Terms of Reference for Evaluation

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1. Evaluation Summary

Program/Project, Project Number	1. "Reduction of avoidable blindness through improvement of eye health services in the Eastern Province, Zambia", 2011 - 2015
	2. "Building Children's Ophthalmic and Rehabilitation Care for Children, Togo", 2014 – 2018
	3. "Strengthening the right to education and health through access to eye care and education for blind and visually impaired children, Côte d'Ivoire", 2016 - 2019
	4. "Reducing Avoidable Blindness by Strengthening Ophthalmic Services, Zimbabwe", 2013 - 2017
Partner Organisation	1. St. Francis Anglican Hospital (SFH), Zambia
	2. Croix Rouge Togolaise (CRT), Togo
	3. CBM RHO AFWC in collaboration with Centre Hospitalier Universitaire de Treichville (CHU Treichville), Centre Hospitalier Universitaire de Bouaké (CHU Bouaké), Centre Medico Social El Rapha (CMSER), Côte d'Ivoire
	4. Zimbabwe Council for the Blind, Zimbabwe
Evaluation Purpose	The ex-post evaluation of the 4 completed projects shall assess their impact and sustainability. Promising approaches and recommendations shall be identified for the promotion of ophthalmic services.
Evaluation Type	Ex-post evaluation
Commissioning organisation/contact person	CBM, Marie Florence Prümm
Evaluation Team members (if known)	Team of external consultants with one international lead consultant and four consultants in countries (Zambia, Togo, Zimbabwe, and Côte d'Ivoire).

Primary Methodology	Mixed methods, incl. desk review and stakeholder interaction. Potential need for remote methods.
Proposed Evaluation Start and End Dates	August – October 2021
Anticipated Evaluation Report Release Date	October 2021
Recipient of Final Evaluation Report	Stiftung der Deutschen Lions (Lions Foundation Germany, SDL), The Federal Ministry for Economic Cooperation and Development (BMZ), partner organisations, CBM

2. Project Background and Description

The project **"Reduction of avoidable blindness through improvement of eye health services in the Eastern Province" in Zambia** from 2015 to 2019 aimed to increase the quality of life of the visually impaired population of the Eastern Province and reduce their risk of poverty by mitigating the effects of disability. This included strengthening of capacities of eye care services in the Eastern Province.

The project **"Building Children's Ophthalmic and Rehabilitation Care for Children" in Togo** from 2014 to 2018 aimed to improve the quality of life of children with (impending) visual impairment. This included the development of children's eye care and access to education for children with visual impairments.

The project **"Strengthening the right to education and health through access to eye care and education for blind and visually impaired children" in Côte d'Ivoire** from 2016 to 2019 aimed to improve the quality of life of children with visual impairment and their families. This included the establishment of children's ophthalmology hospital departments, as well as the training of medical professionals.

The project **"Reducing Avoidable Blindness by Strengthening Ophthalmic Services" in Zimbabwe** from 2013 to 2017 had the central goal of improving eye health and reducing avoidable blindness. In addition to persons with visual impairments, the project also aimed to improve the living situation and prospects of families.

In line with CBM's Inclusive Eye Health approach, one common objective of all projects was the strengthening of national eye health systems on the one hand and improved access to inclusive eye health services on the other. Sub-goals were improved access to education and access to other health services such as rehabilitation services.

All projects have the following in common: In the long term, the aim was to improve the quality of life of persons at risk of or affected by visual impairment and to reduce their risk of poverty.

The priority was the expansion and development of infrastructure of the partner hospitals in the form of construction measures and/or equipment with medical devices and instruments. Subsequently, human resource capacities were strengthened through training and education in the field of ophthalmology at all levels of the health system. Starting from tertiary level staff such as (paediatric) ophthalmologists and ophthalmic nurses, to secondary and primary level medical staff and community health workers. This should enable the target group to access eye care services. In addition, the

population was to be reached through sensitisation and education measures to create knowledge on the topic of disability and eye health as well as on the available services. Initial contact with the target group took place during screening visits and/or through outreaches in rural communities, with community health workers and professionals working closely together. Depending on the clinical picture and the need for further treatment, patients were referred to the relevant health facility for secondary and possibly tertiary eye health care.

