



The Fred Hollows
Foundation



**VISION FOR KENYA: IMPROVING EYE HEALTH
THROUGH STRONGER SYSTEMS PROJECT
BASELINE SURVEY REPORT
DECEMBER 2022**

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CITATION

Fred Hollows Foundation, 2022: Vision for Kenya: Improving Eye Health through Stronger Systems Project Baseline Survey Report.

LIST OF ACRONYMS

AWP	-	Annual Work Plans
CHMT	-	County Health Management Teams
COG	-	Council of Governors
FHF-K	-	Fred Hollows Foundation Kenya
IPEC	-	Integrated People Centered Eye Care
KEMSA	-	Kenya Medical Supplies Authority
KHIS	-	Kenya Health Information System
KIIs	-	Key Informant Interviews
KQMH	-	Kenya Quality Model of Health
MoH	-	Ministry of Health
NEHWG	-	National Eye Health Working Group
NHIF	-	National Health Insurance Fund
NGOs	-	Non-Government Organizations
NSPEH	-	National Strategic Plan for Eye Health
OSU	-	Ophthalmology Services Unit
PBB	-	Program Based Budget
PDD	-	Project Development Document
SOPs	-	Standard Operating Procedures
ToRs	-	Terms of Reference
UHC	-	Universal Health Coverage
WHO	-	World health Organization

KEY MESSAGES

- While there are disease-oriented eye health guidelines, there is no integrated eye health policy that captures all system aspects of eye health. There is need for collaborative development and dissemination of an integrated eye health policy. Further, designate and empower Eye Health champions to collaboratively work with other staff towards quality improvement in eye services at county level.
- There is limited visibility of Eye Health services at planning and budgeting levels in both National and county levels which engenders in inadequate financing of Eye Health and significant donor dependence in financing of Eye Health Services. There is thus a need for advocacy for improved eye health coverage and reimbursement by NHIF alongside advocacy for facility autonomy over eye health reimbursements.
- Existing coordinating structures of eye health are weak, mostly donor driven and there is low inclusion of eye health coordinators in county health management teams. There is need for advocacy for increased government leadership and coordination; and inclusion of eye specific quality indicators in an integrated support supervision system.
- Counties acknowledge the burden of eye disease in their plans but do not effectively address it due to limited financing, and weak monitoring systems. There is limited eye health commodity quantification and forecasting at county level with engagements between the counties, ministry of health and KEMSA being Adhoc.
- Most counties have integrated health equipment maintenance plans but with limited focus on eye equipment; and are often not implemented due to limited resources including few eye equipment specific biomedical engineers, technologists and technicians to support eye health equipment maintenance.

EXECUTIVE SUMMARY

Fred Hollows Foundation ("Foundation") commissioned an evaluation team ("Team") to conduct a baseline evaluation aimed at establishing the status of the eye health ecosystem indicators across the identified three pillars prior to implementation of the Improving Eye Health through Stronger Systems project, against which performance can be measured during the project lifecycle. The evaluation was carried out from October – November 2022. This document details the evaluation findings and recommendations.

The project builds on previous Fred Hollows Foundation Kenya successes in positioning The Foundation as a key player in the eye health sector and focuses on influencing policy decisions for eye health and capacity building in respective health system pillars.

The evaluation took on an exploratory design whose qualitative findings were partly buttressed by quantitative data from selected budget indicators. Nonrandom sampling techniques, specifically purposive and snowball sampling methods, were applied in the selection of a) the 4 focus counties (West Pokot, Kitui, Homabay and Kilifi); and b) the respondents to the Key Informant Interviews and electronic surveys. The respondents included representatives from the National and County governments with specific focus on those who interface with governance, supply chain management and Health Information Systems. The primary data was complemented by secondary data drawn from existing national and county level health policy sources alongside global best practice in Eye Health.

The resultant findings were analyzed and summarized in keeping with the client-defined outcomes framework augmented by the WHO Health System Building Blocks.

Findings and Recommendations

a) Policies, Standards and Guidelines

While there are disease-oriented eye health guidelines, there is no integrated eye health policy that captures all system aspects of eye health. Further, the existing guidelines are not only weakly disseminated to key stakeholders but are also not adapted to county contexts.

Recommendations

- Collaborative finalizing of the development, updating, and dissemination of an integrated eye health policy
- Counties to have the flexibility to tailor the policy recommendation to their respective contexts.

b) Eye Health Financing

There is limited visibility of Eye Health services at planning and budgeting levels in both National and county levels which engenders in inadequate financing of Eye Health and significant donor dependence in financing of Eye Health Services. Additionally, facilities lack autonomy over resources internally raised through NHIF reimbursements for eye services rendered.

Recommendations

- Increased visibility of eye health priorities and needs in county and national planning and budgeting tools.
- Advocacy for increased government financing for eye health for improved sustainability beyond donor financing.
- Improved collaboration between counties and NHIF for improved design and uptake of eye health packages.
- Advocacy for improved facility autonomy over eye health reimbursements from NHIF.

c) Service Delivery and Quality of Eye Care (KQMH)

There are no Eye Health Specific indicators of service delivery or quality of care captured across all KQMH dimensions and levels of care.

Recommendations

- Inclusion of priority eye health indicators in the integrated KQMH indicators across all dimensions and levels of care.
- Designate and empower Eye Health champions to collaboratively work with other staff towards quality improvement in eye services at county level.

d) Coordination of Eye Care

While there is effort at coordination of eye health at national and county level, the existing coordinating structures (including NEHWG) are weak, mostly donor driven and there is low inclusion of eye health coordinators in county health management teams. There is an integrated support supervision system across counties but with limited focus on priority eye health indicators.

Recommendations

- Strengthen governance capacity and structures for coordination of eye health at national and county levels. Have more structured platforms including NEHWG with proper Terms of References.
- Advocacy for government leadership and coordination of eye health services
- Include eye specific indicators of quality care in the integrated support supervision guide/ checklist.

e) Human Resources for Eye Health

Health resource management is largely done in line with the other general established policies for health workers. While there are established staffing needs and norms, implementation and adaptation of the findings is varied across the counties; and strained by inadequate and ineffective staffing of eye health facilities.

Recommendation

- Advocacy for adequate staffing of eye health facilities based on need at county level.

f) Eye Health Commodities and Products

Counties acknowledge the burden of eye disease in their plans (AWPS and procurement plans) but do not effectively address it due to limited financing, and weak monitoring systems. There is limited eye health commodity quantification and forecasting at county level with engagements between the counties, ministry of health and KEMSA being Adhoc.

Integrated supply chain trainings are hardly cascaded to subcounty and facility levels. Most counties have integrated health equipment maintenance plans but with limited focus on eye equipment; and are often not implemented due to limited resources including few eye equipment specific biomedical engineers, technologists and technicians to support eye health equipment maintenance.

Recommendations

- Strengthen capacity for forecasting, quantification, specification and monitoring of eye health commodities and products at facility, sub county, county and national levels.
- Build capacity for eye health specific biomedical engineers across all levels (national and county level).
- Inclusion of eye equipment maintenance plans in the integrated maintenance plans at county level.

g) Eye Health Information Systems

Eye health indicators are integrated in the KHIS across multiple reports for all facilities, and designated Ophthalmology Services Unit report for specialized eye care facilities. Notably, the Eye

health indicators captured across all facilities are general and lack specificity on disease and quality of outcomes of care. There is limited use of eye health data for decision making at county level.

