answers ***Evaluation Objective 4: To assess the sustainability of the PRBPP activities***. It includes:

- the extent to which Programme benefits are owned by Timor-Leste, PNG and participating Pacific governments, local NGOs and universities and how the Programme has contributed to domestic ownership
- the extent to which the Programme is likely to be sustainable in terms of ownership, management arrangements, funding and sustainability of benefits
- factors that constrain or enhance Programme sustainability
- how, if at all, would Programme sustainability be impacted should the governance and structure of the FHFNZ change.

## 6.1 Country ownership of Programme benefits

This section reviews the extent to which Programme benefits are owned by Timor-Leste, PNG and participating Pacific governments, local NGOs and universities, and how the Programme has contributed to domestic ownership.

The PRBPP (PEI, PNG and Timor-Leste) are at different levels of maturation. This, along with differing levels of resources, has had a significant impact on the extent to which local ownership of benefits has been achieved.

In Fiji, PEI is broadly viewed by stakeholders as a Pacific regional organisation working with the Government of Fiji. MOH stakeholders, however, had a strong sense of ownership of the Programme benefits in terms of service provision in the Fiji health system. In Vanuatu and Solomon Islands, the PRBPP is strongly associated with PEI, which is seen as a regional Programme (staffed by Pacific nationals) rather than one that is owned in-country. Most in-country stakeholders (MOH and hospital staff) showed a strong sense of owning specific Programme benefits, however, namely the up-skilling of medical staff. In PNG and Timor-Leste, the country Programmes are broadly viewed as foreign, run by FHFNZ and staffed by expatriates. However, in common with Fiji, Vanuatu and Solomon Islands stakeholders, the PEI is considered to be a Pacific organisation and operation.

Local ownership of the Programme by universities and NGOs differs in Fiji, PNG and Timor-Leste. Both PEI and PNG Programmes are associated with local universities but at different levels of integration. There is a close working relationship between the PNG Programme and DWU; the PGDEC is part of DWU Faculty of Health, and DWU has committed to expansion of eye health academic capacity by creating two new posts in the Eye Department, one funded by DWU, the other by FHFNZ. DWU has also expressed its intention for all training to be undertaken by local people by 2018. The location of the PNG Programme at Madang is perceived by stakeholders to be slightly problematic in terms of its lack of a joined-up approach (with UPNG) to eye health workforce development in PNG.

UPNG is the only institution training doctors and ophthalmologists in PNG. Stakeholders also perceived some distance between PRBPP in Madang and the PNG MOH.

In Fiji, PEI courses are accredited by FNU but are delivered completely separately. At present, medical students at FSM do their eye health rotation through CWMH and thus at PEI, but there is no integration of these student doctors into PEI teaching and learning. The delivery of PRBPP-supported training in Timor-Leste is not done in partnership with a university. In Timor-Leste, FHFNZ has worked closely with a national eye care NGO (FNTL) and the RACS to build its institutional capacity. This has included strengthening the integration of eye health into wider national health activities such as community health (FHFNZ, 2009 Annual Report: 44).

There is evidence that FHFNZ has actively pursued efforts to strengthen local ownership of the Programme. Key points to note for specific Programme sites are listed below.

- The Programme and FHFNZ have advocated strongly with country governments to develop and commit to national eye health plans.
- FHFNZ has supported the Timor-Leste MOH to establish its Eye Health Unit to support the implementation of the 2006–11 National Eye Health Strategy of which PRBPP is part.
- Local capacity building of management and clinical staff has occurred. This includes local recruitment, when possible, and training and mentoring promising individuals to take over expatriate-filled roles, such as that of nurse manager in PNG. There is also early progress of PNG graduates taking some teaching roles, for example, teaching the operating theatre module.
- Fostering active participation by country Programme staff in annual reflections to build and strengthen their practice and professional development.
- FHFNZ has celebrated Programme successes as country successes, for example, the official opening of the new PEI building.

PEI and the Timor-Leste Programmes are actively building relationships with country institutions (MOHs, universities and hospitals). In PNG, building Programme relationships with central government institutions is challenging because the Programme is located in the capital, Port Moresby, and is associated with a regional university (DWU) rather than the national medical training institution (UPNG), although two PNG doctors who trained under PRBPP received their degrees from UPNG.

## 6.2 Sustainability of ownership

This section considers the extent to which Programme benefits are likely to be sustainable in terms of ownership, management arrangements, funding and sustainability.

Any consideration of the extent to which Programme sustainability can be achieved within a three-year Programme period must be realistic. PEI builds on PRBPP Phase 1 and matured quickly, which may positively relate to sustainability. PEI has strong internal management and ownership and, with its current staff, could, with the right support, move to self-management in the short-to-medium term. PNG and Timor-Leste operations are at an earlier stage of institutional development and any future sustainability is further away. Across the three Programme sites, sustainability of ownership, management, funding and

benefits is unlikely in the near future, but PEI is closest to it. The reasons for this are outlined below.

Although Programme staff in PEI, PNG and Timor-Leste are operating within countries' health systems (that is, PRBPP training clinics are located in CWMH, Modilon and Timor-Leste hospitals' eye health clinics), these staff are independent FHFNZ and PEI employees rather than in-country MOH employees. There is joint working, for example, in the PEI-CWMH Joint Management Committee and Modilon Hospital Management Committee, but PRBPP systems are independent of hospital systems in PEI, PNG and Timor-Leste. This has ensured FHFNZ maintains control over quality standards but has meant lack of harmonisation of systems, such as patient flow management and data management.

Most of the senior staff at PEI are Pacific nationals, but expatriates make up the core Programme teams in Timor-Leste and PNG. This limits the immediate to short-term local sustainability of management arrangements of the Programme in these sites. It is particularly difficult to recruit Pacific nationals for roles requiring a combination of training, qualifications and clinical experience (FHFNZ, 2009 Annual Report). It is also important to note that clinical specialists take five years plus to train, and thus building specialist health and education capacity requires a long-term strategy.

Underlying sustainability is the degree to which the Programme is integrated into countries' health infrastructure, including support from country budgets:

> *We want countries to own eye health, not the PRBPP. Ownership is around being prepared to fund it [eye health].* (Donor)

The Government of Fiji supports PEI operating costs (for example, utilities and consumables) under its Memorandum of Understanding with PEI. It is unclear whether the Government of Fiji would be in a position to support full PEI costs that are currently supported under the PRBPP. In addition, the Programme represents a significant resource for Fiji and other governments' eye health care.

Several stakeholders noted that country budgets for eye health have shrunk as a result of the Programme. For both MOHs and eye departments, there may then be a perverse incentive to access resources for eye health care from out-of-country donors. A few stakeholders also felt that the Programme had insufficient emphasis on sustainably integrating eye health into primary and community health care; such integration would reduce the risks of vertical delivery of eye health care.

Programme documentation indicates that the development of sustainability plans is a key concern for the Programme, but it is unclear whether any plans have been signed off. However, there is evidence that sustainability planning is being explored, particularly for PEI (FHFNZ, 2010g). FHFNZ has sought to develop a sustainability strategy for PEI and has undertaken discussions with MOHs, FSM and the University of the South Pacific (USP) (FHFNZ 2009a: 15; FHFNZ 2010g: 24). One potential option considered for PEI is a merge with the FSM. FSM capacity and capability to incorporate PEI in the immediate or near future was questioned by several stakeholders, however, particularly given FSM's own recent merger with FNU. PEI is currently seeking sources of alternative funding, such as fees and student sponsorship. There are, however, limits to revenue generation via self-funding students because of the low salaries in the region.

## 6.3 Facilitators and barriers to Programme sustainability

Stakeholders identified several factors that constrain or enhance Programme sustainability across different country contexts as listed below.

- The extent to which the Programme is integrated in country health infrastructure (hospitals and universities). For example, DWU is building academic expertise in eye health via two new roles established for 2012 (one role is funded by FHFNZ, the other by DWU).
- The strength of country management and systems for human resources for health planning and resourcing. It is unlikely that specialist training, particularly for eye health nurses, would be funded by Pacific governments in the absence of the PRBPP in the near future.
- The extent to which eye health is integrated into national health eye plans. Outreach countries such as Vanuatu and Solomon Islands at present rely on the Programme for a substantial proportion of service provision because they do not have sufficient country numbers of specialist eye professionals. This reliance will continue in the short-to-medium term.
- Lack of priority to recognise and support eye health in budgets. Eye health is perceived by some stakeholders to be essential but not currently prioritised, perhaps in part because it is externally resourced (by PRBPP and visiting medical teams).
- Individual leaders and mentors, such as Dr John Szetu, are critical to mobilising interest in and support for eye health.
- Alternative sources of funding. If the Programme is significantly funded by dedicated donor money, this makes sustainability more challenging.

## 6.4 Impact on Programme sustainability of FHFNZ change

The evaluation was asked to assess how any change in FHFNZ governance and structure may affect Programme sustainability.

The current funding round comes to an end in December 2011, and FHFNZ and MFAT are at present in discussion about the immediate-future funding arrangements. This may mean potential governance and structural changes for PRBPP in the future. If there is a significant funding reduction, and therefore fewer external resources, this may impact on PRBPP staff resources in PEI, PNG and Timor-Leste. This represents a considerable risk to maintaining the sustainability of Programme operations, particularly in PNG and Timor-Leste. PEI is less reliant on management and governance structures from Auckland but is currently reliant on FHFNZ and PRBPP for core funding.

## 6.5 Conclusion

The PEI, PNG and Timor-Leste Programmes show different levels of maturation. Across the three Programme sites there is localised evidence of country ownership of benefits, and

there is evidence that FHFNZ has contributed to this ownership. Overall, however, the current three-year Programme has not been established long enough to achieve local ownership, particularly for the PNG and Timor-Leste operations. There is potential for local sustainability of PEI, with the appropriate planning and support.

Expatriates currently make up most PRBPP staff in PNG and Timor-Leste, and the Programme faces challenges in recruiting local staff for these positions.

Sustainability is closely linked to the degree to which the PRBPP is integrated in PICs' health infrastructure. Many facilitators and barriers to Programme sustainability thus lie within country infrastructure and systems.

Any significant change in FHFNZ governance and structure, as a result of decreased PRBPP resources, represents a risk for ongoing Programme sustainability.

# 7. Lessons Learnt and Recommendations

This section answers ***Evaluation Objective 5: To identify lessons learnt and to make recommendations.*** It summarises the key lessons learnt in relation to the relevance, effectiveness, efficiency and sustainability of the PRBPP. This section also makes recommendations to improve the relevance, effectiveness, efficiency and sustainability of the Programme, as well as informing FHFNZ's future work and MFAT and AusAID in terms of their future relationship with FHFNZ.

## 7.1 Lessons learnt and recommendations

### *Relevance of the PRBPP in PNG, Timor-Leste and the Pacific region*

The Programme's focus on workforce development and support is highly relevant to PNG, Timor-Leste and the Pacific region, and this relevance is compounded by the concurrent increase in clinical service. The Programme is relevant to broad eye health priorities, but the PNG programme may benefit from a national eye health survey to increase its relevance to particular local priorities.

The Programme has adapted training curricula to meet local needs and contexts and is focused on developing a workforce able to appropriately operate in a range of settings, including at community level and in support of surgical visits in district or provincial centres.

Countries' capacity to absorb eye care specialists and their services at all levels will take time and require ongoing support. The evaluation found evidence of debate in some Programme countries regarding conceptual and practical programming models, including the appropriate balance of effort on public and primary health versus a specialised, vertical model.

There are no government or international partner initiatives comparable to the PRBPP that are providing support for the training of mid-level eye care workers at the same scale or with similar rigor and focus.

Gender mainstreaming principles have not been strongly incorporated into Programme implementation to address this major cross-cutting development issue.

**Recommendations to improve the relevance of the PRBPP to country and regional needs**

- ⇨ Consider ways to strengthen the integration of PRBPP eye health training and service into primary health to increase relevance to country health delivery contexts.
- ⇨ Explore and expand online delivery options so that health personnel can combine study and work as appropriate.
- ⇨ Continue the strong research into Pacific eye health and consider a population-based eye health survey in PNG.
- ⇨ Consider undertaking a gender audit of PRBPP to inform the development of a strategy that would respond to gender disparities in eye health and eye health programming, and address gender-related issues of professional workforce development.

### *Effectiveness of the PRBPP*

The Programme has achieved a great deal over its three-year timeframe and has made significant progress against its major outcomes: well-managed training institutes and clinics; good working relationships with most partner institutions; a significant increase in the number of trained eye professionals and a quality eye service. This success has been facilitated by the strong overall leadership and management by FHFNZ.

The PRBPP model of training, combined with ongoing workforce support and development, is highly valued by graduates and MOH stakeholders. In some sites, Programme maturation has enabled more targeted planning for recruitment and placement approaches, for example, pairing graduates in home clinics. Workforce support for doctor graduates could be improved to resemble the formal model supporting nurse graduates.

FHFNZ has sought to align and coordinate its activities with other donor activity, particularly in Timor-Leste where FHFNZ works closely with RACS, but this is a challenging issue requiring dedicated partnership working.