3. Evaluation Objective and Intended Use

The ex-post evaluation will examine the completed inclusive eye health projects regarding their relevance, coherence, effectiveness, efficiency, impact, and sustainability. The project and impact analysis will help the SDL and its partners to incorporate and implement important recommendations in new programmes and projects. This is to continuously improve the quality and reach of its work. The ex-post evaluation is intended to ascertain the extent to which improved access to eye care services has improved the eye health of children and how this has led to an improvement in the quality of life. It should also be assessed how far the services at the hospitals itself are being continued and sustained, e.g., partners who were equipped with knowledge, skills, and other resources are continuing with same or improved level of service provisioning. The following target groups (direct, indirect, intermediaries) were identified in the four projects:

Direct target groups:
- Children (Ivory Coast, Togo, Zambia)
- Persons with low-income (Ivory Coast, Zambia)
- Persons with untreated visual impairments and eye diseases (Zimbabwe, Zambia)

Indirect target groups:
- Families/households of the direct target groups (Ivory Coast, Zimbabwe, Zambia, Togo)

Intermediaries:
- Community health workers (Côte d'Ivoire, Zimbabwe, Togo)
- Doctors (Ivory Coast, Togo)
- Paramedical and health professionals (Côte d'Ivoire, Togo, Zambia)
- Ophthalmic nurses (Ivory Coast, Togo, Zimbabwe)
- Midwives and/or traditional birth attendants (Ivory Coast, Togo)
- Heads of primary health care facilities (Togo)
- Educational specialists, special needs teachers and teachers (Côte d'Ivoire, Togo)
- Parents' representatives of school children (Togo)

The central question related to the core problem is:

To what extent have the projects contributed to a lasting improvement in living conditions for the target groups in the 4 countries by improving eye care?

To evaluate whether the desired effects have been achieved in the medium to long term through the corresponding measures, the following questions were

developed along the different components of the projects and following the DAC criteria of relevance, coherence, effectiveness, overarching developmental impact, efficiency and sustainability.

Structural changes (clinical expansion, reimbursement, and referral system)

1. To what extent has relevant infrastructure and ophthalmic facilities in the projects been built, made accessible and how are they being maintained?

2. How has access to quality and affordable eye care services improved? Have improved technical (human resources, infrastructure, service delivery, eye health data, financial systems, and management) and non-technical (patient-centred care, patient safety and reporting systems) changes led to improvement in eye health? Could an increase in the number of patients be determined on a permanent basis? What services were used and at what level (primary, secondary and tertiary)? How many of the persons identified in outreaches have used treatments (discounted through the fee system)?

3. To what extent were referral and patient fee systems strengthened and made more effective and sustainable? Has this led to increased uptake of service, more patients, or other observations?

4. Has the referral system contributed to early detection and prevention of visual diseases in a cost-, time- and resource-efficient way? Do the health facilities (primary, secondary and tertiary) have a data management system that ensures efficient treatment and referral of patients? How do health facilities store patient data so far? How has the cooperation between the different levels of health centres and health professionals (centralised and decentralised) worked in terms of an efficient referral system? Has the referral system strengthened cooperation between the different actors?

5. Has a fee system been introduced that guarantees the financial sustainability of the services established? Can the cross-financing of the established patient fee system ensure that patients with low-income will be able to receive treatment in the future?

6. Were the eye departments able to continue offering their services to all patients after the end of the project? Are screenings still carried out and if so, to what extent? Are outreach activities continued by the partner facilities?

Education, inclusion, and empowerment of direct target groups

1. Were inclusive structures created and maintained in the education sector? If yes, please elaborate on the structures, their role and effectiveness in promoting inclusivity.

2. What measures helped to ensure that persons with disabilities were actively involved in the projects, had access to eye care services and could participate in screenings?

3. Has the income situation, education, and health status of the direct target groups and for persons with disabilities improved? If yes, how?

4. Through which measures could the direct target groups be effectively sensitised on the topic of eye health?

5. How has basic knowledge about eye diseases been conveyed in schools and prevention or early detection been promoted and maintained through cooperation with the education and health sector? Did it lead to the strengthening of the self-help competences of the target groups and the establishment of self-help groups?

6. How could the inclusion of persons with irreversible visual impairment in the national education systems be ensured and maintained?

7. Could the population be sensitised efficiently through radio and television programmes regarding prevention and treatment options for eye diseases? How is this awareness maintained? Has awareness raising had an impact and did it improve attitudes and behaviour towards eye health issues?

8. How did self-help groups and self-help services develop and how can they continue to be strengthened? Could the living conditions of the direct target group in the regions be sustainably improved through education and awareness-raising measures?