Recommendations

- Include eye specific indicators of quality care in the integrated KHIS.
- Advocacy for improved reporting, uptake and use of eye health data in planning and management.

b) Eye Health Research

There is no clear eye health research agenda at both national and county level. Further, while the county and national teams acknowledge the value of research, there is limited funding for eye health research and limited capacity and training for research.

Recommendations

- Collaborative development and dissemination of an integrated eye health research agenda.
- Advocacy for increased funding and capacity development for eye health research.

MAIN REPORT

INTRODUCTION

PROJECT BACKGROUND

Improving Eye Health Through Stronger Systems project is designed to support and strengthen eye health services within the broader national and county level health systems in Kenya and aligns with priorities of the National Strategic Plan for Eye Health (NSPEH) 2021-2025 that highlights eye health as an integral part of the government's flagship program to achieve Universal Health Coverage (UHC).

It is aligned with the World Health Organization's framework for Integrated People Centred Eye Care (IPEC) and specifically focuses on two of the four main strategies recommended by IPEC - namely, creating an enabling environment and coordinating services within and across the sectors. The project directly supports the achievement of a responsive health system that ensures equitable access and provision of quality eye health services for sustained improvements in the health outcomes of the population.

The project builds on previous FHFK successes in positioning The Foundation as a key player in the eye health sector and focuses on influencing policy decisions for eye health and capacity building in respective health system pillars.

Service delivery systems will be improved by implementing interventions across three system functions:

- i. Improved governance, accountability, and policy implementation,
- ii. Strengthened health information system for evidence-base decision-making and program planning; and
- iii. Strengthened supply chain systems for improved availability, quality and accountability of eye health products and technologies.

Three main approaches will inform delivery of the project at national and county level: advocacy and influencing, capacity building of key leaders, and technical support across the three focus pillars. It is envisaged that investment in these 3 pillars will improve governance mechanisms for efficient leadership and coordination, effective and sustainable policies, plans and programs for eye health, and support effective integration of eye health in the government driven universal health coverage (UHC).

BASELINE SURVEY FRAMEWORK

A survey framework to systematically and comprehensively assess the questions set out in the Terms of Reference (ToR) for the final evaluation will be developed. This will address the expected key outcomes integrated with the World Health Organization Health System Building Blocks as below:

Outcome 1: Strengthened leadership, Governance, and coordination both at National and County level that drives more efficient and effective eye health service delivery.

Outcome 2: Strengthened supply chain system that ensures efficient supply of high-quality eye health commodities and medicines at the county level.

Outcome 3: Strengthened eye health information systems and the use of data and information for evidence-based decision-making, advocacy, and program planning.

METHODOLOGY

EVALUATION PURPOSE

This baseline assessment was aimed at establishing the status of the eye health ecosystem indicators across the three pillars prior to implementation of the Improving Eye Health through Stronger Systems project, against which performance can be measured during the project lifecycle. We refer to the indicative evaluation questions to analyse the status of each pillar. The resultant findings were analyzed and summarized in keeping with the client-defined outcomes framework augmented by the WHO Health System Building Blocks.

The primary intended users of this baseline survey will be The Foundation's:

- Programs Division (including Program Development Team and country program teams)
- Kenya Team
- Country Support Network and other country teams
- Development Effectiveness Team

These teams provide advice and/or make decisions about the choice and design of programs across The Foundation.

The evaluation is also likely to be of interest to a range of secondary users, including: the Ministry of Health in Kenya and 13 counties targeted for direct programming; International eye health sector NGOs, the Australian Department of Foreign Affairs and Trade.

EVALUATION SCOPE AND KEY QUESTIONS

Define the scope of the evaluation and the key questions the evaluation set out to answer.

This is a baseline survey of the 'Improving Eye Health through Stronger Systems' project indicators at the National and county levels in Kenya to be implemented in 2022 – 2025.

9 Key national level informants and 15 county key informant were sampled.

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
Outcome 1: Strengthened leadership, Governance, and coordination both at National and County level that drives more efficient and effective eye health service delivery.				
1. Which policies are in place to guide eye health service delivery and disease management?	<i>List the policies in place. Also Ask for those which are missing. This is across eye health disease areas</i>	<i>Policies in place</i>	OSU	Document review Key informant interviews
2. Which policies needs to be in place to enhance coordination of eye health at all levels in the country?	<i>Ask for policies needed to be in place at the minimum</i>	<i>Policies in place</i>	OSU	Document review Key informant interviews
3. What gaps exists in the implementation of eye health policies, standards, and guidelines at both county and sub- county level.	<i>What are the existing standards?</i>	<i>Standards are in place</i>	OSU; county eye coordinator	Document review Key informant interviews
4. What plan or guidelines exists to enhance support supervision for continuous quality improvement in eye health?	<i>Is there a continuous quality improvement in place at national and county levels?</i>	<i>Existence of quality improvement plans, guides etc.</i>	OSU/ county eye coordinator /Partners	Support supervision Documents review Key informant interviews

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
5. To what extent has eye health been integrated in the Kenya Quality Model for Health?	<i>Which eye health elements are integrated in KQMH?</i>	<i>KQMH standards for eye health</i>	MoH Division of Quality and Standards	KQMH review Key informant interviews
6. To what extent have the counties (CoG) and the national health promotion platforms e.g., National Eye Health Working Group (NEHWG) coordinated delivery of eye health services?	<i>How does COG address eye health?</i> <i>How often does NEHWG meet?</i>	<i>Eye health as an agenda in COG health address</i> <i>Set</i>	MOH-NEHWGs/COG	Key informant interviews
7. To what extent are human resource management policies and plans developed and implemented to enhance equitable eye health service delivery	<i>How does HRM address eye health service delivery?</i> <i>Is there a focus on Eye Health staffing across the county?</i> <i>How many eye health staff in the county?</i>	<i>Eye health Staff in place at the various county organization structures?</i>	OSU/MOH/CH MTs chair	HRM policy review Key informant interviews
8. To what extent is eye health funded and integrated in annual plans and budget for effective service delivery for various counties?	<i>Is there funding of eye health by the county?</i> <i>How much?</i> <i>How much is the non-government funding for eye health?</i>	<i>Presence of an eye program or budget line in the annual work plan and budget.</i>	CHMTs	<i>Review of the county annual plan and budget.</i> <i>Key informant interview</i>
9. To what extent has eye health agenda been included in inter-governmental co-ordination committee meetings?	<i>Is eye health in the intergovernmental agenda?</i> <i>When is the last time it was discussed?</i>	<i>Presence of eye care as part of the main agenda.</i>	MOH Dir of Inter govt. Coordination	<i>Key informant interview</i> <i>UHC documents</i>