**Recommendations to improve the effectiveness of the PRBPP**

- ⇨ Develop a formal workforce support model for doctors as well as nurse graduates.
- ⇨ Design a model of workforce support that responds to the increasing numbers of graduates across PEI, PNG and Timor-Leste (particularly those working in remote and/or isolated locations).
- ⇨ Continue to support PacEYES as a regional organisation working with PIC government partners.
- ⇨ Increase and improve engagement with MOHs and country primary and tertiary health systems.
- ⇨ Continue to advocate for professional association membership and other formal recognition for nurses.

### *Efficiency of the PRBPP in delivering Programme outputs and outcomes*

Overall, PRBPP delivery has been conducted in an efficient manner and has achieved desired outputs and outcomes, and FHFNZ is broadly viewed by Programme stakeholders as an efficient organisation that has met country needs.

The FHFNZ has offered strong governance and management of the PRBPP in PEI, PNG and Timor-Leste. The centralised PRBPP governance and management from FHFNZ Auckland has allowed Programme efficiencies across certain activities, such as HR management policies, monitoring and evaluation and donor reporting. Country Programme stakeholders perceived some gaps in regional staffing, however, specifically in education oversight and public health expertise.

Efficiencies of partnership through working with universities and hospitals in PNG and Timor-Leste have been affected by systemic challenges in health infrastructure and service delivery. There is room for improvement in the coordination between the PNG Programme and UPNG to achieve the efficiencies of a more unified national eye health workforce development program.

PRBPP training and workforce development has allowed a concurrent expansion in the number of people accessing eye care in Fiji, PNG, Timor-Leste and PICs visited by PEI outreach services. This offers efficiency and value for money benefits.

**Recommendations to improve the efficiency of the PRBPP in delivering Programme outputs and outcomes**

- ⇨ Consider recruiting an education specialist to provide regional curriculum and education oversight in the same model as the Medical Director provides clinical oversight.
- ⇨ Seek ways to address the current disconnect between UPNG and PRBPP training in DWU.
- ⇨ Increase advocacy and coordination with the PNG MOH.
- ⇨ Continue to seek ways to strengthen partnership working with PIC MOHs to avoid vertical delivery of eye health training programming and service provision.
- ⇨ Seek to harmonise data collection and management with country MOH systems.

### *Sustainability*

There are differing levels of Programme maturation across the three Programme sites. There is also localised evidence of country ownership of Programme benefits, such as the up-skilling of Pacific nationals, increased professional competence and confidence to provide clinical care and increased service delivery.

The PEI Programme is closer to local sustainability than those in PNG and Timor-Leste. Sustainability is closely linked to the degree to which the PRBPP is integrated in PICs' health infrastructure and the local HR capacity.

The capacity and capability of FHFNZ as a regional NGO strengthens the sustainability of graduates' clinical skills, particularly in the period immediately following graduation by

having a Medical Director and Professional Development Manager to support doctors and nurses.

With the end of PRBPP Phase 2 in December 2011, there are uncertainties over future funding and what this means for the sustainability of Programme benefits.

**Recommendations to improve the sustainability of PRBPP activities**

- ⇨ Continue to build local human resource capacity for clinical and management roles.
- ⇨ Explore ways to strengthen PRBPP links with other regional health mechanisms in the Pacific.
- ⇨ Commit to a sustainability plan for PEI.
- ⇨ Continue to develop and strengthen comprehensive strategies to localise teaching and management roles.

# 8. Appendices

## Appendix 1: Glossary

| | |
|---|---|
| AusAID | Australian Agency for International Development |
| CEC | Certificate in Eye Care |
| CPD | Continuing Professional Development |
| CWMH | Colonial War Memorial Hospital, Fiji |
| DO | Diploma in Ophthalmology |
| DWU | Divine Word University (Madang, Papua New Guinea) |
| FHFNZ | The Fred Hollows Foundation New Zealand |
| FNTL | Fo Naroman Timor-Leste |
| FNU | Fiji National University |
| FSM | Fiji School of Medicine |
| HR | Human resource |
| ICEE | International Centre for Eyecare Education |
| IAPB | International Agency for the Prevention of Blindness |
| IHS | Institute of Health Sciences |
| MCEC | Master of Community Eye Care (for Nurses) |
| MFAT | Ministry of Foreign Affairs and Trade, New Zealand |
| MMed | Master of Medicine (Ophthalmology) (FNU) |
| MOH | Ministry of Health |
| NCD | Non-communicable disease |
| NGO | Non-governmental organisation |
| NZAID | New Zealand Agency for International Development |
| PacEYES | Pacific Eye Care Society |
| PEI | Pacific Eye Institute |
| PGCDEC | Postgraduate Certificate in Diabetes Eye Care |
| PGDEC | Postgraduate Diploma in Eye Care |

| | |
|---|---|
| PGDMVD | Postgraduate Diploma in the Medical Management of Vitreo-Retinal Disease |
| PICs | Pacific Island countries |
| PNG | Papua New Guinea |
| PRBPP | Pacific Regional Blindness Prevention Programme |
| RACS | Royal Australian College of Surgeons |
| UPNG | University of Papua New Guinea |
| USP | University of the South Pacific |
| WHO | World Health Organization |

# Appendix 2: PEI Country Report

This annex presents findings for the Fiji based operations of the Pacific Regional Blindness Prevention Programme (PRBPP).

Data sources are outlined in the main body of this report. In brief, the evaluation conducted thirteen interviews with PEI stakeholders, a mini-focus group with five current students and a survey questionnaire with nineteen students and graduates.

### *Overview of regional and country situation*

There are approximately 60,000 visually impaired people in the Pacific, and of these, around 20,000 are blind. The region faces specific eye health issues such as the high incidence of NCDs as well as wider systemic health care delivery issues (low ratios of medical professionals to population, low per capita government health spending, weak infrastructure and dispersed populations (PEI 2010c: 4). For many PICs eye health provision is restricted to visiting specialist teams, and overall, there are inadequate numbers of eye health professionals and clinic facilities to prevent and treat the main causes of eye disease in the Pacific (cataracts, diabetic retinopathy, corneal blindness due to trauma and eye infections, and uncorrected refractive error (PEI 2010c: 5).

Given this need, PEI is a key plank in the PRBPP goal to prevent and reduce avoidable blindness in the Pacific.

### *Overview of PEI*

The PRBPP in the Pacific region is implemented through the Pacific Eye Institute (PEI) in Suva, Fiji, an initiative of the Fred Hollows Foundation New Zealand (FHFNZ). The PEI delivers eye health training and workforce support for nurses and doctors from Fiji and the Pacific region. The PEI seeks to train sufficient eye health workers to meet eye health needs in Fiji and the region.

The PEI was established with a team of three in Solomon Islands by FHFNZ in 2006. PEI delivered PRBPP Phase 1 2002 – 2008 (supported by NZAID).

Until November 2010, the PEI operated from premises within the Tamavua Hospital and Colonial and War Memorial Hospital (CWMH). From November 2010, the new PEI building opened, representing a significant improvement in the space and facilities available for teaching and clinical practice. In addition to delivering training, the PEI (with the CWMH) delivers eye care to the people of Fiji. There is also a PEI Diabetes Clinic based in the CWMH which opened in October 2009.

There are a number of agreements in place to govern PEI relationships with the Fiji MOH (Memorandum of Agreement) and FSM (Memorandum of Understanding) (FHFNZ 2010e: 101). As part of its MOA with the Fiji MOH, PEI and CWMH Eye Department sit on a joint management committee. PEI stakeholders felt that this joint management was generally proceeding well, but that there were also some challenges around PEI and CWMH different systems (e.g. patient management and data systems) and organisational cultures.

#### *PEI activities*

The key objectives of the PRBPP in Fiji are to deliver training courses that are tailored to Pacific eye health planning needs and service delivery contexts. Courses are delivered at the PEI with an emphasis on clinical experience in similar conditions that graduates will be working in once back in their own countries. A key element of the training is the practical clinical experience that students gain via eye care service delivery in the PEI. In addition to this, students gain further experience through participating in outreach team visits to more remote parts of Fiji, and to other Pacific Island countries.

The PEI delivers training courses to attain the following qualifications:

For Nurses and Health Technicians

1. Postgraduate Certificate in Eye Care (Six months)
2. Postgraduate Certificate in Diabetes Eye Care (Six months)
3. Postgraduate Diploma in Eye Care (One year)
4. Masters in Community Eye Care (2 years part-time while working. Delivered online via the Pacific Open Learning Health Net)

For Doctors

5. Postgraduate Diploma in Ophthalmology (One year)
6. Master of Medicine in Ophthalmology (Three years)
7. Postgraduate Diploma in the Medical Management of Vitreo-retinal and Diabetes Eye Care (PGDMVD)

Qualifications are conferred by Fiji National University.

The intention of PEI training is for graduates to return to their home countries to practice eye health care. To this end, PEI managers (as well as PRBPP/FHFNZ managers) advocate with in-country MOHs to release nurses and doctors for study with a commitment to employ them in eye care upon graduation. Support for graduates includes each student returning with equipment, on-going support from the clinical teaching staff at PEI, and supervised clinical experience during PEI outreach visits. Outreach visits involve a team of PEI staff and students travelling to locations in Fiji (beyond Suva) and other Pacific countries to treat patients. Such visits provide an important opportunity for current students to gain valuable practical experience. Once students graduate and are practising eye care in their home country, they both support (by referring patients), and are supported by, the outreach team to continue their professional development. Additionally, graduates do follow up care for patients treated by the outreach team. PEI staff also endeavour to advocate on behalf of graduates who have been pulled into general medical provision rather than eye care due to in-country HRH resource issues. Although outreach visits are a key element of PRBPP workforce training and support, outreach visits are primarily viewed by most stakeholders as being about the provision of eye care.

Over 2009 – 2011 PEI conducted thirty outreach visits: 11 in Fiji; 3 in PNG, 5 in Solomon Islands, 6 in Vanuatu and 5 in Samoa (FHFNZ 2009: 25; FHFNZ 2010e: 36-37; PEI email communication 20.10.11).

***Staffing***

The PEI is staffed by a team of twenty four academic, clinical, management, administration and support staff. This represents a reasonable staff load with a strong management team of four. Three of these management posts are held by Pacific people. PEI has experienced difficulty in recruiting a Pacific Education Manager however, and also still requires the international expertise of visiting faculty. In the medium term, PEI will need these overseas tutors as the 'pool' of PEI graduates is not yet big enough or experienced enough to fulfil this function..

Staffing resource overall has been significantly scaled up under PRBPP Phase 2, allowing a growth in both student numbers and clinical provision:

> *"The clinical training of doctors and nurses in eye care has concurrently made PEI a significant provider of clinical services, not only in Fiji but in outreach locations in other Pacific Island Countries, performing about 2,000 eye surgeries a year." (PEI 2010c:5)*

There is a sense of 'local ownership' by PEI stakeholders of the PEI mission, goals and activities (training, clinical delivery and workforce support). This ownership includes elements of a 'by Pacific people for Pacific people' approach. This includes PEI leadership's active advocacy role in regional agencies, including PacEYES and the International Agency for Prevention of Blindness (IAPB) Pacific sub-region.

The Programme has proven very successful in attracting nurses and doctors to the PEI courses. In some regards, this is both a success and a challenge; as student intake rises, there is a concomitant requirement for patient cases, and other teaching and learning resources. PEI management reports a high level of interest from PIC governments for their medical personnel to attend training courses, and anticipates that oversubscription will continue and increase.

Key points for the period from January 2009 – July 2011 are:

- PEI courses are becoming more popular and some were oversubscribed in 2011.
- There are few trained ophthalmologists and eye health nurses and technicians relative to the country and regional population as a whole. Some countries have no trained eye health medical personnel.
- While there a number of eye health team visiting countries in the region, none are providing capacity building or formal training in the same way as the PRBPP.
- Relatively few PICs have completed National Strategic Eye Health Plans. Of those PICs that have completed Strategic Plans, the PEI is aware of, and working within, the needs identified in these.
- The PRBPP curricula are based on the region's specific eye health needs and service delivery context.
- FSM does not currently have the eye health expertise of PEI. FSM training is also hospital bound and the field experience of the PRBPP courses offer invaluable practical clinical learning.

PEI is a strong lobbying force for the continuing professional development of its graduates; examples of this include PEI securing membership privileges for its graduates (doctors) at a discounted rate from the Royal Australian and New Zealand College of Ophthalmologists.

### *PEI Outputs and Outcomes 2009 - 2011*

PEI outputs and outcomes over 2009-2011 indicate that the PRBPP in Fiji has made significant progress in achieving Programme goals in this period. Key outputs and outcomes include:

- The successful completion of the new PEI building operating with well-resourced facilities
- Approximately 65 doctors, nurses and technicians have completed or are currently enrolled on courses at the PEI
- PEI student profile covers 9 Pacific Island Countries and thus represent a significant increase in trained eye health knowledge in the region
- There have been a significant number of patients treated both within the PEI and during outreach visits (in 2010, 2,534 surgical procedures were performed by PEI staff and students in Fiji and the Pacific region)
- Most PEI graduates are working in eye health after graduation.
- A number of graduates have enrolled on further qualifications at PEI.
- There is a high student retention rate for PEI courses.
- The PEI has successfully achieved Fiji National University accreditation for PEI courses.

MOH stakeholders considered the PEI model of training and service delivery to be a star model for other initiatives in Fiji. Elements of the model have been effectively transferred to the training of staff in the MOH Prosthesis unit.