9. Through which project components did a sustained cooperation between the Ministry of Education and the Ministry of Health develop? Was it possible to sustainably consolidate inclusive structures through educational work at the schools? Does basic knowledge about eye health still exist in schools today and are primary eye care and visual acuity assessments still offered? How was the knowledge disseminated in the school context?

Capacity development

1. Were capacity-building activities carried out at all relevant locations and how were they maintained?

2. Has there been a demonstrable increase in the capacity of professional staff and medical and educational intermediaries? Was it possible to increase the basic knowledge of all the above-mentioned target groups and intermediaries? How could the knowledge be effectively disseminated?

3. Could local training opportunities for health professionals be developed and implemented efficiently?

4. Do the knowledge and regular training opportunities still exist today? What functionality do the newly created structures and project implementing partners have currently?

Staff

1. Were all occupational groups with identified training and further education needs addressed accordingly?

2. Which knowledge transfer measures were most effective? Was it possible to successfully provide staff with specialised and medical training? How high was the additional benefit for the achievement of the project objective? Have ongoing or temporary influxes and outflows of professional staff or community health workers had an impact on the project? If there has been staff turnover, how has this been compensated for, and necessary expertise secured?

3. Were the contents of the training and further education courses aimed at achieving overarching development policy goals for eye health? How was their alignment with the country's own policy for eye health?

4. Which trainings were the most efficient in terms of cost and time? Have local training opportunities been sufficiently considered as an alternative?

5. Were the trainings provided to (para)medical staff sufficient to sustain the eye health services after the end of the project? How was the knowledge made widely available after individual staff members had participated in training? How was further knowledge transfer ensured?

Strengthening the competences of local project partners

1. To what extent have the projects contributed to strengthening relevant technical structures and human resource capacities that are still being used and deployed today?
   a) Have the implementing partners been institutionally strengthened by the projects? How can this be demonstrated?
   b) Has the broad impact of their work increased? How can this be demonstrated?
   c) Have the methods for project implementation and monitoring of the target groups improved? Please elaborate.

2. To what extent were the selected measures of the project effective in terms of the objectives to be achieved and addressing the needs of the target groups?

3. Were there other problems of the target groups that were not covered by the projects? If yes, why not?

4. Did lobbying and networking with government institutions and other NGOs take place during the project? In which form, and to what extent have they been successful?

5. How did the implementing partners monitor the projects? Which monitoring methods were most efficient?

6. Can the implementing partners carry out their tasks independently and on their own responsibility? Have stable and suitable organisational structures been developed for this purpose?
    a) Has the technical and medical know-how been sufficiently expanded? If yes, please expand on how.
    b) Are there needs and possibilities to continue to implement trainings and workshops for staff to continue to achieve a broad impact?

7. Was the transition to financial and professional sustainability from SDL and partners after the end of the project funding seamless and without problems? What measures to support independence were helpful?

Networking / Cooperation

1. Was it possible to establish and maintain a network of local project implementers with other NGOs and political institutions? To what extent have the projects with a focus on inclusive eye health addressed a relevant country-specific developmental problem in each case? Were representatives of relevant state institutions, for example the Ministry of Health, informed about the project and included in the project planning?

2. How did the cooperation between the involved stakeholder work (project executing agency SDL, implementing partners in the respective countries, CBM country offices, project teams, participants from the target regions)? Were there any contractual agreements between state institutions and the local project implementers regarding the implementation of the project? What lobbying activities were carried out at the state level by the project partners and/or by Organizations of Persons with Disabilities (OPDs)?

3. Has the involvement of national associations of persons with disabilities (e.g. in Côte d'Ivoire "COPHCI - Organisation de Personnes Handicapées en Côte d'Ivoire) been effective in raising awareness and disseminating basic knowledge on eye health? How has cooperation with OPDs taken place?

4. Did the projects fit into national health strategies? To what extent were national health policies addressed in the project? Did the projects fit into overarching national development strategies in the 4 countries, or did they even set their own, previously neglected accents? Could a contribution to the achievement of national development plans and Vision 2020 be achieved? Did the projects have an influence on the development strategies and the concrete work of responsible state institutions in their regions?

5. How can cooperation with other specialist clinics, reference hospitals and university hospitals be made more efficient so that permanent support and broader geographical networking can take place? Which networking arrangements turned out to be particularly efficient in achieving the project goals?

6. With the activities of which national, international or political organisations could synergies be created? How could these be used sustainably and built upon? Did the projects achieve the integration of any eye health services in the catalogue of

benefits of the health insurance companies, to ensure long-term cost-effective access?