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
	<i>Is eye health part of UHC?</i>			<i>review</i>
10. To what extent are eye health workers included in CHMTs?	<i>Are there any eye health workers in CHMT? What are their roles?</i>	<i>Defined roles of eye health workers in CHMTs</i>	CHMTs or County eye coordinator	<i>Key informant interview</i>
11. To what extent have eye health resourcing plans and strategies and programmes been developed and used by different counties?	<i>Is there a resource plan for eye health? Are there programs to address eye health capacity?</i>	<i>Availability of un updated resource plan.</i>	CHMTs or County eye coordinator	<i>Key informant interview</i>
12. Are there regular stakeholder engagements and coordination forums for eye health at national and county levels, with defined deliverables?	<i>Which are the stakeholder engagements for eye health at national/county levels? Are there TORs for these? What eye health issues are being addressed?</i>	<i>Availability of the TORs engagements including deliverables.</i>	OSU/Partners	<i>Key informant interview</i>
Outcome 2: Strengthened supply chain system that ensures efficient supply of high-quality eye health commodities and medicines at the county level.				
1. To what extent are the supply chain management processes and plans updated	<i>Are there regular meetings between KEMSA, OSU/MOH to ensure regular updating of the</i>	<i>Set meeting to update eye health</i>	OSU/KEMSA/ MoH Division of	<i>Key informant interview</i>

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
to support effective delivery of eye health services?	<i>eye health supply chain?</i>	<i>supply chain</i>	Health Products of Technologies	
2. To what extent have eye health workers and county pharmacists and CHMTs trained on supply chain management for effective delivery of eye health services?	<i>Which trainings have been done for county pharmacists/CHMTs on supply chain for effective delivery eye health services?</i> <i>What training gaps exists for these cadres?</i>	<i>A set training schedule for CHMTs on eye care service delivery.</i>	CHMTs	<i>Key informant interview</i>
3. To what extent are equipment maintenance plans available and resourced for effective eye service delivery? What are the main issues affecting equipment maintenance and how well could this be addressed?	<i>Is there an inventory of all equipment including their functionality status?</i> <i>Is there an eye health equipment maintenance schedule?</i> <i>How are obsolete equipment identified and disposed of?</i>	<i>Availability of eye equipment maintenance schedule.</i>	MoH Division of Medical Engineering/ CHMTs	<i>Key informant interview</i>
4. To what extent have policies and/or SOPs for eye health supplies management been developed and used?	<i>Are there SOPS and policies in place and up to date?</i> <i>Is there utilization of the SOPs</i>	<i>Availability of current SOPs and policies.</i>	KEMSA/CHMT s/ OSU	<i>Key informant interview</i>
5. What needs to be done to ensure eye health services are included in the supply chain management?	<i>Any recommendations on strengthening integration of eye health into existing health supply chain management?</i>	<i>Identified gaps and potential solutions</i>	KEMSA/CHMT s/OSU	<i>Key informant interview</i>
OUTCOME 3: Strengthened eye health information systems and the use of data and information for evidence-based decision-making, advocacy, and program planning.				

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
1. To what extent is data management and use resourced for effective decision making in eye health services?	<i>What data is kept for eye health services?</i> <i>Who is in charge of recording keeping for eye health services?</i> <i>How is data used in management of eye health services?</i>	Complete eye health records kept, are traceable and used for decision making.	CHMTs/OSU/MoH Division of HMIS	Key informant interview
2. To what extent have capacity in data management and use been enhanced among eye health staff and management	<i>Has there been training among eye health staff and their supervisors on data management and use?</i> <i>What training gaps still exist?</i>	Recent training records on eye health staff on HMIS	CHMTs/OSU	Key informant interview Records review
3. To what extent are data management and review sessions integrated in the day-to-day eye health service delivery?	<i>Are all the necessary patient records on eye health kept and notified when necessary?</i> <i>Has there been management meetings that reviews data in the eye service delivery?</i>	Are patient records and summarized reports are well kept and discussed in management meetings.	CHMTs/OSU	Key informant interview Records review
4. To what extent are data management and quality assurance plans coordinated between national and county government?	<i>What support supervision on data management is done?</i> <i>Is there data audit?</i> <i>Where is support supervision report on data shared?</i>	Data audit schedule and report seen.	CHMTs/OSU/MoH Division of Quality and Standards	Key informant interview Records review
5. To what extent are data quality assurance	<i>What data QA is carried out?</i>	An updated	CHMTs/OSU/P	Key informant

Key evaluation questions	Sub-questions	Performance standard (what constitutes 'success')	Data source	Method of data collection and analysis
activities regularly conducted and findings used for decision making?	<i>Are there regular QA plans in place?</i>	<i>Quality assurance plan in plan.</i>	artners	<i>interview</i> <i>Records review</i>
6. What measures needs to put in place to ensure eye health data are used for decision making?	<i>How is eye health data used for decision making?</i>	<i>Presence of checked and escalated reports</i>	CHMTs/OSU	<i>Key informant interview</i> <i>Records review</i>
7. To what extent have eye health indicators been integrated and reported in mainstream health data?	<i>What reports of eye health indicators are kept?</i> <i>Where are eye health records reported?</i>	<i>Availability of eye health reports</i>	CHMTs/OSU/MoH Division of HMIS/MoH Division of CHS	<i>Key informant interview</i> <i>General Health reporting records review</i>
8. To what extent has research and learning plans and strategies been developed and integrated in eye health service delivery by relevant organizations e.g., OSU and NEHWG? To what extent are these plans resourced?	<i>Is there research and learning plan?</i> <i>How is the funding for the research agenda?</i> <i>Is there training for research on eye health?</i>	<i>Availability of a research agenda that is adequately funded.</i>	CHMTs/OSU/NEHWG	<i>Key informant interview</i> <i>Records review</i>

APPROACH

The evaluation took on an exploratory design whose qualitative findings were partly buttressed by quantitative data from selected budget indicators. Nonrandom sampling techniques, specifically purposive and snowball sampling methods, were applied in the selection of a) the 4 focus counties (West Pokot, Kitui, Homabay and Kilifi); and b) the respondents to the Key Informant Interviews and electronic surveys. The respondents included representatives from the National and County governments with specific focus on those who interface with governance, supply chain management and Health Information Systems. The primary data was complemented by secondary data drawn from existing national and county level health policy sources, the KHIS, the internal project development documents, alongside global best practice in Eye Health. Annex I shows the respondents sampled at national and county levels.

The resultant findings were analyzed and summarized in keeping with the client-defined outcomes framework augmented by the WHO Health System Building Blocks.

EVALUATION TEAM

Name	Role	Responsibilities
1. Mr. Joseph Githinji	Project Lead Consultant	Contract management Proposal development Coordination Report development and dissemination
2. Dr. Mike Mulongo	Health Systems Consultant	Development of data collection tools Data collection and analysis Report Writing
3. Ms. Rosemary Wang'ombe	Monitoring and Evaluation consultant	Monitoring data progress Data collection Data analysis
4. Mr. Kennedy Alwenya	FHF-K contact	Contract Supervisor and General Support
5. Mr. Chrispory Ombuya	FHF-K contact	General Support
6. Mr. Henry Mwangi	FHF-K Contact	Monitoring and evaluation Advisor

LIMITATIONS

Due to limited or incomplete data across some of the variables at county and national level some alternative sources or estimates were sought and cited from peer reviewed sources, gray sources, inter alia.

Given the timing of the exercise, there was an overlap with the transition process of leadership in the respective county departments of health and hence some county informants were a bit guarded in their responses.

Some of the Key informants had previously been supported by FHF and were therefore a bit biased. Some respondents opted to fill out the information and we had to create an online form. This may lack the rigors of an interview.