The following table outlines the PEI student profile 2009-2011

**Table 11: Pacific Eye Institute graduates 2009 - 2011**

| Course | Year | Country | Gender | | Working in eye care | |
|---|---|---|---|---|---|---|
| | | | Female | Male | Yes | No |
| PGCEC | 2009 | Fiji | | M | Y | |
| PGCEC | 2011 | Tokelau | F | | Y | |
| PGCEC | 2011 | Tokelau | F | | Y | |
| PGCEC | 2011 | Timor-Leste | | M | Y | |
| | | | | | | |
| PGDEC | 2009 | Vanuatu | | M | Y | |
| PGDEC | 2009 | Solomons | | M | Y | |
| PGDEC | 2009 | Solomons | F | | Y | |
| PGDEC | 2009 | Solomons | | M | Y | |
| PGDEC | 2009 | Kiribati | F | | Y | |
| PGDEC | 2009 | Cook Is | F | | Y | |
| PGDEC | 2009 | Fiji | F | | Y | |
| PGDEC | 2009 | Samoa | | M | | |
| PGDEC | 2010 | Vanuatu | F | | Y | |
| PGDEC | 2010 | Vanuatu | | M | Y | |
| PGDEC | 2010 | Solomons | F | | Y | |
| PGDEC | 2010 | Solomons | | M | Y | |
| PGDEC | 2010 | Fiji | F | | Y | |
| PGDEC | 2010 | Fiji | F | | Y | |
| PGDEC | 2010 | Fiji | F | | Y | |
| PGDEC | 2010 | Fiji | F | | Y | |

| | | | | | | |
|---|---|---|---|---|---|---|
| PGDEC | 2010 | Tonga | F | | Y | |
| | | | | | | |
| PGDEC | 2010 | Samoa | F | | Y | |
| PGCDEC | 2010 | Solomons | F | | Y | |
| PGCDEC | 2010 | Solomons | F | | Y | |
| PGCDEC | 2010 | Fiji | F | | Y | |
| PGCDEC | 2010 | Fiji | F | | Y | |
| PGCDEC | 2010 | Fiji | F | | Y | |
| PGCDEC | 2010 | Tonga | F | | Y | |
| PGDO | 2010 | Fiji | F | | Y | |
| PGDO | 2010 | Fiji | F | | Y | |
| PGDO | 2010 | Fiji | F | | *Doing MMO* | |
| PGDO | 2010 | Cook Islands | | M | Y | |
| PGDO | 2010 | PNG | | M | Y | |
| PGDO | | PNG[12] | | M | Y | |
| | | | | | | |
| MMed | 2009 | Solomons | | M | Y | |
| TOTAL | | 35 | 23 | 12 | 33 | |

**Table 12: Pacific Eye Institute: Current students**

| Course | Year | Country | Gender | |
|---|---|---|---|---|
| | | | Female | Male |
| PGDEC | 2011 | Fiji | F | |
| PGDEC | 2011 | Fiji | F | |
| PGDEC | 2011 | Fiji | | M |
| PGDEC | 2011 | Fiji | F | |
| PGDEC | 2011 | Solomons | F | |
| PGDEC | 2011 | Solomons | | M |
| PGDEC | 2011 | Solomons | | M |
| PGDEC | 2011 | Tonga | F | |
| PGDEC | 2011 | Vanuatu | | M |
| PGDEC | 2011 | Kiribati | | M |
| | | | | |
| PGCDEC | 2011 | Fiji | | M |
| PGCDEC | 2011 | Fiji | F | |
| PGCDEC | 2011 | Fiji | F | |
| PGCDEC | 2011 | Fiji | F | |
| PGCDEC | 2011 | Nauru | F | |
| PGCDEC | 2011 | Tonga | F | |
| PGCDEC | 2011 | Tonga | F | |
| | | | | |
| PGDMVD | 2011 | Fiji | F | |
| PGDMVD | 2011 | Fiji | F | |
| | | | | |
| PGDO | 2011 | Fiji | F | |
| PGDO | 2011 | Fiji | F | |

[12] Conferred by UPNG

| | | | | |
|---|---|---|---|---|
| PGDO | 2011 | Fiji | F | |
| PGDO | 2011 | Kiribati | F | |
| | | | | |
| MCEC | 2011 | Fiji | F | |
| | | | | |
| MMO | 2011 | Solomons | | M |
| MMO | 2011 | Solomons | F | |
| MMO | 2011 | Fiji | F | |
| | | | | |
| **TOTAL** | | **27** | **20** | **7** |

There is overall strong agreement across all stakeholders that the PEI is highly relevant to both Fiji and Pacific regional health needs and Human Resources for Health requirements. The focus on eye health was cited as particularly relevant given the rising incidence of NCDs and diabetes in Fiji and the region.

Current students and graduates were asked to rate their training courses. Key points to note are as follows:

- Overall, most students and graduates (n=19) rated the training overall (academic training, clinical training, facilities, structure/format, curricula, and support received) as 'very good' or 'good'. A few students rated specific aspects - the clinical training and structure/format - of the training as 'fair' (3 out of 19)
- All students and graduates agreed that the training had increased their knowledge and skill in eye care, and had contributed to their professional development
- The majority of graduates (n=6) considered that they had been able to apply their training to their clinical setting, and rated the support received from the Programme as 'very good' or 'good'.

The following table summarises the successes achieved 2009 - 2011 and challenges faced by the Fiji/regional PRBPP in the future.

**Table 13: PEI 2009 - 2011 key achievements, success factors and future challenges**

| **Key achievements** |
|---|
| ▪ Increasing numbers of students applying<br>▪ High student retention and completion rates.<br>▪ High rate of graduates remaining in eye health.<br>▪ Opening of the new PEI building, uniting academic and clinical learning on one site.<br>▪ Opening of the PEI Diabetes Eye Clinic in 2009, providing teaching and learning resource for the PGCDEC<br>▪ New training courses developed (Masters in Community Eye Care in 2009 and Postgraduate Certificate in Diabetes Eye Care and PGDMVD in 2010)<br>▪ Annual workforce support visits to nurse graduates and continuing professional activities (such as the Pacific Eye Care Conference 2010).<br>▪ Raised profile of eye health in Fiji and the Pacific. |
| **Success factors** |
| ▪ Highly skilled and experienced professional staff, the majority of whom are Pacific nationals.<br>▪ Effective relationships with Fiji MOH.<br>▪ Relationship with FHFNZ as the overall PRBPP manager and having the support of a large regional NGO<br>▪ The well-established relationship between the PEI Director and eye health personnel in Solomon Islands and Vanuatu. |

| Future challenges and considerations |
| --- |
| ▪ Reliance on expatriate training staff due to the small 'pool' of Pacific personnel inhibits local ownership and sustainability in the short-medium term<br>▪ There is a tension between training nurses and doctors to meet Pacific eye health needs and low ratios of medical professionals to meet general health needs. This can mean in-country MOHs find it difficult to release staff to train in Suva for 1-3 years.<br>▪ To date the Programme has not had explicit targets to ensure reach across the region in student selection.<br>▪ There is a need to diversify sources of funding, including investigating fees and charges and student sponsorship.<br>▪ Meeting the workforce support needs of much higher graduate nurse numbers. |

# Appendix 3: Papua New Guinea Country Report

This Annex presents findings for the Madang, Papua New Guinea based operations of the Pacific Regional Blindness Prevention Programme (PRBPP).

Data sources are outlined in the main body of this report. The evaluation conducted thirteen interviews with Fred Hollows Foundation New Zealand stakeholders in Madang and Port Moresby, a focus group with eight current students completing the Post Graduate Diploma in Eye Care (PGDEC), and survey questionnaires with eight current students and 15 graduates who completed their training in 2009 and 2010.

### *Country background*

Papua New Guinea is the largest and most populous country in the Pacific with 6.6 million people, with an estimated 87% living in rural areas. Its 463,000 square kilometres of land area includes 600 islands and extensive mountainous highlands that cover nearly half the country. The country is divided into 22 provinces and 89 districts. Official languages are English, Pidgin and Motu, and there are over 800 spoken languages. It is the most linguistically diverse nation on the planet.

Papua New Guinea ranks 153 out of 182 countries on the United Nations Human Development Index. Health indicators are poor, with average life expectancy at 62 years, an under five mortality rate of 68 per 1,000, and a maternal mortality rate of 250 per 100,000 deliveries[13]. The government's multiple health priorities include improving maternal and child health, responding to the generalised HIV & AIDS epidemic, and reducing communicable and non-communicable diseases. The largely decentralised health system is weak, particularly in rural areas, hindered by rundown facilities, unreliable drugs and consumable supply. Overall, the health system is providing limited and uneven access to basic services, including eye care.

### *Overview of Eye Health in Papua New Guinea*

FHFNZ estimates that 58,000 people over 50 in PNG are blind, with an additional 10,000 cases each year. Cataracts account for 70% of blindness, followed by corneal disease, uncorrected refractive error and trauma. Eye trauma from lime burns, knife wounds, violence against women, and assaults are prevalent. Eye conditions include infections, HIV related eye complications, and diabetes retinopathy. Glaucoma, Vitamin A deficiency- related night blindness and trachoma affect some populations, though prevalence is not known due to poor data. Eye health workers in PNG report that eye conditions are often entirely untreated and progress to stages clinically unknown or documented in medical literature.

PNG's current cadre of eye health personnel is insufficient for the population's needs. Based on the World Health Organisation's human resource recommendations for eye health workers, PNG requires 60 ophthalmologists and more than 260 mid-level eye care workers to enable comprehensive provision of eye care services. There are currently about 14 ophthalmologists actively practising and approximately 60 nurses or eye care workers providing various levels of eye care throughout the country. Many of these personnel are not working full time on eye health, and many without appropriate facilities, equipment or drugs to provide adequate eye services. PNG has a draft National Eye Plan (Papua New Guinea National Eye Plan 2011-2015) that outlines targets for needed personnel at different health service delivery levels.

[13] AusAID http://www.ausaid.gov.au/country/png/png_intro.cfm, last accessed 21/22/11

### *The PRBPP in Papua New Guinea*

Fred Hollows Foundation NZ began work in Madang, PNG in 2007, and received PRBPP funding from 2009. The Programme delivers a 12 month Post Graduate Diploma in Eye Care (PGDEC) to an average of eight students each year. Most participants are nurses, who are trained to diagnose and provide non-surgical treatment and management of eye conditions and vision problems, and refraction and prescription of spectacles. Through the Programme, graduates are provided individual professional and clinical support in their workplace.

The Programme has focused on extending the reach of PGDECs across the country. Increasingly, students are selected from health facilities where there is an ophthalmologist or another eye nurse as a deliberate mechanism to enable teamwork and professional support for the specialist eye nurses. FHFNZ is also leading an effort to get formal recognition of the PGDEC qualifications by the Papua New Guinea Medical Board to ensure that the specialist skills and capacities are acknowledged by hospital management and providing a platform for eye nurses to better advocate for eye health policy and resources.

The approach of the PRBPP aligns with the government's National Health Plan 2011-2020, which has a "Back to Basics" goal of strengthened primary health care, and it's rural and urban disadvantaged focus. The approach also aligns with the PNG National Eye Plan 2011-2015, which was developed with technical support from the current FHFNZ Education Manager.

### *PRBPP Activities*

The FHFNZ **Eye Unit at Modilon Hospital** serves as a teaching institution, and provides clinical and surgical services in a facility considered to be one of the best in the country. The clinic is staffed by an international ophthalmologist and supported by PGDEC graduate eye nurses. The programme prioritises quality and outcomes over patient numbers and delivery (i.e., cataract surgery rate), though the demand for services exceeds delivery capacity. Surgical outreach from the facility is limited but PGDECS do undertake some primary care outreach visits.

The **PGDEC curriculum** for PNG was developed over several years by FHFNZ specialist staff, ophthalmic nurses and optometrists. It was reviewed in 2009/2010 and adapted to better correspond with PNG context and language capacity of most students (the course is taught in English). There is some tension around the optometry emphasis of the curriculum, with a number of stakeholders expressing a need for a stronger public health focus to reflect the country's needs and government priorities. FHFNZ has recently begun implementation of a Certificate course aimed at lower level health personnel who will work primarily in the community (funded through FHFNZ core funding). The course is designed to give basic primary eye care skills to a range of community based health workers, and to complement the work of PGDECS, primarily through appropriate referrals, but there is no workforce support component.

Divine Word University is Fred Hollows' **partner institution** and confers the PGDEC degree, and provides accommodation, academic resources, social support services and sports activities to students over their year of residency at the university. A Head of Eye Care department role has been created within the University's Health Faculty, and is currently held by FHFNZ's Education Manager.

The **workforce development** component of the programme entails two to three technical and administrative visits to PGDEC graduates per year by the Workforce Development Coordinator and the Country Manager. The technical visits are intended to evaluate graduates' clinical skills and performance, and provide professional mentoring and troubleshooting. The Workforce Development Coordinator also aim to engage with hospital leadership on adherence to hospital/FHFNZ MOUs on provision of equipment, space and support to the PGDEC, and there is a need for clearer guidelines on the this engagement. There is also a need for a standardised competency assessment framework and guidelines to ensure consistency across all PGDECS and the Workforce Development team, especially given the Coordinator is a consultant not based in PNG. An annual workshop that convenes all graduates for professional development and networking comprises a key pillar of the support to graduates.