Sustainability of the projects

1. Was it possible to ensure a seamless transition to autonomy for the partner organisations after the end of the project? To what extent have preparatory measures for the financial and technical independence of the project executing agencies been effective?

2. How are the overall results in terms of institutional, organisational/structural, technical, personnel and financial sustainability (for implementing partners and target groups)?

3. Social and cultural: Was it possible to raise the reputation of the partners and thus sustainably increase the interest of the population in the demand of services?

4. Did the services provided in the projects sustainably improve the living conditions of the target groups in essential areas?

5. Have the target groups been strengthened, and have they substantially developed their autonomy and self-determination? If yes, please explain how and also how they have exercised their role in health-seeking and health-improvement behaviour.

6. Technical: Did capacity building measures ensure technical sustainability in the projects? If yes, please elaborate how, and to what extent is it sustainable.

7. Has the knowledge of eye diseases and their treatments (basics and specifics) been consolidated by the trained professionals and health workers? Are refresher courses (theoretical and practical basic and specialised knowledge) provided to counteract the loss of knowledge? If yes, what training methodologies have been applied?

8. Financial: Who is covering the running costs (for consumables, staff costs, repair and maintenance of medical equipment) after the end of the projects?

9. To what extent are governments involved in the further assumption of costs? What costs are covered by the governments?

10. Institutional and political: Were the projects able to sustainably strengthen the awareness, networking, and development of the local project partners? If yes, please explain how and also how they have exercised their role in health-seeking and health-improvement behaviour.

Unintended or problematic effects

- What are the unintended or negative outcomes with a potential longer-term impact on the target groups?
- What is the proportion of project beneficiaries in relation to the total population of the respective municipality/region? Were/are there conflicts between beneficiaries and non-beneficiaries?
- What external factors may have had a negative impact on the implementation of the projects (e.g. migration, droughts, politically tense periods, etc.) and what countermeasures were taken?
- What are the unintended or negative outcomes with potential longer-term effects on the target groups?
- Which of the measures/instruments have been particularly effective in terms of access to inclusive eye health services, and which less so (equipping and building health facilities, strengthening professionals, field investigations, lobbying, education and awareness-raising measures)?
- What has contributed to or prevented the lasting continuation of the services introduced by the projects and their effects?
- What are the potentials and, if applicable, also the risks for sustainable effectiveness at the level of the project implementers and the target groups?

4 Methodology

The SDL attaches importance to ensuring that its evaluations comply with the evaluation standards of the German Evaluation Society (DeGEval) and the OECD/DAC principles and standards for participatory, credible, gender-sensitive and equitable evaluation. Wherever possible, participatory methods shall be used to promote self-reflection. The methods chosen shall be inclusive and respect the social and cultural context. Documentation for the methodological approach is requested by SDL as a basic part of the evaluation report. Conducting a debriefing or workshop with the local partner organisations is considered a key element of the evaluation.

Method	Sources
Desk study/file review	Planning documents, project progress reports (PPR, narrative reports), financial reports, audits, project evaluations, Hospital management systems, and/or other forms of patient registration system, other existing assessments, and studies.
Focus group discussions	Target groups, families, community members, local OPDs and other NGOs, project staff of the local implementing partners and staff in the hospitals.
Key informant interviews	Project managers, persons who have been involved in and benefited from the projects, persons from administrations and local authorities, NGOs and OPDs, etc.
Observation	Eye units, equipment, infrastructure, Functioning referral pathway (since VHWs and other community orgs were trained and involved), Observation of patient journey to validate effectiveness of referral pathway.

Due to the expected constraints of the ongoing Covid-19 pandemic, remote methods for the evaluation shall be considered, such as the use of IT-based data collection tools. Methods that require direct interaction with stakeholders in the project regions are desirable and should be implemented whenever possible. The methodology should be designed to be flexible enough and allow for possible necessary adaptation to current and local circumstances at any time.

1. Management Responsibilities and Evaluation Team

Commissioning responsibility

The supervision of the evaluation is led by a steering group of CBM's Inclusive Eye Health Initiative and the CBM Focal Point for evaluations.

Management Responsibility and Logistics

All in-country travel bookings are made by the evaluators themselves. CBM country offices and/or regional offices can provide support in this regard.

The respective CBM Country and/or Regional offices will support the access to further relevant documents. Furthermore, they will provide administrative and office logistics and support in scheduling any site visits in coordination with the partner organisations.

Evaluation Team

The team shall consist of one international lead consultant and four consultants in the respective project countries (Zambia, Togo, Zimbabwe, and Côte d'Ivoire)
The international consultant will have the overall responsibility for the quality and timely submission of all deliverables.