ETHICAL AND OTHER APPROVALS OBTAINED

While the nature of the assessment and the intended use of the resultant outputs posed no harm to the respondents as to warrant ethical approval, the evaluation was conducted in keeping with the tenets of **good research practice**. As such, we obtained **informed consent** from all respondents prior to data collection. It was made clear that participation in this assessment was **purely voluntary** and under no coercion. Participants were thus **free to opt out** of the assessment at any point without any loss or reprimand. **Confidentiality** was upheld while collecting and managing the resultant data. **Appropriate attribution, citation and recognition of intellectual property rights** shall underpin our use of content or material that is not original to ourselves.

Additionally, the exercise was conducted in keeping with the ethical terms of the Fred Hollows Foundation and in **compliance** with existing laws in Kenya anchored on the Constitution of Kenya 2010.

EVALUATION FINDINGS

The findings are from desk of review of key documents and 24 key informants' interviews at the national level are involved in policy making in regards to standards, staffing level assessment, medical products and technologies; and health financing. The county level included the eye health coordinators, records information officers and county pharmacists who are health managers and part of the County health management teams.

The findings are arranged according to the three key outcome areas and the specific key questions.

Outcome 1: Strengthened leadership, Governance, and coordination both at National and County level that drives more efficient and effective eye health service delivery.

Which policies are in place to guide eye health service delivery and disease management?

While there are general health policies and guidelines, there are few eye health specific policy guides and those available are not well disseminated to the facility level providers of care. The policies and guidelines include the following: Constitution of Kenya 2010, Vision 2030, Medium Term Plan III, Kenya Health Policy 2014-2030, Health act 2019 , Revised NHIF Act of 2021, Kenya Essential Package for Health, Kenya Quality Model for Health, Kenya Health Sector Strategic Plan 2018-2023, UHC Policy 2020-2030, Kenya Primary Health Care Strategic Framework 2019-2024, The NCDs strategic plan 2021/22-2025/26, National Clinical Guidelines for Management and Referral of Common Conditions levels 1-6 2009; Scope of practice for various cadres of eye services,

Kenya Health Financing Strategy, Kenya Eye Health Strategic Plan 20-25, Kenya Health Information Systems (HIS) Policy, County Governments' Act inter alia.

Most respondents sampled were not aware of any Eye Health Specific policies at national and county level but were aware of the integrated policies such as The Kenya Health Policy 2014-2030, the Kenya Health Sector Strategic Plan, Kenya Health Information Systems (HIS) Policy inter alia. The most cited Eye Health specific policy document was the National Eye Health Strategic Plan. Other specific documents are largely local and global disease-oriented guidelines including:

- National Diabetes retinopathy guidelines
- National Glaucoma guidelines
- Retinopathy of Prematurity (R.O.P) guidelines
- International guidelines such as International Council of Ophthalmology (I.C.O) guidelines on Diabetic retinopathy.

At the national level it was reported that the eye health policy development is in progress.

Most respondents highlighted the need for policy level guidance on Eye health service delivery at all levels of care as well as the linkage of care across the levels (from community to national level). The policy would also provide guidance on integration, surveillance and quality monitoring, data management, supply chain management, leadership and governance of Eye health at county and national level.

The following were noted as critical hindrances to the implementation of eye health policies, standards, and guidelines:

- Limited awareness of eye health policies and standards among health workers, including eye health workers.
- Limited financing for eye health at county and national level across all dimensions including staffing and capacity development, commodities, equipment, data management systems, quality assurance and governance.
- Few facilities that are adequately equipped and staffed to provide quality eye care
- Limited political will and visibility of Eye Health to policy and decision makers
- Limited training and opportunities for training on Eye Health

What plan or guidelines exists to enhance support supervision for continuous quality improvement in eye health?

There is an existing support supervision framework developed by OSU for use at the national and county levels. However, there is inadequate allocation of resources in the budget at both levels.

Department of standards has trained eye care services providers on how to carry out quality improvement through identification of existing quality gaps through a process of self-assessment.

There is ongoing setting up of a Health Products and Technology (HPT) governance structures at the county level.

There is no Eye specific supervision guide but a generic integrated supervision guide used in the quarterly support supervision across all facilities.

“There is no eye health specific support supervision, just general support supervision guidelines.” County Based Eye Health Stakeholder

The Kenya Quality Model for Health provides a threshold on the standard of quality for health services in Kenya. Unlike other services such as maternal and newborn care that have care specific indicators, there are no Eye Health Specific indicators of service delivery or quality of care captured in the indicators across all QMH dimensions. However, there are general and cross cutting indicators touching on leadership, standards and guidelines, human resource management, facility, infrastructure, supplies and equipment, surgical and anesthetic care, health records and information, and patient centeredness of care inter alia.

To what extent are human resource management policies and plans developed and implemented to enhance equitable eye health service delivery

Most counties had few eye health staff and highlighted the fact that no notable affirmative action towards improving human resource capacity for eye health had been taken in the respective counties. There is no specialized handling of eye care but is integrated with the mainstream Human resource management. OSU advises on rational distribution of the staff across the country following an established national eye health needs plan. Majority of county level stakeholders are not aware of the said norms.

“No policies have been developed, and the current worker: population ratio as stipulated by WHO are way below the prescribed standards.” County Based Eye Health Stakeholder

While the counties recognize the burden of Eye Health conditions in their respective Annual Work Plans, most do not capture the respective eye health work force levels in the work plans, and most do not provide the regular monthly staffing reports on KHIS (IHRIS).

“Devolution has come with a challenge where the staffing is interfered with by the county government especially in terms of training where some counties end up with more than necessary capacity” National Key Informant

To what extent is eye health funded and integrated in annual plans and budget for effective service delivery for various counties?

Eye Health Budgets

- There is limited visibility of Eye Health in the Program Based Budgets in the selected counties. Most of the PBBs do not capture specific eye health interventions except for the general allocations to Non-Communicable Diseases, Neglected Tropical Diseases.
- While the Annual Work Plans for most counties have some detail on Eye Health needs and priorities, these do not follow through into the Program Based Budgets
- While most counties on average allocate about 30% of their budgets to health, eye health needs are estimated to receive significantly lower than 1% of the county health budgets as depicted in figures 1-4.
- Eye health priorities are not explicitly captured in the planning and budget documents and are thus assumed to be covered in other services e.g., under NCDs, Neglected Tropical Diseases etc.
- In most of the counties, the County Health Budgets approved in the Program Based Budgets were significantly lower than those proposed in the Annual Work Plans as shown in figure
- There is a significant reliance on donors for the funding of Eye Health Services in the counties. This threatens prioritization and sustainability of the respective interventions in view of the transitions in donor financing.