### *Key issues in the PNG context*

A number of key issues influenced the overall Programme over January 2009 – July 2011. These include:

#### *Relationship with government*

Stakeholders felt that FHFNZ's relationship with national government partners suffered as a result of the formal establishment of FHFNZ in Madang. FHFNZ provided professional and technical support, and equipment and consumables to the National Hospital in Port Moresby. There is indication that the relationship has been slow to recover from the decision to relocate and partner with a private university (Divine Word) in Madang. In the past year, more concerted efforts by FHFNZ PNG and Auckland based senior staff to improve the relationship has enabled dialogue and an increased interest to explore partnerships.

#### *Eye Health Sector*

The FHFNZ Education Manager has championed the establishment of a nascent national Working Party on Prevention of Blindness to review the issues of eye sector policy and practice, and to work toward better dialogue and stronger relationships with eye care sector partners. The IAPB (International Agency for the Prevention of Blindness) intends to put a Secretariat in Port Moresby and stakeholders agreed that FHFNZ should have higher visibility at the policy level.

#### *Unmet need for eye health services*

Stakeholders noted that surgical teams visit PNG far less frequently than other Pacific countries, largely due to the security risks. Despite recognised challenges with fragmented 'fly-in fly-out' cataract surgery models and the weakness of the health system, the scope of the unmet need in PNG is vast and the lack of ophthalmologists a persistent barrier to preventing blindness, and more surgical outreach is considered essential in the sector. There are also limited opportunities for graduate eye nurses to use and keep current the full complement of their skills to deliver results for their patients.

#### *Role and relationship with University of PNG (UPNG)*

There are no lecturers in ophthalmology at the UPNG and two ophthalmology candidates are training through PEI. The lack of capacity to train ophthalmologists

within PNG is perceived as undermining national leadership on eye health and its ability to address the countries' complex eye issues, including those that are related to the rising prevalence of non-communicable diseases such as diabetes. There is an agreed need to improve the image of and opportunities for specialising in ophthalmology. This requires, in part, increased local ownership and scholarship.

### *PNG Outputs and Outcomes 2009 - 2011*

Outputs and outcomes in PNG over 2009-2011 indicate that the PRBPP has made progress toward achieving programme goals in this period. Selected outputs include:

- Rising numbers of patients treated at the Modilon Hospital Eye Unit
- Eye Unit staffed by Papua New Guinean nurses and PGDEC graduates, and managed by one expatriate
- PGDEC graduates have access to ready-made spectacles; 3000 glasses delivered through the spectacle support program
- Approximately 17 PGDEC graduates from 2009-2010 and 8 current PGDEC students
- Eye Care Department at Divine Word University established and headed by the FHFNZ Education Manager.

The following table outlines the student profile 2009 - 2011.

**Table 14: PNG: PGDEC Graduates 2009 - 2010**

| Course | Year | Location | Province | Gender | | Working in eye care | |
|---|---|---|---|---|---|---|---|
| | | | | Female | Male | Yes | No |
| PGCEC | 2009 | Kimbe | West New Britain Province | F | | Yes | |
| PGDEC | 2009 | Kimbe | West New Britain Province | F | | Yes | |
| PGDEC | 2009 | Wabag | Enga Province | | M | Yes | |
| PGDEC | 2009 | Mt Hagen | Western Highlands Province | F | | Yes | |
| PGCEC | 2009 | Wewak | East Sepik Province | F | | Yes | |
| PGDEC | 2009 | Lae | Morobe Province | F | | Yes | |
| PGDEC | 2009 | Madang | | F | | Yes | |
| PGDEC | 2009 | Kundiawa | | F | | Yes | |
| PGDEC | 2010 | Silanga | | | M | Yes | |
| PGCEC | 2010 | Lae | Morobe Province | F | | Yes | |
| PGDEC | 2010 | Madang | Madang Province | F | | Yes | |
| PGDEC | 2010 | Mt Hagen | Western Highlands Province | F | | Yes | |
| PGCEC | 2010 | Bialla | West New Britain Province | F | | Yes | |
| PGDEC | 2010 | Goroka | Eastern Highlands Province | | M | Yes | |
| PGDEC | 2010 | Alotau | Milne Bay Province | | M | Yes | |
| PGDEC | 2010 | Wewak | East Sepik Province | F | | Yes | |
| PGDEC | 2010 | Bogia | Madang Province | | M | Yes | |
| | | | | **12** | **5** | **17** | **0** |

There is agreement amongst PRBPP stakeholders on the overall need for the Fred Hollows New Zealand programme in PNG, its importance to PNG's eye health needs and alignment with health policy. Some particular successes and challenges that have impacted the Programme's overall achievement include:

**Table 15: PNG 200- 2011 key achievements, success factors and future challenges**

| **Key achievements** |
|---|
| ▪ Good student retention and completion rates<br>▪ High rate of graduates remaining in eye health<br>▪ Graduates demonstrate high level of performance and competency, including supporting general doctors with eye treatment in the absence of ophthalmologist<br>▪ Good Eye Clinic at Modilon with excellent opportunity for practical experience to link to classroom theory<br>▪ Contribution to the drafting and advocacy for the PNG National Eye Plan (2011-2015)<br>▪ Patients coming from around the country to the Madang Eye Clinic, numbers increasing |
| **Success factors** |
| ▪ Annual workshop of PGDECs builds professional connections and collegial support<br>▪ Centralised programme support for affordable supplies and equipment fit for the environment<br>▪ Review of curriculum resulted in successful adaptation of content to PNG language levels and context.<br>▪ Shift to more rigorous entry requirement for students (year 12 Maths requirement) has facilitated learner classroom success<br>▪ Student recruitment based on "buddying" approach to enable graduates to support each other<br>▪ MOUs with hospital CEOs before training has contributed to supported work environment when returning after graduation |
| **Future challenges and considerations** |
| ▪ National leadership on preventable blindness and eye health is fragmented and relatively weak. FHFNZ's role as trainers and support to mid-level eye care workers is pivotal to national dialogue.<br>▪ Localisation of Country Manager, Education manager and Workforce Support Coordinator estimated to be between 7 and 15 years away<br>▪ More advocacy with government on certifying PGDEC's specialist qualifications is needed to ensure status is recognised<br>▪ Agreement on standardised mechanism and classification criteria for collecting nationwide data on eye conditions needed.<br>▪ Currently no PGDEC graduates are based in Port Moresby, and programme unable to recruit potential students from the capital<br>▪ Need for greater commitment from Modilon Hospital to provide security, maintenance, consumables and insurance to the programme, as agreed<br>▪ Internal (FHFNZ) dialogue needed to resolve tension between public health and optometry/medical model in the PGDEC curriculum and approach to workforce support<br>▪ Impact of security issues in PNG and violence against women has strong negative |

impact on students and staff

- Relationship between FHFNZ and UPNG can continue to be strengthened
- Workforce support programme will need increased resources and/or evolving models to accommodate growing pool of graduates.

# Appendix 4: Timor-Leste Country Report

This Annex presents findings for the Timor-Leste based operations of the Pacific Regional Blindness Prevention Programme (PRBPP).

Data sources are outlined in the main body of this report. The evaluation conducted twenty interviews with Fred Hollows New Zealand stakeholders and received survey questionnaires from 14 graduates.

### *Country background*

Timor-Leste is a post-conflict state and one of the poorest countries in the world, ranking 147 out of 187 countries in the United Nations Human Development Index. It has an estimated population of 1,066,409, divided into 13 administrative districts. More than seventy per cent of the population is rural, living in villages isolated by mountains and poor roads. Dili is the capital and largest city.

Timor-Leste became an independent nation in 2002. Conflict, at times extremely violent, has erupted periodically since a 1999 referendum endorsed independence from Indonesia. Civil disorder, internal displacement and the destruction of infrastructure, as well as the enduring fragility of public institutions, have impacted the nation's development, particularly its social services.

Nineteen languages are spoken in Timor-Leste.[14] Tetum is the most common and is the first official national language, along with Portuguese, which is spoken by fewer people. Bahasa Indonesia is a working language, as is English, though this is not widely spoken.

### *Overview of Eye Health in Timor-Leste*

According to FHFNZ, there are over 13,000 blind people in Timor-Leste, with an estimated 70% as a result of cataracts. An additional 40,000 people are visually impaired. Eye health issues are predominantly cataracts and uncorrected refractive error, and also include trauma, eye infections, and some Vitamin A deficiency related night blindness.

Barriers to blindness prevention are extensive in Timor-Leste. Maternal and child health indicators are among the world's worst, and along with communicable and vector-borne diseases, they are a major focus of national and international resources. Years of conflict and instability has resulted in a weak health system and public sector institutions, and a low educated workforce. Inadequate equipment, shortages of health supplies, and insufficient health personnel further constrain health services. Out of 70 doctors in the country, only 35 are working clinically.

Access to facilities providing eye health services and eye service infrastructure is uneven across districts and facilities. A temporary operating theatre at an urban Community Health Centre in Dili and the theatre at the National Hospital are currently the only sites permanently equipped to perform eye surgery. Prevention and primary eye care outreach to remote villages by eye care workers is very limited. Utilisation of health services is also extremely weak in Timor-Leste and outreach and promotion to create demand is an important aspect of all health programmes in Timor-Leste, including blindness prevention.

[14] Lewis, M. Paul (ed.), 2009. Ethnologue: Languages of the World, Sixteenth edition. Dallas, Texas, last accessed 19/12/11 http://www.ethnologue.com/.

Given the limited number of resident ophthalmologists in Timor-Leste, eye health services at the tertiary level are largely limited to visiting specialist teams. There is one Timorese ophthalmologist and three expatriate ophthalmologists resident in Timor, all based in the capital. Only one ophthalmologist is available to perform surgical outreach visits to rural districts.

There are a total of twelve eye care nurses and thirteen eye care technicians in the country, based in the capital and in a number of district facilities. The eye care technicians are not permitted to prescribe drugs and focus primarily on refraction. The small number of eye health personnel and inadequate resources for primary eye health outreach results in limited prevention and treatment of the main causes of blindness.

There is currently no routine screening in Timor Leste eye clinics for certain eye diseases prevalent in the Pacific, including diabetic retinopathy and glaucoma. According to stakeholders consulted during the review, a basic preliminary survey undertaken in 2011 through the Royal Australian College of Surgeons (RACS) indicates there may be an unmet need for glaucoma diagnosis and treatment in the population, and that more attention should be paid to up-skilling eye care practitioners in the diagnosis and management of glaucoma.

***FHFNZ in Timor-Leste***

FHFNZ has been working in Timor-Leste since 2005, when it supported the development of the first National Eye Health Strategy and its implementation. The focus has been on research, clinical service delivery, and technical support, including in the set-up of Fo Naroman Timor-Leste (FNTL), a local NGO partner that undertakes health promotion, vision screening, refraction and spectacle dispensing services throughout the country.

New management of the Timor-Leste programme in 2010 represented a shift in focus, with a more explicit development approach, an increase in community outreach and stronger efforts to create demand for services in the districts. Closer alignment with government has also been a specific focus. Formal agreements with the Ministry of Health include a Letter of Intent in support of capacity building and assistance to Eye Health Workers, and an MOU related to the establishment and management of the new National Eye Clinic.

Relationships with other eye health partners have been strengthened. Stakeholder meetings convened to enhance coordination have resulted in joint programming and more harmonised approaches. In particular, an Eye Health Sector Working Group (EHSWG) has recently been established to ensure coherent support and policy advice to the MoH, and will become an increasingly important mechanism for developing the sector, in particular as the National Eye Centre becomes operational.

- Collaboration with the Royal Australian College of Surgeons (RACS), who provide regular surgical outreach visits, has improved significantly. A Letter of Agreement was signed between the two organisations to formally constitute cooperation in programming and planning in 2011. One component of this partnership involves an FHFNZ team undertaking pre-surgery outreach visits to screen and recruit patients in preparation for RACS Medical Team surgical outreach. FHFNZ subsequently follows up with patients, a process that has enabled a successful mutual leveraging of resources and strengths. FHFNZ in Timor-Leste operates out of a stand-alone office building in Dili, a short walk from the Clinic it supports, and is co-located with Fo Naroman's office and optical dispensary.

Components of the programme include;

- **Eye Clinic in Centro Saude Health Centre**– Five Fred Hollows Timorese staff and one government supported eye health technician provide eye services at the Centro Saude Eye Clinic, based in the Centro Saude urban health centre. The Eye Clinic utilises an operating theatre constructed in a converted shipping container on the Health Centre grounds. Until mid-2011, the Clinic was also staffed by a full time (expatriate) ophthalmologist who actively trained and supported the eye health personnel and performed surgery. Currently, an ophthalmologist jointly funded by FHFNZ and RACS provides surgery at the Eye Clinic one day per week, and works from the National Hospital clinic on other days.

- **Outreach Support Programme** –This programme identifies potential patients and builds community blindness awareness using behaviour change communication. Staff establish relationships with local leaders and undertake primary eye health promotion, mass vision screenings (with FNTL), cataract screening and mobilisation in support and preparation for RACS surgical teams. The program is integrated into the National Hospital schedule.

- **Workforce Development Programme** –Supervision, mentoring, and on-site training and competency monitoring to Eye Care Nurses and Technicians to maintain quality in their clinical and management skills.