The team must have the following expertise and experience:
- University degree in a public health or social sciences related to the topic.
- Knowledge of local health systems with special consideration of eye health, especially primary health.
- 10 years of practical work experience in development cooperation with in-depth knowledge of inclusive development.
- At least 5 years of proven experience in evaluating complex programmes in African countries - references should be available.
- Proven experience with projects of international donors
- Experience with capacity-building measures.
- Experience in disability inclusive development is an advantage.
- Practical experience with rights-based participatory evaluations.
- Ability to work independently, proactively seek information and manage feedback and input.
- Experience with remote working methods is an advantage.
- Excellent written and oral communication skills in English and French. Language skills in German are an advantage. Appropriate measures must be planned for interviews with target groups in the local language (e.g. translators).
- Ability to analyse and translate results into practical guidance and present them in an appropriate format.

2. Deliverables

1. Inception report and presentation

The consultant(s) will prepare a detailed work plan including the evaluation methodology and tools in English. This will be presented to SDL and CBM during an online meeting and in the form of an inception report and agreed upon jointly.

Inception Report and presentation due by: September 8th 2021

2. Draft report and presentation of preliminary findings

The consultant(s) will conduct an in-depth analysis of the data gathered during the inception and field phase. After the data analysis is finalized, a presentation meeting with SDL and CBM should be organized to present and validate preliminary findings. A draft report is to be submitted three weeks after field phase to CBM and SDL (for distribution to the implementing partners and for feedback). Comments will be incorporated in the final report by the consultant team.

Draft report and presentation due by: October 1st 2021

3. Final report

Based on the inputs to the draft report, the consultant(s) will prepare a final evaluation report based on the CBM Report Template in English. The final report is to be submitted electronically, no later than 10 days after receipt of comments on the draft evaluation report. Ideally, the report shall have max 30 pages plus annexes and include a comprehensive summary that could potentially be used for publication.

4. Online Presentation
The consultants are responsible for the preparation of an online presentation in cooperation with SDL and CBM that targets SDL, BMZ, partner organisations, local governments, national governments, and CBM.

Finalised report and webinar due by: October 14th 2021

3. Evaluation Schedule

The evaluation is to be carried out from August to September 2021 within a total of 57 working days.
Tentative timetable:

Date	Number of days and location	Central evaluation measures
Mid- August	5 days Home based	Contract conclusion and desk study
Mid-August	4 days Home based	Briefing with SDL and CBM, project officers of the project executing agencies in Zimbabwe, Zambia, Togo and

		Côte d'Ivoire
End of August	5 days Home based	Inception report and presentation
End of August	6 days per country Project sites in Zambia, Zimbabwe, Togo & Côte d'Ivoire	Interviews, focus groups, direct observation (as far as possible); remote interaction, surveys
Early September	2 days Home based	Briefing on initial results with SDL, CBM and the project managers of the project executing agencies
Early September	15 days Home based	Data analysis
Mid-September	5 days Home based	Preparation of the draft reports and online presentation
End of September	5 days Home based	Discussion of the working drafts with the SDL and CBM
Early October	10 days Home based	Preparation of the final report and online presentation (in German and English)

4. Payment Mode

Contract and payment will be managed by CBM Inclusive Eye Health Initiative. Payment will be made in 2 instalments: 30% upon delivery of an accepted Inception Report and 70% upon full and satisfactory delivery of all the deliverables outlined above.

The following costs will be covered:

- Consultant costs: professional fees
- Logistic costs: airfares, accommodation, visa fee, local transport, communication cost and potential translation fees (costs will be reimbursed upon receipt of proper invoices)

5. Applications

Please insert here:

Expressions of Interest shall be submitted by August 3rd 2021 to Marie Florence Prümm marieflorence.pruemm@cbm.org and shall include:

- Brief description of consultancy firm/consultant/team
- Detailed CVs of each suggested team member
- Understanding of this TOR and suggested methodology
- Availability of team and suggested schedule
- Financial proposal

Only complete applications will be considered. The contractor may ask for references and/or examples of previous work and reports during the recruitment process. The contractor reserves the right to terminate the contract in case the suggested and agreed upon team members are unavailable at the start of the evaluation and no adequate replacement can be provided.

Each team member, incl. interpreters, enumerators etc need to fully comply with and sign CBM's or the partner organisation's Code of Conduct and Child Safeguarding Policy as well as commitment to data security and privacy.