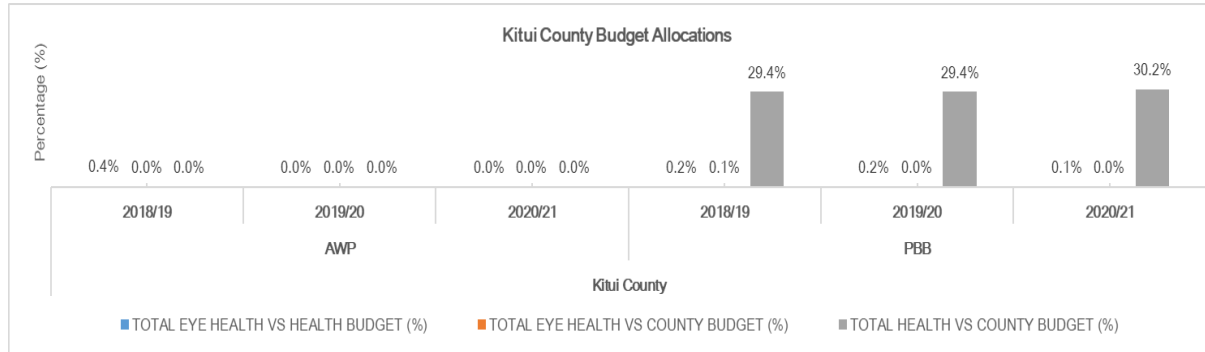
“ No real plans for eye as they are regarded as the orphaned diseases and left to facilities to give prominence. Not part of the biggest public concerns and is left to NGOs to relieve the headache” National level informant.

To what extent have eye health resourcing plans and strategies and programs been developed and used by different counties?

Some of the counties have factored eye care in the County Integrated Development Plans (CIDP), Annual Development Plans (ADPs) and Annual Work Plans (AWPs) but do not get budget allocation.

County Eye Health Allocations

Figure 1: Health Allocations in Kitui County

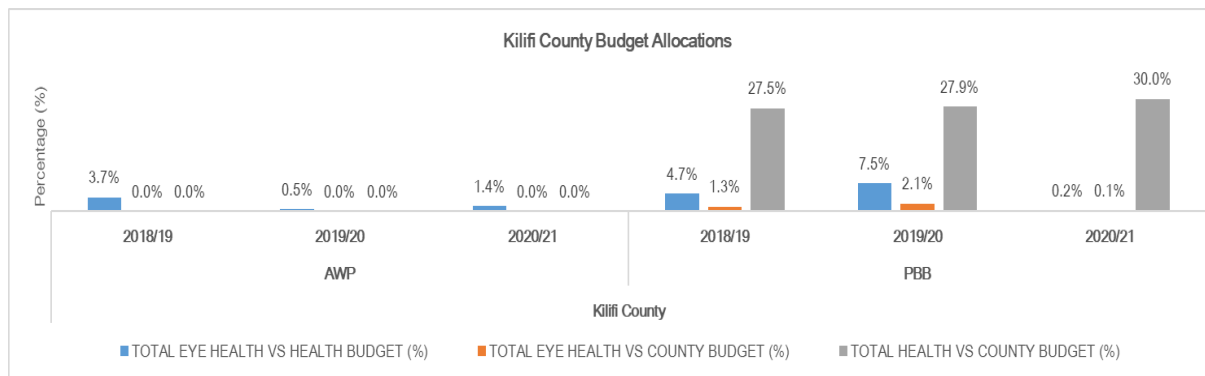


The eye health allocations in both the Annual Work Plans and Programme Based Budgets are below 1% across all the years under study.

PBB allocations to health from the county budgets are estimated to be between 29 and 30%.

Source: County PBB and AWP

Figure 2: Health Allocations in Kilifi County

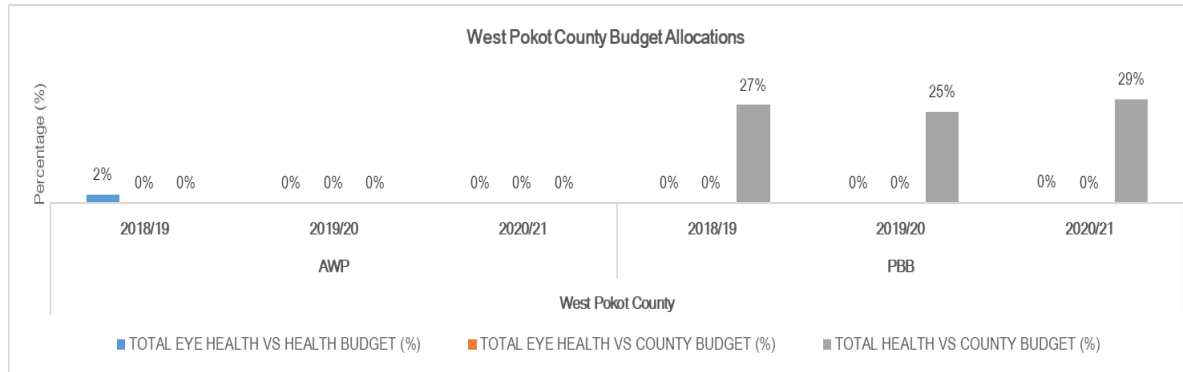


The eye health allocations in the Annual Work Plans are below 4% of the health budgets, and below 2% of the county budgets. In the Programme Based Budgets, they are below 8% of the health budgets and 3% of the county budgets across all the years under study.

PBB allocations to health from the county budgets are estimated to be between 27 and 30%.