- **Eye Education Programme** – Delivery of a ten month Diploma in Eye Care through the Institute of Health Sciences, the Ministry of Health's in-service training organisation. The Diploma was delivered in 2008/9 and 2010, but not in 2011 due to reform and a change in mandate of the Institute of Health Sciences (to providing only in-service training to health workers).

- **Health Promotion –** In collaboration with the Outreach Support programme, community level eye health messages are disseminated, including through radio, print and community partners (including schools).

There is no other organisation offering a similarly focused approach or package of community targeted services in Timor-Leste.

***Key Issues in the Timor-Leste Context***

A number of key issues influenced the overall programme over the January 2009 – July 2011 period, including:

- **Staffing -** FHFNZ in Timor-Leste is currently staffed by a team of twenty clinical, management, and administrative support staff. Five senior posts (Country Manager, Program Manager, National Eye Clinic General Manager, Office Finance Manager and Ophthalmologist Advisor), in addition to the Eye Education Manager, are filled by expatriate staff. Timorese staff hold second tier management positions in the outreach, workforce development, health promotion and clinical services programmes. Some staff have received external training and the Programme Manager and other senior staff provide capacity building support. The Centro Saude Eye Clinic is staffed by Timorese personnel.

- **Language -** Language is a persistent challenge in Timor-Leste, and for the Programme. Senior FHFNZ staff are primarily English speakers, some have basic Tetum and/or Bahasa Indonesia language skills. Timorese managers speak Tetum, and have Bahasa Indonesia, Portuguese and/or English skills to varying levels.

  Programming resources, training curriculum development and ongoing workforce development and support is significantly impacted by the low levels of English language ability. In the context of the PRBPP, Timor shares many development issues with other Pacific countries, but these are compounded by the language difficulties. Thus, resources, networking and training (at PEI, as well as on the job through support from visiting doctors and nurses), are difficult to leverage in Timor-Leste due to English language limitations of FHFNZ staff, graduates and potential students.

- **Eye care education** – FHFNZ delivered a Diploma in Eye Care to nurses and school leavers in 2008 and 2010, and planned to train 18 students in a 2011 intake. Due to the restructure and change in mandate of the training partner institution, (Institute of Health Sciences), as well as the introduction of a National Qualifications Framework, the 2011 Diploma course was unable to be implemented. There is an agreed need by all stakeholders for more trained eye care workers to provide primary and mid-level services.

  Issues regarding the curriculum in relation to the needs of the sector were raised by stakeholders. Some noted that an emphasis on refraction in eye care technician training, limited theory on disease and pharmacology, and insufficient opportunity for clinical attachments, represents a gap in students' understanding of, and competency to treat, primary eye conditions and to make referrals, particularly in rural areas where this capacity is most needed. Additionally, lack of sufficient training in eye surgery operating theatre skills limits Timorese eye nurses' ability to accompany visiting surgical teams. Further, eye nurses' ability to practice in the new National Eye Centre will be inadequate unless their skills are upgraded with recognised qualifications.

  Students' capacity to train in more complex clinical tasks is also impacted by recruitment practices. Several students in the 2010 intake were selected by government without having identified an intention to learn or practice eye care. This may significantly impact longer term retention in the sector.

- **Sector coordination**– There is strong indication that coordination in the eye health and blindness prevention sector has improved, and that the sector overall has grown more cohesive. The construction of the new National Eye Clinic and its official opening has resulted in more public awareness of eye health and blindness prevention. The expanded formal and working relationship between RACS, FHFNZ and FNTL has generated better integrated service delivery and capacity development at primary and tertiary levels, and represents a commitment to effectiveness and coherence. Formal mechanisms such as the Eye Health Working Group and the governance committee of the National Eye Clinic are positive indicators of the trend in better collaboration.

  Continued partnerships among all stakeholders are especially critical to maximising the opportunities of the new National Eye Clinic, which has potential as a centre of excellence and hub for services, training, research and policy in the eye sector.

- **Relationship with government (MoH) –** Stakeholders indicate that FHFNZ's efforts to improve alignment with government needs to continue and be enhanced, particularly at the district level. FHFNZ has provided support to the Eye Health Unit on its framework for eye health policy and is strengthening its links with other key government stakeholders, including the National Institute for Labourforce Development and the National Agency for Academic Assessment and Accreditation.

  Strong government leadership and policy making capacity is needed to ensure the training that is essential to build the cadre of mid-level eye care workers, and their clinical and professional support, is provided. Commitment on support for community outreach is particularly critical for effectiveness and equity.

***Outputs and Outcomes 2009 - 2011***

Outputs and outcomes in Timor-Leste over 2009-2011 indicate that the PRBPP has made progress toward achieving Programme goals in this period. Selected outputs include:

- Increased number of patients treated at Centro Saude Eye Clinic and in outreach surgical visits.
- Nearly all graduates are working in clinical eye health practice after graduation.
- Formal partnerships and joint planning established with eye health sector stakeholders, particularly RACS.
- Some integration of eye care into primary care services through relationships with community leaders and organisations and development of health promotion materials and campaigns.
- Eye Clinic staffed by competent Timorese eye health workers and staff.
- A Letter of Intent with the MoH signals support for the Workforce Development Programme, and progress toward a continued and strengthened relationship.
- While not funded through the PRBPP, the near completion of the National Eye Clinic indicates FHFNZ's success in raising public awareness of blindness prevention work and its contributions to convening eye health organisations operating in Timor-Leste to provide a comprehensive eye health service and resource.

The following table outlines the student profile 2009-2011

**Table 16: Timor-Leste: 2010 graduates**

| Course | Year | Province | Gender | | Working in eye care | |
|---|---|---|---|---|---|---|
| | | | Female | Male | Yes | No |
| Eye care technician | 2010 | Aileu | | M | Yes | |
| Eye care technician | 2010 | Maubisse | F | | Yes | |
| Eye care technician | 2010 | Bacau | F | | Yes | |
| Eye care technician | 2010 | Bobonara/Maliana | F | | Yes | |
| Eye care technician | 2010 | Covalima/Suai | F | | Yes | |
| Eye care technician | 2010 | Dili | F | | Yes | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Eyecare technician | 2010 | Dili | F | | Yes | |
| Eye care technician | 2010 | Ermera | F | | Yes | |
| Eye care technician | 2010 | Liquica | F | | Yes | |
| Eye care technician | 2010 | Manufahi/Same | F | | Yes | |
| Eye care technician | 2010 | Manatuto | F | | Yes | |
| Eye care technician | 2010 | Oecusse/Ambeno | F | | Yes | |
| Eye care technician | 2010 | Viqueque | | M | Yes | |
| **TOTAL** | | | **11** | **2** | **13** | **–** |

There is agreement amongst PRBPP stakeholders on the overall need for the Fred Hollows New Zealand programme in Timor-Leste, and its relevance and responsiveness to Timor Leste's eye health needs. Some particular successes and challenges that have impacted the programme's overall achievement include:

**Table 17: Timor-Leste 2009 - 2011 key achievements, success factors and future challenges**

| **Key achievements** |
|---|
| ▪ Raised awareness of eye health and blindness prevention among key stakeholders<br>▪ Good student retention and completion rates<br>▪ High rate of graduates remaining in eye health in first years as practitioners<br>▪ Institutional framework for eye care policy in the Ministry of Health<br>▪ Network of community leaders and organisations disseminating eye health messages through a variety of appropriate media (comic books, posters, TV and radio spots, etc.)<br>▪ A gradual increase in the uptake of eye services<br>▪ Development of behaviour change communication (BCC) materials on eye health promotion and care |
| **Success factors** |
| ▪ Strengthened relationship with RACS and other stakeholders in the eye health sector<br>▪ Intensified community outreach using appropriate methods.<br>▪ A unifying exercise in the development of the National Eye Clinic. |
| **Future challenges and considerations** |
| ▪ The restructure and change in mandate of the Institute of Health Sciences, and the introduction of a national qualification framework, requires identification of the appropriate training institution to provide accreditation for the Diploma in Eye Care.<br>▪ A MoH shift to upgrade the Diploma in Eye Care to a Level III Post-Graduate Diploma course requires additional curriculum development and policy decisions on course delivery. |

- English language issues will continue create challenges for the sector, including utilisation of Pacific regional expertise, training and professional development opportunities and support.
- Views are mixed on the imperative to train nurses (as opposed to school leavers) who have established skills in pathology and pharmacology, given the MoH's reluctance to release nurses for training. Identifying students with sufficient capacity to complete a more rigorous Diploma may present challenges.
- Ongoing discrepancies between the MoH goals for eye health services and human resource requirements, and its policy and practices towards the achievement of these goals. It is envisioned that discussion and response to these issues will be part of the development of the new Eye Health Strategy .
- Quality assurance in district level service delivery and the provision of consistent supplies and basic operating equipment.
- More rigorous data collection and monitoring.

## Appendix 5: Documents Reviewed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# Appendix 6: Terms of Reference

**Fred Hollows Foundation New Zealand**

**Pacific Regional Blindness Prevention Programme**

**Evaluation**

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## 1. Background information and context

Within the Pacific and Timor-Leste, the World Health Organisation estimates there are approximately 80,000 people who are blind, and a further 243,000 vision impaired people; over 80% of all vision impairment is preventable. The social and economic impact of blindness and vision impairment is significant and could grow to USD110 billion globally by 2020 if not addressed.

The New Zealand aid Programme through the Ministry of Foreign Affairs and Trade (MFAT) has supported the Fred Hollows Foundation New Zealand (FHFNZ) since 2002. During a New Zealand aid Programme-commissioned independent evaluation in early 2008, NZ and AusAID commenced discussions on cooperation arrangements in support of FHFNZ. A tripartite arrangement between FHFNZ, MFAT and AusAID was subsequently entered into to provide further support for blindness prevention in the Pacific. New Zealand takes the lead for development partners.

The Pacific Regional Blindness Prevention Programme (PRBPP) was designed as a three (calendar year) Programme 2009 – 2011. The total cost of the Programme is NZD16.8million. The New Zealand Aid Programme contributes one-third (NZD5.6 million) and AusAID contributes two-thirds (NZD11.2 million).

The PRBPP provides appropriate training and related support for eye care nurses, doctors and ophthalmologists. The training and related support are provided from training institutions (for academic learning) and clinical services (for practical learning) in Fiji (servicing the region), Papua New Guinea and Timor-Leste.

The tripartite arrangement represented a scale up of the existing FHFNZ Programme. The scale-up supports an increase in students trained and a more comprehensive support package (including in-country workforce coordinators in the three main countries).

## 2. Project goals and objectives

The overall goal of the PRBPP is to:

*Prevent and reduce avoidable blindness and vision impairment in the Pacific by increasing people's access to quality eye care services provided by appropriately trained eye care personnel.*

Work towards this goal is implemented through four objectives (below) with a number of corresponding outputs:

- Strengthening sustainable training institutes
- Strengthening eye health training service facilities
- Developing appropriately trained eye health personnel in numbers commensurate with country eye health human resource plans
- Supporting eye health graduates and ensuring they are retained within the public health sector to provide accessible, effective and sustainable eye health care

## 3. Purpose of the evaluation

The purpose of the evaluation is to provide an overall assessment of the PRBPP, to determine the degree to which the Programme has been effectively and efficiently managed, to assess the results achieved by PRBPP to date and to assess and provide options on sustainability of activities into the future.

The evaluation report is primarily for the use of MFAT, AusAID, FHFNZ and participating countries.

MFAT and AusAID may use the evaluation to inform support for FHFNZ activities in the Pacific, PNG and Timor-Leste (noting that the evaluation results are only one consideration in decisions on future support). FHFNZ will use the findings to determine whether any changes are required to enhance FHFNZ management of the PRBPP in its final months and to inform any future Programmes.

## 4. Scope

The evaluation will cover all aspects of the PRBPP since MFAT and AusAID funding commenced in early 2009.

The evaluation will address the following Development Assistance Committee (DAC) evaluative criteria: relevance, effectiveness, efficiency, and sustainability.

The main stakeholders in the evaluation are country Ministries of Health, FHFNZ, MFAT, AusAID, in-country Programme staff and students.

## 5. Evaluation Objectives and key focus areas

*Note: questions are not be limited to those stated*

**a) To assess the ongoing relevance of the PRBPP in Timor-Leste, PNG and the Pacific region**

- To what extent does the PRBPP as a whole, and *individual* project work streams (including intended design and implementation), remain relevant to country priorities and to local development priorities?
- Within the broader eye health context has the Programme focused on the highest priority issues that need to be addressed?
- What other donor and government activities are being implemented to strengthen eye health in Timor-Leste, PNG and the Pacific region? To what extent is there effective coordination of Programmes and activities?

**b) To assess the effectiveness of the PRBPP to date**

- To what extent were the goals and objectives (outcomes) of the PRBPP clearly defined and feasible?
- To what degree is the Monitoring and Evaluation Framework fit for purpose i.e. has this provided appropriate and robust information on outputs and contribution towards outcomes and impact? If not, why not?
- To what extent has progress been made towards achievement of project goal, objectives (outcomes) and outputs to date (including positive/negative and intended/unintended outcomes)?
- What factors support and constrain achievement of outputs and outcomes? How are these being addresses by FHFNZ (for those within FHFNZ control)?

**c) To assess the efficiency of the PRBPP in delivering project outputs and outcomes.**

- To what extent has the Programme been efficiently delivered (i.e. inputs to outcomes, management arrangements, governance arrangements) both in-country and in Auckland?
- Has administration and management of the Programme been efficient and effective (e.g. organisational structure, operational procedures, policies, personnel management)?
- To what extent has the Programme provided value for money? i.e.

    - Is FHFNZ approach to workforce training and support cost effective? Are there other approaches that could be used which are more cost effective?
    - Could the same outcomes been achieved with less money (e.g. savings made with different procurement, administration and management processes);
- What has enhanced and constrained ongoing efficiency of project implementation? Identify those things within the control of FHFNZ and those outside of its control.

**d) To assess the sustainability of the PRBPP activities**

- To what extent are project benefits owned by Timor-Leste, PNG and participating Pacific governments, and how has the project contributed to domestic ownership?
- To what extent is the project likely to be sustainable in terms of ownership, management arrangements, funding and sustainability of benefits?
- What factors constrain or enhance project sustainability?

**e) To identify lessons learnt, and make recommendations that will improve implementation, efficiency, monitoring and evaluation, and/or achievement of outcomes in the final stages of the Programme; inform FHFNZ in their future work and inform MFAT/AusAID in terms of their future relationship with FHFNZ.**

## 6. Methodology

The evaluation will be designed to enable standalone assessment of the Programme in each of the PNG, Timor-Leste and Pacific regional Programme components, as well as an assessment of the PRBPP as a whole to meet the TOR objectives.

The evaluation will involve field visits to Timor-Leste, PNG, Fiji and at least one other Pacific country that has had students trained at the PEI. It is envisaged that country reports will be appended to the main report.

A detailed evaluation plan will be developed by the evaluator(s) after an initial desk review and prior to commencement of the evaluation. The final evaluation plan should be appended to the main report. The evaluation plan will include:

- Retrospective assessment of the programme logic and M&E Framework as a basis against which to evaluate the achievement of goal, objectives (outcomes) and outputs;
- A schedule of stakeholder groups, describing their interest, type and any issues there might be with their involvement in the review;
- Any changes or additions to evaluation questions
- Identification of information (including from whom) needed to answer the key questions and sources of this information (e.g. documents, people, groups).
- Methods to be used for data collection,
- Description of how gender and human rights will be assessed in the evaluation;
- Discussion of how information will be cross-checked and analysed (including for qualitative data);
- How findings will be fed back/discussed with appropriate stakeholders;
- What risks, limitations, constraints there might be and how these will be mitigated;
- How ethical issues (e.g. confidentiality, informing participants, etc) will be addressed;
- What, if any, support and involvement from FHFNZ (NZ and country-based) is required;
- Interview questions and/or surveys questionnaires appended;
- Reporting framework

A draft evaluation plan will be shared with MFAT, AusAID and FHFNZ International Programmes Director for comment prior to finalisation (and prior to in-country visits). Revisions may be required if the plan is unclear or incomplete.

The following principles should be employed in development of the evaluation plan and the evaluation more broadly:

- Working in partnership

- Ensuring transparency and independence
- Ensuring a consultative participatory process

## 7. Governance and Management of the evaluation

The evaluation is commissioned by MFAT in partnership with FHFNZ and AusAID. MFAT will manage the evaluation, and the evaluation team is accountable to MFAT.

A steering group will be established by MFAT to oversee the evaluation. The steering group will be chaired by an MFAT representative and will include a representative of AusAID and FHFNZ. The steering group will:

- approve the TOR
- oversee the selection of the evaluator(s)
- provide feedback to the consultant on the evaluation plan and budget
- provide practical support to the consultant
- provide written comment on the draft report
- approve the final report.

The evaluation team is responsible for managing feedback from stakeholders and ensuring accurate analysis is included in the reporting.

## 8. Composition of the evaluation team

The evaluation consultant(s) will be recruited by MFAT through an open tender process.

The evaluation may be undertaken by a single evaluator or a team of evaluators. Where a proposal includes two evaluators, one person will be nominated as the team leader. The team leader will be responsible for all deliverables. The evaluator(s) will have strong professional skills and experience in:

- Monitoring and evaluation for international development (minimum 10 years of experience);
- Working with government systems in developing countries (PNG, Timor-Leste, Pacific preferred)
- Experience in working in a Pacific and / or South East Asian context in an inclusive and participatory manner
- Ability to work with a wide range of stakeholders in developing countries – particularly in the health field - including Ministries of Health, health care workers and NGOs
- Developing country health sector expertise, in particular health workforce training and development
- Research, report writing and presentation;
- Some knowledge of Tok Pisin and/or Tetun languages (desirable)

An independent MFAT evaluation specialist may contribute as a third member of the formal evaluation team (arrangements to be discussed with the evaluators). MFAT and AusAID may participate as observers on the country visits (arrangements to be discussed with the evaluators).

The evaluation team is responsible for presenting the findings, analysis and any recommendations throughout the report. In support of partnership and participation principles, the evaluation team is expected to engage AusAID, MFAT, FHFNZ and other stakeholders as appropriate in the preparation of the evaluation report, including feedback of key findings, and discussion with stakeholders in-country prior to leaving.

## 9. Outputs and reporting requirements

The consultant(s) will produce the following outputs:

- A detailed evaluation plan for discussion with MFAT, AusAID and FHFNZ.
- In-country end of visit workshops for key stakeholders to feedback initial findings and verify these with stakeholders.
- Aide memoire for each country visited (within 5 days of visit).

- Verbal debrief with MFAT, AusAID and FHFNZ in Wellington after completion of all field work.
- Draft country reports for each of Timor-Leste, PNG and the Pacific Eye Institute plus draft consolidated report for the Programme as a whole.
- Final report (s) for each of PNG and Timor-Leste and the Pacific Eye Institute plus final consolidated report for the Programme as a whole.

The report will meet the OECD DAC Quality Standards for Development Evaluation. The final integrated Programme report will be structured as per MFAT evaluation report requirements. The main body of the final integrated Programme report should be no longer than 20 pages (excluding annexes). The main body of the country reports should be no longer than 10 pages.

The draft report will be peer reviewed by AusAID, MFAT and FHFNZ. Further work, or revision of the report, may be required if it is considered the report does not meet the ToR, there are errors of fact or the report is incomplete or of an unacceptable standard. The final report will be approved by the steering group taking into account feedback from AusAID and FHFNZ. In the event of disagreement over the final report the chair of the steering group will make the final decision on whether to accept the report.

**10. Timeframes**

The evaluation (including acceptance of the final integrated report) should be completed by 30 August 2011. It is preferred that the first in-country visit will be to Timor-Leste in June 2011. It is expected that this assignment will take up to 70 person days including travel. Timeframes should be based around the following sequence of activities:

i) Briefing
ii) Desk review and evaluation plan
iii) Field visits: Timor-Leste, PNG, Fiji and 1 other country (including aide memoires)
iv) Reporting writing - draft report(s)
v) Reporting writing - final report(s)

**11. Follow-up of evaluation**

The final report will be referred to MFAT's Evaluation Committee as part of MFAT's evaluation quality process and for disseminating learning within the Ministry.

**NOTE:** MFAT will place a summary of the report on its aid website and release the full report on request. To facilitate this, information that could prevent the release of the report under the Official Information or Privacy Acts, or would breach evaluation ethical standards should be placed in a Confidential Annex.

AusAID will publish the full report on its website subject to senior management approval.

**12. Sources of written information**

NZAID Evaluation and Research Committee Process Guideline
NZAID Evaluation Policy Statement
NZAID Guideline on Evaluation and the Activity Cycle
NZAID Evaluation Guidelines on Participatory Evaluation
NZAID Guideline on the Structure of Review and Evaluation Reports
NZAID Guideline on Dissemination and Use of Evaluation Findings
NZAID Screening Guide for Mainstreamed and Other Cross Cutting Issues
NZAID Operational Guideline on Value for Money
OECD DAC Evaluation Quality Standards

# Appendix 7: Evaluation Plan

## 1. Pacific Regional Blindness Prevention Programme Evaluation Plan

The Evaluation Plan for the Fred Hollows Foundation Pacific Regional Blindness Prevention Programme (PRBPP) Evaluation outlines:

- The purpose, objectives and questions for the evaluation
- A retrospective outcomes framework for the PRBPP and associated indicators
- Data sources to inform the evaluation, including key stakeholders
- Analysis and reporting
- Risks, limitations and ethics
- Project team and timing
- Evaluation tools.

## 2. Fred Hollows Foundation New Zealand PRBPP

### 2.1 Background and context

Within the Pacific and Timor-Leste, the World Health Organisation (WHO) estimates there are approximately 80,000 people who are blind, and a further 243,000 vision impaired people; over 80% of all vision impairment is preventable. The social and economic impact of blindness and vision impairment is significant and could grow to USD110 billion globally by 2020 if not addressed.

The New Zealand Aid Programme through MFAT has supported FHFNZ since 2002. During a New Zealand Aid Programme-commissioned independent evaluation in early 2008, MFAT and AusAID commenced discussions on cooperation arrangements in support of FHFNZ. A tripartite arrangement between FHFNZ, MFAT and AusAID was subsequently entered into to provide further support for blindness prevention in the Pacific. New Zealand takes the lead for development partners.

The PRBPP was designed as a three (calendar year) Programme 2009 – 2011. The total cost of the Programme is NZD16.8million. MFAT, through the New Zealand Aid Programme, contributes one-third (NZD5.6 million) and AusAID contributes two-thirds (NZD11.2 million).

The PRBPP provides appropriate training and related support for eye care nurses, doctors and ophthalmologists. The training and related support are provided from training institutions (for academic learning) and clinical services (for practical learning) in Fiji (servicing the region), Papua New Guinea and Timor-Leste.

The Programme is implemented in Fiji through the Pacific Eye Institute (PEI), Papua New Guinea and Timor-Leste. The Programme also provides outreach services to other Pacific Island countries.

The tripartite arrangement represented a scale up of the existing FHFNZ Programme. The scale-up supports an increase in students trained and a more comprehensive support package (including in-country workforce coordinators in the three main countries).

### 2.2 Project goals and objectives

The overall goal of the PRBPP is to:

> *Prevent and reduce avoidable blindness and vision impairment in the Pacific by increasing people's access to quality eye care services provided by appropriately trained eye care personnel.*

PRBPP has four key objectives:

1. Strengthening sustainable training institutes
2. Strengthening eye health training service facilities
3. Developing appropriately trained eye health personnel in numbers commensurate with country eye health human resource plans
4. Supporting eye health graduates and ensuring they are retained within the public health sector to provide accessible, effective and sustainable eye health care.

## 3. Evaluation Purpose, Scope, Objectives and Questions

### 3.1 Evaluation purpose

The purpose of the evaluation is to provide an overall assessment of the PRBPP and across the three locations (Fiji, Papua New Guinea and Timor-Leste), to determine the extent to which the Programme has been effectively and efficiently managed, to assess the short and medium term outcomes achieved by PRBPP and to assess and provide options on sustainability of activities into the future.

The evaluation findings will also be used:

- To inform FHFNZ over whether any changes are required to enhance Programme management.
- To inform MFAT and AusAID in terms of their future relationship with FHFNZ, recognising the evaluation findings are only one source of information that will be used to determine future relationship and decisions on funding support.

### 3.2 Evaluation scope and principles

The evaluation will focus on the current three year Programme (1 January 2009 to 31 December 2011).

Specifically, the evaluation will focus on the period 1 January 2009 to 31 July 2011.

The evaluation will address the following Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) evaluative criteria: relevance, effectiveness, efficiency, and sustainability.

Core principles underpinning the conduct of the evaluation will be:

- Working in partnership
- Ensuring transparency and independence
- Ensuring a consultative and participatory process.

The evaluation will be guided by the principles of human rights and gender equality. In collecting data, we will strive to ensure women and disadvantaged groups are adequately represented, and data will be disaggregated by gender. Further, data will be analysed through multiple lenses, including sex, country and where applicable socio-economic grouping, ethnicity and disability.

### 3.3 Evaluation objectives

The evaluation has five key objectives:

1. To assess the on-going relevance of the PRBPP in Timor-Leste, PNG and the Pacific region
2. To assess the effectiveness of the PRBPP
3. To assess the efficiency of the PRBPP in delivering project outputs and outcomes
4. To assess the sustainability of the PRBPP activities
5. To identify lessons learnt (in relation to relevance, effectiveness, efficiency and sustainability of the PRBPP) and to make recommendations that will improve implementation, efficiency, monitoring and evaluation, and/or achievement of outcomes in the final stages of the Programme; inform FHFNZ in their future work and inform MFAT and AusAID in terms of their future relationship with FHFNZ.

### 3.4 Detailed evaluation questions

Detailed evaluation questions for each of the five objectives are as follows:

1. **To assess the on-going relevance of the PRBPP in Timor-Leste, PNG and the Pacific region:**
   - To what extent does the PRBPP as a whole, and individual project work streams (including intended design and implementation), remain relevant to country priorities and to local development priorities?
   - Within the broader eye health context has the Programme focused on the highest priority issues (that ultimately will contribute to better outcomes for poor people) that need to be addressed?
   - What other donor and government activities are being implemented to strengthen eye health in Timor-Leste, PNG and the Pacific region? To what extent is there effective coordination of Programmes and activities?