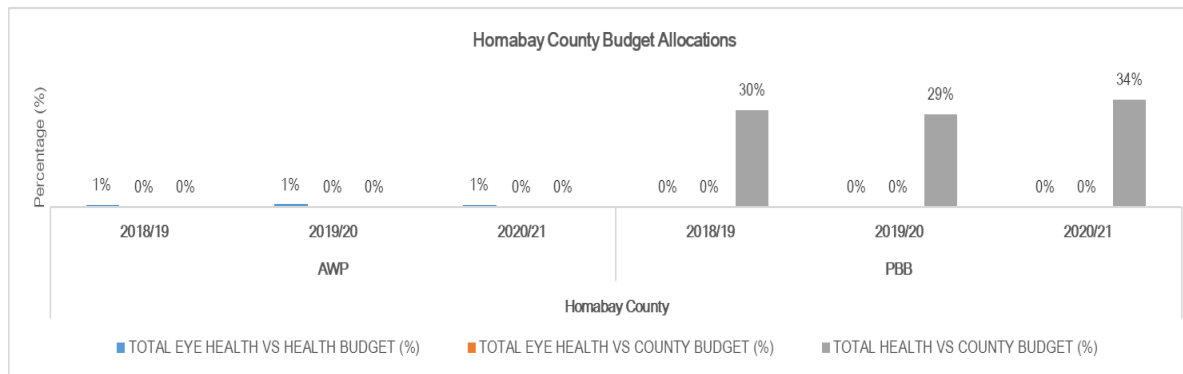
Source: County PBB and AWP

Figure 3: Health Allocations in West Pokot County



Source: County PBB and AWP

Figure 4: Health Allocations in Homabay County



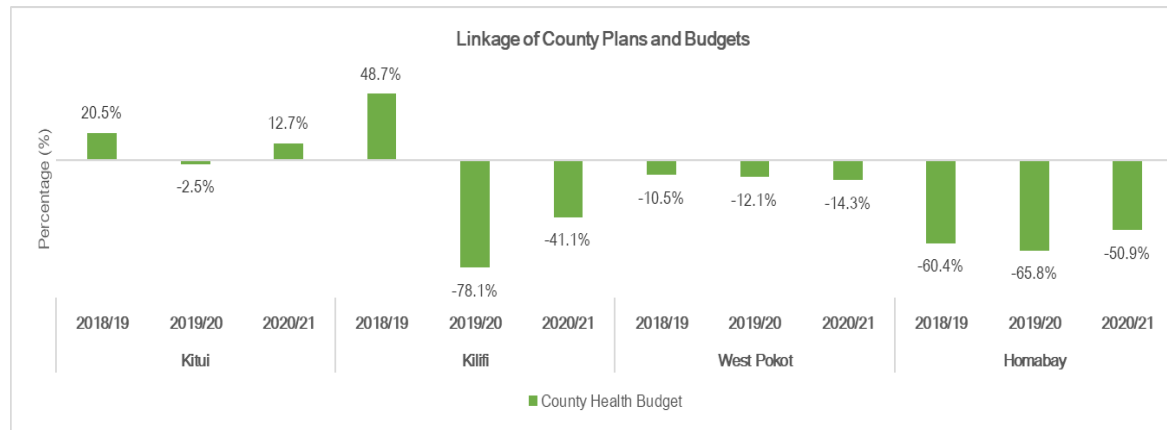
Source: County PBB and AWP

The eye health allocations in both the Annual Work Plans and Programme Based Budgets are below 2% across all the years under study.

PBB allocations to health from the county budgets are estimated to be between 25 and 30%.

The eye health allocations in both the Annual Work Plans and Programme Based Budgets are below 1% across all the years under study.

PBB allocations to health from the county budgets are estimated to be between 29 and 34%.



In most of the sampled counties, except for Kitui County, the approved allocations to health (captured in the PBBs) were significantly lower than the projections in the Annual Work Plans.

Commented [HM1]: Explain the table so it is clear what the negative values mean

Source: County PBB and AWP

To what extent has eye health agenda been included in inter-governmental co-ordination committee meetings?

The respondents acknowledge some progress in coordination of county and national level eye health services through a) the Council of Governors which convenes meetings among eye health stakeholders and the counties; b) National taskforces and technical working groups such as the National Trachoma Taskforce. It is however noted that disease focused initiatives are better coordinated than the general/ integrated Eye Health services, likely due to donor support and influence.

“Periodic review meetings are done aimed at pursuing deliverables as defined by the NGOs.” County Based Eye Health Stakeholder

To what extent are eye health workers included in County Health Management Teams?

Notably, while County Eye Coordinators were well embedded within some of the respective county health management teams in the sampled counties, not all counties had their coordinators as part of CHMTs.

What kind of stakeholder engagements and coordination forums do you have for eye health at national levels?

OSU leads quarterly forums that bring together various partners who are involved in implementing the broad health strategy at the national level. The coordination forums do not have defined TORs and deliverables. Most stakeholder convenings were however donor initiated and driven.

OSU has a working relationship with NHIF to carry out costing and developing standards for accrediting eye health services.

Outcome 2: Strengthened supply chain system that ensures efficient supply of high-quality eye health commodities and medicines at the county level.

To what extent are the supply chain management processes and plans updated to support effective delivery of eye health services?

While the Annual Work Plans for most counties have some detail on Eye Health needs and priorities, these do not follow through into the Program Based Budgets and hence limited procurement of the Eye Health products by counties. Most purchases of commodities and supplies are done by donors and not the counties.

“Supplies are mostly done by NGOs. Very little comes via county procurement processes.” County Based Eye Health Stakeholder

While there is engagement between the County Eye Health coordinators, the CHMT and the County Pharmacists responsible for procurement of health products and commodities, the linkage and feedback systems on procurement planning is weak in most counties. There has been irregular engagement between OSU, county and KEMSA.

Supplies chain follows through the normal hospital system through quarterly ordering of commodities.

“The eye health coordinator has access to the county pharmacist and director HPTs.” County Based Eye Health Stakeholder

Department of Health Products and Technologies has carried out the quantification and specification of the needed resources. The 2022 essential drug is being developed and OSU has been consulted.

To what extent have eye health workers and county pharmacists and CHMTs trained on supply chain management for effective delivery of eye health services?

Eye health workers who included Eye coordinator, County pharmacists and County health administrators have been trained on quantification, ordering and general commodity management. The sub county level has not been trained.

“The meeting was to create awareness and emphasis on the need to mainstream eye health supply chain management.” County level informant

Training of the key county staff on supply chain systems for health in general is done by the county governments in collaboration with KEMSA and partners. Notably, no eye specific supply chain management training is done by the county governments but by partners including Fred Hollows Foundation.

Most respondents highlighted the need for sensitization of the county health teams on eye health procurement needs and inclusion of the prioritized commodities in county forecasts and procurement plans and reports.

“Inclusion in the Forecasting and quantification annual reports of MOH and at counties.” County Based Eye Health Stakeholder

To what extent are equipment maintenance plans available and resourced for effective eye service delivery? What are the main issues affecting equipment maintenance and how well could this be addressed?

Most counties make general equipment maintenance plans, not eye health specific, but the implementation of the said plans is often hindered by limited financial and technical resources. Further, most of the sampled counties did not have any specific SOPs for eye health supplies management.

Equipment maintenance was carried out in line with the national guidelines. There are inventories but no maintenance schedules. Some counties had an ongoing stock taking to identify obsolete equipment. There is a shortage of bio medical engineers in the county who have been allocated to carry out maintenance.

“...Lack of Biomedical Technologists conversant with eye equipment... retrain Biomedical Technologists on eye equipment maintenance”. County Based Eye Health Stakeholder

OUTCOME 3: Strengthened eye health information systems and the use of data and information for evidence-based decision-making, advocacy, and program planning.

To what extent is data management and use resourced for effective decision making in eye health services?

Most counties sampled highlighted the limited financing for Eye health and respective data management for effective decision making. Further, it was noted that there was not only limited eye health data collected at county level, but also limited utilization of the data in planning and decision making.

There is continued engagement and collaboration between the county and national level data teams in the collection and transmission of health data through the KHIS. However, quality assurance is general to health and not specific to eye health. Performance reviews and quality audits are integrated in the general supervision checklists and quarterly support supervision visits.

Respondents highlighted the following as essential to improving data management:

- Increased sensitization and awareness creation on eye health among health workers, county health leadership and partners.
- Training and retraining of health workers on eye health data management
- Increased financing of Eye Health at both national and county levels.
- Improved and targeted quality assurance for eye health services with clear indicators
- Improved availability of data tools at facility level.

To what extent have capacity in data management and use been enhanced among eye health staff and management?

70% of the eye services providers have been trained on data management. Specific tools for eye data collection have been developed and deployed for use in data collection and analysis.

There are no government sponsored eye health data management trainings in the sampled counties but there are few general health data management trainings largely due to limited financing. Revisions of existing tools were noted to be ongoing at national level and subsequent retraining of staff executed collaboratively at both national and county levels.

“Despite appearing as a major agenda in the previous strategy, the Kenya Eye Diseases and Systems Survey (KEDSS) has not been undertaken to provide eye health prevalence data to guide planning. There is a general under-funding of eye health research.”

Eye Health Strategic Plan FY 2020-2025

To what extent are data management and review sessions integrated in the day-to-day eye health service delivery?