2. **To assess the effectiveness of the PRBPP:**
   - To what extent were the goals and objectives (outcomes) of the PRBPP clearly defined and feasible?
   - To what degree is the Monitoring and Evaluation Framework fit for purpose i.e. has this provided appropriate and robust information on outputs and contribution towards outcomes and impact? If not, why not?
   - To what extent has progress been made towards achievement of project goal, objectives (outcomes) and outputs to date (including positive/negative and intended/unintended outcomes)?
   - To what extent are PRBPP activities sufficiently integrated into primary care services and other clinical settings/training?
   - What factors support and constrain achievement of outputs and outcomes? How are these being addresses by FHFNZ (for those within FHFNZ control)?

3. **To assess the efficiency of the PRBPP in delivering project outputs and outcomes:**
   - To what extent has the Programme been efficiently delivered (i.e. inputs to outcomes, management arrangements, governance arrangements) both in-country and in Auckland to meet regional/multi-country/individual country needs?

- Has administration and management of the Programme been efficient and effective (e.g. organisational structure, operational procedures, policies, personnel management)?
- To what extent has the delegated aid arrangement facilitated Programme efficiency?
- To what extent has the Programme provided value for money? i.e: Is FHFNZ approach to workforce training and support cost effective?

  Are there other approaches that could be used which are more cost effective?

  Could the same outcomes have been achieved with less money (e.g. savings made with different procurement, administration and management processes)?
- What has enhanced and constrained on-going efficiency of project implementation (including factors within the control of FHFNZ and those outside of its control)?

4. **To assess the sustainability of the PRBPP activities:**
   - To what extent are project benefits owned by Timor-Leste, PNG and participating Pacific governments, local NGOs, universities, etc, and how has the project contributed to domestic ownership?
   - To what extent is the project likely to be sustainable in terms of ownership, management arrangements, funding and sustainability of benefits?
   - What factors constrain or enhance project sustainability?
   - How if at all would Programme sustainability be impacted should the governance and structure of FHFNZ change?

5. **To identify lessons learnt and to make recommendations**
   - What lessons have been learnt in relation to relevance, effectiveness, efficiency and sustainability of the PRBPP?
   - Based on the evidence, what conclusions can be drawn and what recommendations can be made to improve implementation, efficiency, monitoring and evaluation, and/or achievement of outcomes in the final stages of the Programme; inform FHFNZ in their future work and inform MFAT and AusAID in terms of their future relationship with FHFNZ.

## 3.5 Outcomes framework

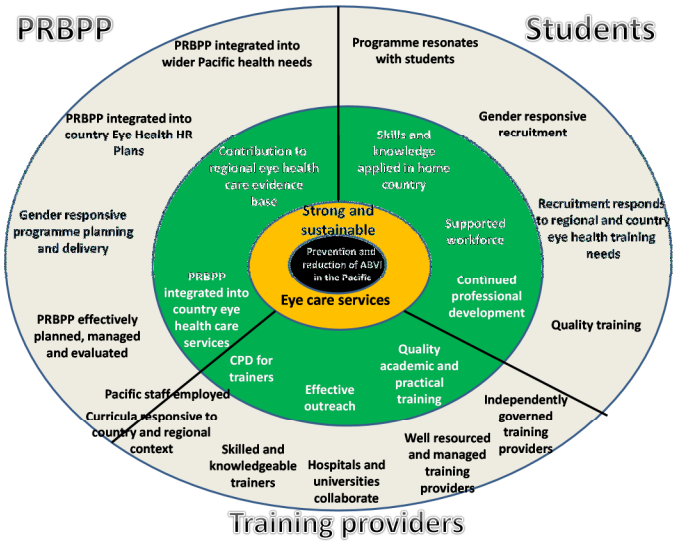
A preliminary outcomes framework was surfaced through reviewing core documents and briefing meetings with FHFNZ, MFAT and AusAID. It encompasses both the four Programme objectives ('strengthening sustainable training institutes', 'strengthening eye health training service facilities', 'developing appropriately trained eye health personnel in numbers commensurate with country eye health human resource plans' and 'supporting eye health graduates and ensuring they are retained within the public health sector to provide accessible, effective and sustainable eye health care'. It also encompasses the outcome mapping process undertaken by FHFNZ in August 2011.[15]

The draft outcomes framework will be tested for logic and accuracy during the evaluation implementation and will be presented as a final outcomes framework in the evaluation report.

It will be mainly used to inform, objective 2 (assessing PRBPP's effectiveness) in relation to the extent to which short-term (grey ring) and medium-term (green ring) outcomes are being achieved. The evaluation is not intended to determine the extent to which long-term outcomes (orange ring) or the ultimate outcome (black ring) is being achieved. However, the evaluation may highlight some perceptions of long-term outcomes for the Programme.

[15] FHFNZ, 2010. *Outcome Mapping Progress Report,* FHFNZ, Auckland

**Figure 1: Outcomes framework for PRBPP**




## 3.6 Indicators

The following sets out the indicators that will be used to assess PRBPP outcomes at the Programme, training provider and student areas.

| Outcome area | Short-term | Medium –term |
|---|---|---|
| | | |
| 1.Programme area | 1. Alignment with country eye health HR plan | 11. Alignment with country eye care services |
| | 2. Robust polices and procedures | |
| | 3. Budget allocated and spent | |
| 2. Training provider area | 4. Independently peer reviewed curricula | 12. % of training and management staff retained in universities and hospitals |
| | 5. # of qualified managers and trainers (total and total Pacific people) | |
| | 6. Robust polices and procedures | |
| 3. Student area | 7. # of enquiries received (total, total women, total by country) | 13. % of graduates retained in public eye care services |
| | 8. # of applicants received (total, total women, total by country) | 14. % of graduates visited/supported |
| | 9. % of successful applications (total, % of women, % by country) | 15. % of graduates undertake higher level training |
| | 10. % of students who graduate (total, % of women, % by country) | |

# 4. Data Sources

## 4.1 Data sources relative to objectives

The data sources include a Desk Review, qualitative stakeholder discussions and student/graduate survey.

- The Desk Review will provide information on the first three objectives of the evaluation. It will provide contextual information on the Programme and details of Programme outputs.

- Regional stakeholders (donors, FHFNZ, and United Nations Agencies) will provide information on all evaluation objectives but will have a specific emphasis on Programme design and relevance, monitoring and improvements, value for money, and future implementation.
- National stakeholders (Ministries of Health, universities and hospitals) will provide information on all evaluation objectives but will have a specific emphasis on Programme delivery and outcomes, as well as Programme sustainability and ownership.
- Students and graduates will provide data on their experiences of the PRBPP and whether they have remained in eye care services in country and the extent to which learnings have been integrated into the workplace. These stakeholders views will therefore inform the first three objectives.

The following table summarises the data sources for the evaluation and indicates the objectives they will inform.

| Objective | Documents and data | Regional stakeholders: Donors, FHFNZ, United Nationals agencies | National stakeholders: Ministries, universities, eye health care centres | Students and graduates |
|---|---|---|---|---|
| 1. To assess on-going relevance to the PRBPP in Timor-Leste, PNG and the Pacific Region | ✓ | ✓ | ✓ | ✓ |
| 2 To assess the effectiveness of PRBPP | ✓ | ✓ | ✓ | ✓ |
| 3 To assess the efficiency of PRBPP in delivering project outputs and outcomes | ✓ | ✓ | ✓ | ✓ |
| 4. To assess the sustainability of the PRBPP activities | | ✓ | ✓ | |
| 5. To identity lessons learnt | | ✓ | ✓ | |

### 4.2 Desk Review

Documentation to be reviewed as part of the Desk Review will include proposals, funding requests, contracts and variations, progress reports, student data, previous reviews, meeting notes and correspondence.

### 4.3 Qualitative stakeholder discussions

Face to face consultations will be undertaken in Fiji, PNG, Timor-Leste, Solomon Islands and Vanuatu. Solomon Islands and Vanuatu were selected because they have the most graduates outside of Fiji, PNG and Timor-Leste, as well as have received outreach services from PRBPP. The Vanuatu consultations have been scheduled to coincide with the timing of outreach provision.

AusAID will be accompanying the Evaluation Team in an observer capacity in some or most consultations.

Interviews or small group discussions will be undertaken with:

- Ministries of Health
- Management and trainers in universities and hospitals
- Students and graduates
- MFAT and AusAID
- United Nation agencies

Face to face consultations will also be undertaken with FHFNZ and MFAT in New Zealand and telephone consultations with AusAID in Australia.

A draft stakeholder list been prepared in consultation with MFAT, AusAID and FHFNZ. Once the list has been approved, the Evaluation Team will send emails to potential participants informing them of the evaluation and requesting their participation.

### 4.4 Student and graduate survey

A face to face survey will also be undertaken with students and graduates in the countries selected for in-country consultations. We will work with FHFNZ Country Managers to identify and recruit participants for the survey.

Where graduates in other countries have valid email addresses we will email the survey to them to self-complete. Two reminder emails will also be sent to enhance response rate.

Interview schedules and survey tool are appended.

We will seek to interview approximately 60-80 stakeholders, students and graduates subject to their availability.

## 5. Analysis and Reporting

### 5.1 Aide-memoires

Aide-memoires will be completed for each country visited to assist with report writing. Aide-memoires will include a list of all stakeholders consulted and a summary of key themes from each country visit.

### 5.2 Data analysis

Following the Desk Review and in-country visits the Evaluation Team will undertake an analysis workshop to systematically analyse the data. A deductive approach to data analysis will be used against the five evaluation objectives

Throughout the evaluation, a process of constant comparative analysis will be used to provide an overall assessment of the PRBPP, to determine the extent to which the Programme has been

effectively and efficiently managed, to assess the short and medium term outcomes achieved by PRBPP to date and to assess and provide options on sustainability of activities into the future.

During our investigation of specific outcomes, care will be taken with the interpretation of data. Triangulation of data will occur across the evaluation components to identify supporting as well as conflicting findings and to understand any contradictions noted.

### 5.3 Reporting framework

Before the commencement of report drafting, the Evaluation Team will provide MFAT, AusAID and FHFNZ a framework for reporting.

There will be three country reports for Fiji, Papua New Guinea and Timor-Leste and one summary report.

We envisage the summary report will include an executive summary, background to the evaluation, evaluation objectives, evaluation approach, key findings in relation to each of the five evaluation objectives (drawing from the three country reports and outreach visits), conclusions, recommendations and appendices.

The report will be independently edited and proof read before final submission.

## 6. Risk Management and Ethics

### 6.1 Risks and mitigation strategies

The following risks for the evaluation have been identified, along with mitigation strategies.

| Potential risks | Mitigation strategies |
|---|---|
| Limitations of documentation as an information stream:<br>▪ Difficulties retrieving/ accessing relevant documents<br>▪ Reporting/ author bias in documents reviewed<br>▪ Biased selection of documents to be reviewed | ▪ Where applicable, MFAT, AusAID, FHFNZ and Litmus will use their respective resources to identify documents of relevance to the evaluation<br>▪ Validity of documents will be carefully scrutinised to determine their origin and accuracy, and avoid incorrect or biased data. To this end, documents will be corroborated by evidence from other sources. |
| Lack of willingness to participate amongst key stakeholders, especially graduates who will have left Suva, Madang and Dili | ▪ We use an informed consent process to ensure participants have a clear understanding of the evaluation and their right to withdraw. In addition, we will use:<br>–Careful recruitment processes to establish trust and build rapport<br>–Clear communication about potential usefulness of the evaluation<br>–Reassurances on confidentiality<br>–Reminder emails/phone calls<br>▪ We will work with FHFNZ to invite students and graduates to participate in the evaluation and undertake follow up reminders.<br>▪ An interpreter will be engaged in Timor-Leste |

| Potential risks | Mitigation strategies |
|---|---|
| Participants not available during evaluation period | ▪ If not available, we will seek to make appropriate replacements in discussion with MFAT (as contract manager)<br>▪ We will work with in-country stakeholders to encourage participation. |
| Potential limitations of evaluation approach:<br>▪ Lack of rigour and validity, development of premature conclusions<br>▪ Inconsistent application of data collection and/ or analysis approaches by different members of project team | ▪ Piloting of interview schedules in Fiji (our first in-country visit) to ensure they will deliver the information sought<br>▪ Clear and frequent communication between Litmus and MFAT (as contract manager), including regular debriefs. |
| Limitations of interviews and groups as an information stream:<br>▪ Bias due to poor questions<br>▪ Response bias<br>▪ Incomplete recollection<br>▪ Reflexivity (participant reflects what interviewer wants to hear) | ▪ We use appropriate open-ended questioning, prompts to aid recall and probing to clarify uncertainties and inconsistencies<br>▪ We will ensure interview notes faithfully portray participant feedback<br>▪ Limitations will be documented in the final report. |
| Breach of stakeholders privacy and confidentiality | ▪ Use of informed consent procedures<br>▪ Participants are aware of any instances where guarantees of confidentiality cannot be made |
| Breaching cultural protocols or other sensitivities | ▪ Use of an evaluation team who has significant development and evaluation experience in the health sector. |
| Stakeholder relationships harmed | ▪ Use of a senior and experienced evaluation team with expertise in conducting senior and/or sensitive interviews<br>▪ Reporting to MFAT (as contract manager) any relationship issues as they arise. |
| Delays in field or travel impact adversely on delivery of draft report | ▪ Use of strong project management skills to ensure project stays to timeframe<br>▪ Reporting to MFAT (as contract manager) any slippages in timeframe, reasons for occurring and, if possible, strategies to mitigate their effect. |
| Interviewer safety and security compromised | ▪ Itinerary provided to Litmus, MFAT, AusAID and FHFNZ<br>▪ Two interviewers in country (with exception of Vanuatu)<br>▪ FHFNZ staff to provide transportation and escort services in Madang<br>▪ Consultants to use a reliable and secure taxi service in Port Moresby<br>▪ Registering travel details with www.safetravel.govt.nz<br>▪ Cell-phones carried on person. |

## 6.2 Ethical standards

Litmus is a member of the Australasian Evaluation Society and the Aotearoa New Zealand Evaluation Association. As such, we operate under their codes of ethics.