There are eye health data indicators integrated and captured within the KHIS but in disparate service monthly reports for most of the facilities except for specialized facilities offering eye care services. These include the Outpatient Services Summary (MOH 705) in which Eye Infections and conditions

are captured, the service workload report (MOH 717) in which eye clinic attendance is captured; Inpatient Morbidity and Mortality report (MOH 718) capturing data on eye disease and adnexa conditions; Diabetes and Hypertension Comprehensive Care (MOH 740) report that captures diabetic retinopathy; and the IHRIS that provides a staffing summary but only captures Ophthalmologists, Clinical Officer Ophthalmology/ Cataract Surgery staff and Optometrists.

Notably, the Ophthalmic Services Unit (MOH 735) report captures the eye health specific data for facilities that offer specialized eye services. The indicators in general span Visual Acuity, Clinical Diagnoses, Surgeries conducted, Spectacles and Assistive devices provided, Admissions, Discharges and Referrals.

Some counties (Kitui) had failed to capture data on DHIS for use.

"There was failure to upload the routine data to DHIS and this lack of summarized data made it difficult to use data for management."

Respondents noted the limited scope of indicators specific to eye health services including disaggregated numbers of eye health staff, limited quality related eye health indicators, limited indicators on eye health equipment and commodities.

To what extent are data management and quality assurance plans coordinated between national and county government?

There is a national level system set to support supervision that includes quality assurance for the data. At least each facility has to be visited once in two years. County and national forums are held to share some of the data. Notably, most of the convenings are donor funded and driven.

To what extent are data quality assurance activities regularly conducted and findings used for decision making?

Quality assurance for data is irregularly carried out through the checks on the KHIS during support supervision.

"There was a breakdown in data collection and uploading into KHIS, health records department will work more closely with eye units"

To what extent have eye health indicators been integrated and reported in mainstream health data?

There are established indicators (outlined in preceding page on integration of eye health data management) but only a few are tracked in some of the counties.

"We have not been very keen on the indicators we only have been looking at cataract and Trachoma trichiasis..." County level informant

The integration with mainstream health data is considered low due to inadequate tracers.

To what extent has research and learning plans and strategies been developed and integrated in eye health service delivery by relevant organizations e.g., OSU and NEHWG? To what extent are these plans resourced?

Counties sampled had integrated health research plans but neither had eye health specific priorities nor had dedicated or adequate financing. Further, none of the counties had research training on eye health.

The stakeholders recognize the need for research and learning and especially if they are to adapt any new programs or guidelines. However, the research agenda continues to be ad hoc.

"Data is the new oil" MOH national level informant

"Currently there is a general lack of coordinated mechanisms for eye health research that is occasioned by the un-availability of a national research committee or national eye health research resource centre as had been envisaged in the previous strategy. There is therefore no focused eye health research agenda to guide operational and academic eye health research."

Eye Health Strategic Plan FY
2020-2025

CONCLUSIONS

This review shows that some issues are cross cutting on various outcomes. This highlights the need and shows there is room to improve the mainstreaming and integration of the eye health services in the health system.

The renewed national commitment to strengthening health systems towards universal health coverage necessitates an integrated yet holistic approach to governance of eye health at both national and county levels of care. This is particularly important given the devolved context of health care in Kenya, and the need for increased domestic coordination and financing of health and eye health services. Continued capacity development in supply chain management for eye health and strengthening of integrated procurement systems for health products, including eye health commodities; coupled to improved visibility and management of eye health information within existing data systems are a necessary consideration in the quest to improving eye health services in the country.

All the key players will need to work together in implementing the various recommendations detailed in this report.

RECOMMENDATIONS

Outcome 1: Leadership and Governance of Eye Health Services

1. Collaborative development and dissemination of an integrated eye health policy by the national and county governments supported by the partners.
2. Counties to have the flexibility to tailor the policy recommendation to their respective contexts.
3. County and National government to increase visibility of eye health priorities and needs in their planning and budgeting tools.
4. Advocacy for increased government financing for eye health for improved sustainability beyond donor financing by partners and county health departments.

5. Improved collaboration between OSU, counties and NHIF for improved design and uptake of eye health packages by all the respective units.
6. County health department's advocacy for improved facility autonomy over eye health reimbursements from NHIF.
7. Inclusion of priority eye health indicators in the integrated KQMH indicators across all dimensions and levels of care by MOH department of standards. The county governments together with the Department of standards to establish centres of excellence of care to improve standards of care.
8. County departments of health to designate and empower Eye Health champions to collaboratively work with other staff towards quality improvement in eye services at county level.
9. OSU and county health departments to strengthen governance capacity and structures for coordination of eye health at national and county levels.
10. Advocacy for government leadership and coordination of eye health services by partners and county health departments.
11. Include eye specific indicators of quality care in the integrated support supervision guide/ checklist by OSU and county departments.
12. County departments of health to have the eye care coordinator in their CHMTs. The coordinators will need to be incorporated into the Hospital management teams and County Health Management Teams and also at the sub county levels.

Outcome 2: Strengthened supply chain system that ensures efficient supply of high-quality eye health commodities and medicines at the county level.

1. Department of HPT and county departments of Health to strengthen capacity for forecasting, quantification, specification and monitoring of eye health commodities and products at facility, sub county, county and national levels.
2. Build capacity for eye health specific biomedical engineers across all levels (national and county level) by the MOH department of biomedical engineering together with the departments of health at the county.
3. Inclusion of eye equipment maintenance plans in the integrated maintenance plans at county level by the county departments of health.
4. There needs to be a closer working relationship between the national and county levels in advocacy improving eye health commodities and supplies through the departments of OSU and HPT can closely work together to improve advocacy for eye health supplies.
5. A standardized list of eye health at all counties will enhance uniformity and quality at the county level. Ministry of health (HPT department and OSU) to develop and share the updated list of eye health products to all counties to ensure uniformity and quality of eye health products procured at county level.
6. Development of an eye health kit by KEMSA and OSU. This kit can be considered in the cyclical supply chain to ensure a buffer of the supplies for eye care products for each county needs.
7. There is need to customize the supply chain national guidelines to county level. Lobbying for more biomedical engineers to be trained and be allocated in the counties to support eye care services especially in the maintenance of equipment by the county governments.
8. OSU and the counties should ensure that the low hanging fruits of eye care technology like lenses can be well covered from the inception of the assistive technologies program by the national government.
9. The expected Health Products and Technologies (HPT) governance structures at the county levels need to be strengthened to address eye care services county department of health and national HPT department of MOH at national level.

Outcome 3: Strengthened eye health information systems and the use of data and information for evidence-based decision-making, advocacy, and program planning.

1. OSU and department of M&E, research and Development and Health Informatics at national level to include capture and analysis of eye specific indicators of quality care in the integrated KHIS for better decision making.
2. Advocacy for improved reporting, uptake and use of eye health data in planning and management by county departments of health and partners.
3. Collaborative development and dissemination of an integrated eye health research agenda by the county departments of health and partners.
4. Advocacy for increased funding and capacity development for eye health research by county departments' health and OSU.
5. The Health Act mandates establishment of a robust HMIS. There is need for improved coordination of data management from the national to county levels by the department of HIMS at national level.
6. There is need to improve better relations between frontline eye health workers and Health records officers by the department of health at county level. This will improve data collection and management to ensure there is no break and loss in the flow of data for improved decision making by the CHMTS and county health departments.
7. County departments of health together with the department of standards need to have more focused data collection by developing and using reporting tools that yields eye health data for quality improvement especially in line with KQMH.