The Evaluation Team are experienced evaluators, incorporate participative approaches and apply the guidelines recommended by the Development Assistance Committee of the OECD (DAC/OECD) to ensure 'good practice and aim to improve the quality of development intervention evaluations'.[16]

We will place great emphasis on maintaining client and participant confidentiality. We will actively seek to maintain confidentiality and ensure information received is used solely for the purposes for

[16] DAC Evaluation Quality Standards, DCD/DAC/EV (2006)2, 07 March 2006 English Version

which it is provided. We will not identify individuals in the main body of the report. With stakeholders' permission, we will list the people and their organisations contributing to the evaluation in the annex to the report.

### 6.3 Conflict of Interest

Litmus is an independent social research and evaluation company and has no association or relationship with FHFNZ or the PRBPP.

Margot Szamier (Principal Consultant) is the partner of the New Zealand High Commissioner to Solomon Islands. We do not consider this to be a conflict of interest.

## 7. Evaluation Team and Timing

### 7.1 Evaluation Team

Sally Duckworth (Litmus Partner) will lead the evaluation. She is responsible for designing the Evaluation Plan and tools, leading in-country fieldwork, analysis and reporting.

Margot Szamier (Principal Consultant) and Susanna Kelly (Senior Consultant) will undertake the Desk Review, in-country consultations, analysis and reporting.

Liz Smith (Litmus Partner) will peer review all tools and deliverables.

### 7.2 Timing

The timing of the evaluation is as follows:

| | |
|---|---|
| Completion of Evaluation Plan | 11 August 2011 |
| Completion of in-country consultations | 15 September 2011 |
| Completion of aide-memoires | 20 September 2011 |
| Completion of draft country reports plus consolidated report | 14 October 2011 |
| Completion of final country reports plus consolidated report | 7 November 2011 |

**FHFNZ PRBPP**
**Regional focused guide (Use for donors, Programme managers, UN agencies, etc)**

**Introductions:**

- Introduce self/Litmus
- Outline evaluation purpose
- Informed consent

**Relevance of PRBPP:**

- How relevant is PRBPP to the Pacific Region's (and countries) health priorities?
- Within the broader eye health context has PRBPP focussed on the highest priority issues for the Region (and countries)?
- To what extent is PRBPP integrated into the Region's (and countries) wider health needs (e.g. diabetes)?
- To what extent is PRBPP integrated into countries' eye health human resource plans?
- What other Programmes, if any are being implemented at regional or country level to strengthen eye health?
  Probe: coordination, overlaps and strengths/weaknesses of PRBPP compared with other Programmes.

**Effectiveness of PRBPP:**

- What if any outcomes have been achieved for PRBPP since 2009 at Regional (and country) level?
  Probe against outcomes in Outcomes Framework (and ensure coverage across the four Programme objectives).
- What helped the achievement of outcomes? What got in the way of the achievement of outcomes?

**Efficiency of PRBPP:**

- What parts of PRBPP are working well and why? What parts of PRBPP are not working well and why?
  Probe: governance, management, human resources, workforce training, policies and procedures, curricula, facilities, student/graduate support
- What helped PRBPP efficiency? What got in the way of PRBPP efficiency?
- Could the same outcomes have been achieved with less money?
- Are there other approaches to workforce training that could achieve the same outcomes that are more cost effective?

**Sustainability of PRBPP:**

- To what extent is PRBPP owned by countries?
- How likely is it for countries to own, resource and manage PRBPP?
- What will help countries to own PRBPP? What is getting in the way of countries owning PRBPP?

**Lessons learnt:**

- What learnings are there for the future design and implementation of PRBPP to maximise its contribution to strong and sustainable eye care services in the Pacific?

**FHFNZ PRBPP**
**National focussed guide (Use for Ministries, universities, eye health centres, etc)**

**Introductions:**

- Introduce self/Litmus
- Outline evaluation purpose
- Informed consent

**Relevance of PRBPP:**

- How relevant is PRBPP to your country's health priorities?
- Within the broader eye health context has PRBPP focussed on the highest priority issues for your country?
- To what extent is PRBPP integrated into wider health needs (e.g. diabetes)?
- To what extent is PRBPP integrated into your country's eye health human resource plans?
- What other Programmes, if any are being implemented in your country to strengthen eye health?
  Probe: coordination, overlaps and strengths/weaknesses of PRBPP compared with other Programmes.

**Effectiveness of PRBPP:**

- What if any outcomes have been achieved for PRBPP in your country since 2009?
  Probe against outcomes in Outcomes Framework (and ensure coverage across the four Programme objectives).
- What helped the achievement of outcomes? What got in the way of the achievement of outcomes?

**Efficiency of PRBPP:**

- What parts of PRBPP are working well and why? What parts of PRBPP are not working well and why?
  Probe: governance, management, human resources, workforce training, policies and procedures, curricula, facilities, student/graduate support
- What helped PRBPP efficiency? What got in the way of PRBPP efficiency?
- (If known) Could the same outcomes have been achieved with less money?
- (If known) Are there other approaches to workforce training that could achieve the same outcomes that are more cost effective?

**Sustainability of PRBPP:**

- To what extent is PRBPP owned by your country?
- How likely is it for your country to own, resource and manage PRBPP?
- What will help your country to own PRBPP? What is getting in the way of your country owning PRBPP?

**Lessons learnt:**

- What learnings are there for the future design and implementation of PRBPP to maximise its contribution to strong and sustainable eye care services in the Pacific?

**FHFNZ PRBPP**
**Student and Graduate Questionnaire**

Please take five to ten minutes to answer the following questions about the PRBPP-funded training you received from **(consultant to add in provider name)**

1. What eye care training course(s) funded by the PRBPP are you attending or have graduated from?

| **Training courses:** | **Attended** | **Graduated** |
|---|---|---|
| **Evaluation Team to refill boxes with courses relevant for each country** | | |
| | | |
| | | |
| | | |

2. On a scale of very good to very poor, how would you rate the PRBPP-funded eye care training that you attended.

| | **Very good** | **Good** | **Fair** | **Poor** | **Very poor** | **Not applicable** |
|---|---|---|---|---|---|---|
| **Students and graduates:** | | | | | | |
| Enrolment and application process | | | | | | |
| Academic training staff (i.e. university training) | | | | | | |
| Clinical training staff (i.e. clinical services training) | | | | | | |
| Training facilities | | | | | | |
| Structure and format of training | | | | | | |
| Course materials | | | | | | |
| Curricula | | | | | | |
| Relevance of training to your country's eye care needs | | | | | | |
| Support you received from PRBPP during training | | | | | | |
| Increasing your knowledge and skills on eye care | | | | | | |
| Contributing to your professional development | | | | | | |
| **Graduates only:** | | | | | | |
| Extent to which you were able to apply the training to your clinical setting | | | | | | |
| Support you received from PRBPP on return to clinical practice | | | | | | |

3. Would you recommend other eye care professionals to enrol in PRBPP-funded training?

| | |
|---|---|
| Yes | |
| No | |

4. Please write in your occupation (e.g. optometrist, eye nurse).

_____

5. Please write in the name of the hospital or other place where you work.

_____

6. Please write in the country where you work.

_____

7. Are you:

| | |
|---|---|
| Male | |
| Female | |

8. Other comments

_____

_____

_____

_____

_____

Thank you for taking the time to fill in this survey. Please hand it in or email it back to the consultant.

# Appendix 8: Results from student and graduate questionnaire

1. What eye care training course(s) funded by PRBPP are you attending or have graduated from? (n=50)[17]

| Training courses | First qualification | Second qualification |
|---|---|---|
| *PG Certificate in Eye Care* | - | 2 |
| *PG Certificate in Diabetes Eye Care* | 5 | 1 |
| *PG Diploma in Eye Care* | 36 | - |
| *Masters in Community Eye Care* | - | - |
| *PG Diploma in Ophthalmology* | 7 | |
| *Master of Medicine in Ophthalmology* | 1 | 3 |

2. On a scale of very good to very poor, how would you rate the PRBPP-funded eye care training that you attended?

a. Enrolment and application process
(n=64)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 35 | 24 | 3 | 2 | - | - |

b. Academic training staff (i.e. university training)
(n=62)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 37 | 22 | 2 | 1 | - | |

c. Clinical training staff (i.e. clinical services training)
(n=64)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 35 | 22 | 5 | 1 | - | 1 |

d. Training facilities
(n=62)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 35 | 24 | 3 | - | - | - |

[17] The surveys that were received from Timor-Leste were received at a later date and were not translated in time for some of the data to be included in this draft report.

e. Structure and format of training
(n=63)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 29 | 30 | 4 | - | - | - |

f. Course materials
(n=64)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 31 | 27 | 6 | - | - | - |

g. Curricula
(n=57)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 25 | 28 | 4 | - | - | - |

h. Relevance of training to your country's eye care needs
(n=63)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 41 | 20 | 2 | - | - | - |

i. Support you received from PRBPP during training
(n=60)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 38 | 20 | 2 | - | - | - |

j. Increasing your knowledge and skills on eye care
(n=63)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 46 | 17 | | | | |

k. Contributing to your professional development
(n=64)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 40 | 21 | 2 | - | - | 1 |

l. Graduates only: Extent to which you were able to apply the training to your clinical setting
(n=39)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 18 | 18 | 3 | - | - | - |

m. Graduates only: Support you received from PRBPP on return to clinical practice
(n=39)

| Very good | Good | Fair | Poor | Very poor | n/a |
|---|---|---|---|---|---|
| 17 | 17 | 3 | - | 1 | 1 |

3. Would you recommend other eye care professionals to enrol in PRBPP-funded training?
(n=60)

| Yes | No |
|---|---|
| 59 | 1 |

4. Please write your occupation
(n=60)

| | |
|---|---|
| *Ophthalmic Clinical Specialist* | 3 |
| *Clinical Health Extension Officer* | 1 |
| *Clinical Nurse* | 1 |
| *Consultation Nurse* | 1 |
| *Consultation/Eye Nurse* | 1 |
| *Diabetes Eye Care Technician* | 1 |
| *Diabetes Team Leader* | 1 |
| *Diabetic Eye Nurse* | 1 |
| *Doctor* | 1 |
| *Eye Nurse* | 22 |
| *Eye Technician* | 12 |
| *Eye Nurse Practitioner* | 1 |
| *General Nurse* | 1 |
| *General Practitioner (Trainee Ophthalmologist)* | 1 |
| *Masters Student (Ophthalmology)* | 1 |
| *Medical Officer in Eye Department* | 1 |
| *Nursing Officer* | 2 |
| *Ophthalmologist* | 2 |
| *Ophthalmology registrar* | 1 |
| *PGDEC Student (General Nurse)* | 1 |
| *Registered Eye Nurse* | 3 |
| *Specialist Eye Nurse* | 1 |

5. Please write in the name of the hospital or other place where you work:
(n=49)

| | |
|---|---|
| Alotau Provincial Hospital | 1 |
| Angan Memorial Hospital | 2 |
| Boval General Hospital | 1 |
| Buala Hospital | 1 |
| Callan Services | 1 |
| CWMH | 6 |

| | |
|---|---|
| Gizo Hospital | 1 |
| Good Samaritan Hospital | 2 |
| Goroka General Hospital | 1 |
| Hospital de referencia suai | 1 |
| Kavieng General Hospital | 1 |
| Kukum Honiara City Council | 1 |
| Labasa Hospital | 2 |
| Lautoka Hospital | 2 |
| Madang FHF Eye Clinic Modilan | 1 |
| Mendi Hospital | 1 |
| Modilon Hospital | 1 |
| Mt Hagen Hospital | 1 |
| Narame Rural Health Clinic | 1 |
| National Referral Hospital | 7 |
| Norsup Hospital | 1 |
| Nonga General Hospital | 1 |
| Pacific Eye Institute | 1 |
| Popondetta General Hospital | 1 |
| Rotuma Sub-Divisional Hospital | 1 |
| Saupia Health Centre | 2 |
| Taro Hospital | 1 |
| Tungaru Central Hospital | 2 |
| Vaiola Hospital | 1 |
| Vanimo General Hospital | 1 |
| Vila Central Hospital | 1 |
| Wabag General Hospital | 1 |

6. Please write the country where you work:
(n=62)

| | |
|---|---|
| *Fiji* | 12 |
| *Solomon Islands* | 14 |
| *Kiribati* | 2 |
| *Papua New Guinea* | 15 |
| *Timor-Leste* | 14 |
| *Tonga* | 1 |
| *Vanuatu* | 4 |

7. Are you:
(n=62)

| **Male** | **Female** |
|---|---|
| 19 | 43 |