Annex

ANNEX 1: EVALUATION RESPONDENTS

RESPONDENTS ORGANIZATION	NUMBERS
Ophthalmic Services Unit (OSU) National Eye Health Working Group	1
Division of Quality and Standards- MoH	1
Council of Governors (COG)	1
Division of Health Products of Technologies- MoH	1
Division of Community health services –MOH	1
National Hospital Insurance Fund	1
Ophthalmic Services Unit Heads (OSU); county eye coordinator (West Pokot, Homabay, Kilifi, Kitui)	4
County HMIS head (West Pokot, Kitui, Homabay, Kilifi)	4
County Pharmacists (KEMSA coordinators Kitui, Makueni)	5
CMHT member (Kitui, West Pokot, Homabay, Kilifi)	4
	24

ANNEX 2: MOH 735 (OPHTHALMIC SERVICES UNIT) REPORT ON KHIS

Report organisation unit

Kenya

- Baringo County
- Bomet County
- Bungoma County
- Busia County
- Cyigo Marakwet County
- Embu County
- Garissa County
- Homa Bay County
- Isiolo County
- Kajiado County
- Kakamega County
- Kericho County

Data set

Mohi 735 Ophthalmic Services Unit

Report period

Yearly

Year

2020

☐ Use data for selected unit only

	Total New Visit Patients						148906		Total Revisits Patients		78815							
	New Patients <16years Male						16684		Revisits <16yearsMale		6873							
	New Patients <16years Female						15321		Revisits<16years Female		6440							
	New Patients >16years Male						24725		Revisits >16yearsMale		11518							
	New Patients >16years Female						30120		Revisits >16years Female		14569							
Visual Acuity (better eye) -All Patients			Children			Normal (6/6 - 6/18)				Low Vision (>6/18 - 3/60)				Blind (<3/60 –N PL)				
Age in years			<5Yrs		5-<16Yrs		≥16Yrs		5-<16Yrs		≥16Yrs		<5Yrs		5-<16Yrs		≥16Yrs	
SEX			M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
CLINICAL DIAGNOSIS																		
1	Normal		2387	2227	2173	2234	3392	3564	47	87	234	355	16	13	123	131	636	649
2	Cataract		175	124	234	251	2790	3061	126	195	2926	3667	48	46	229	231	3759	4245
3	Pseudophakia		57	54	409	454	3470	3939	104	201	2260	2685	13	18	39	65	1224	1322
4	Glaucoma		46	43	74	137	1283	1067	109	129	845	734	27	24	51	48	1157	912
5	Strabismus / Amblyopia		176	178	103	93	219	243	19	35	41	47	13	10	11	25	59	39
6	Presbyopia		13	11	122	244	4274	4859	103	44	1468	1601	9	24	52	37	152	132
7	Other RefractiveErrors		105	200	1498	2308	4309	6845	347	481	1842	2244	49	13	93	86	266	337
8	Active Trachoma T1/TF		6	6	16	18	63	91	6	8	26	29	2	2	7	3	27	38
9	Inactive Trachoma -(TS/TT)		4	7	6	13	69	95	3	9	23	143				2	67	118
10	Corneal Scar-Trachoma (CO)		7	7	22	27	83	86	10	8	35	38	4	9	14	9	33	52
11	Corneal Scar -Injury or Infection		182	173	286	266	945	691	87	69	278	266	25	26	77	56	349	280
12	Purulent Conjunctivitis		2260	2025	1692	1881	3101	3516	74	60	228	255	104	84	21	12	100	128
13	Allergic Conjunctivitis		5128	4452	9850	10157	14880	22855	840	869	1643	2083	229	126	258	198	700	833
14	Other conjunctivitis		830	788	979	878	2556	2878	104	87	266	429	103	15	49	56	266	251
15	Ophthalmic Neonatorum		296	310														
16	Corneal/Conjunctiva FB		147	168	379	343	2248	1025	81	77	317	262	7	2	12	16	101	54
17	Corneal Ulcer		245	212	444	352	1612	1281	80	56	554	526	25	14	39	54	401	346
18	Keratitis		89	83	306	352	897	847	70	72	246	254	12	5	22	36	165	147
19	Xerophthalmia		2	4	16	13	38	76	2	18	22				1	4	24	29
20	Optic Atrophy (non-glaucoma)		8	8	14	24	215	200	14	7	117	126	10	3	12	10	152	148
21	Optic neuritis		12	10	45	52	160	158	7	5	48	49	8		7	8	71	72
22	Diabetes without Retinopathy		2		8	22	877	1109	30	15	342	415	13		19	22	152	153
23	Diabetic Retinopathy		3	1	1	7	245	305	16	7	229	239	18		23	42	187	174
24	Other Retinopathy		7	8	16	10	219	215	8	12	80	88	5	1	30	26	149	129
25	Macular Diseases		6	7	23	22	214	192	16	4	156	164	3	2	19	32	218	184
26	Injury		472	395	968	553	2801	1832	117	117	487	232	34	23	190	100	995	385
27	Uveitis		29	24	279	197	1694	1759	74	98	375	387	22	6	58	77	242	247
28	Chalazion / Sty		50	62	133	192	427	601	10	8	51	62	7		4	9	30	36
29	Conjunctival Growths		53	79	269	324	1931	3357	76	54	380	546	19	11	18	14	87	120
30	Retinoblastoma		24	15	3	7	26	66	4	3	16	5	11	6	4	2	4	8
31	Herpes Zoster Ophthalmicus		22	19	11	27	125	155	5	8	38	37	1	1	8	7	44	47
32	Others		1582	1645	1720	2058	6623	9604	408	267	1041	1460	122	84	201	236	1853	2100

	SURGERIES	<5yrs		5 - <16yrs		>16yrs	
		M	F	M	F	M	F
1	Cataract operation with IOL implantation	47	34	115	82	2999	3559
2	Cataract operation without IOL implantation	3	7	14	6	139	114
3	Glaucoma Surgery	18	6	7	2	82	53
4	Penetrating Globe Injury Repair	66	34	104	41	173	63
5	Evisceration/Enucleation	6	5	4	2	88	50
6	Entropion			6	10	32	61
7	Chalazion/Stye Surgery	3	7	39	68	188	266
8	Other Lid Surgery	12	3	18	13	250	229
9	Orbital	1		3		9	4
10	Lacrimal	4		1		13	22
11	Conjunctival Growth Excision	7	7	29	41	239	384
12	Corneal Graft	11	7	12	3	46	21
13	Squint	3	6	3	5	11	23
14	Retinal Laser Treatment	1			1	88	91
15	Vitrectomy	2	1	5	6	92	63
16	All Other Surgeries	96	80	198	154	1259	974
17	TOTAL SURGERY						

NUMBER OF SPECTACLES ISSUED	
NUMBER OF OTHER ASSISTIVE DEVICES	
REFERRALS FROM FACILITY	
REFERRALS FROM SCHOOL: ADMISSIONS	
REFERRALS FROM SCHOOL: DISCHARGES	
Eye Ward Capacity (Beds)	104
Admission	29
Discharge	29