Seeing is Believing

February 20th, 2020.

The contents of this end line research report are the sole responsibility of the Principal Evaluator, and do not necessarily reflect the views of CBM International.

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Acronyms

CBM	Christoffel-Blindenmission	NOA	National Orientation Agency
CCEHIN CEH	Comprehensive Child Eyes Health in Nigeria Child Eye Health	MSC	Most Significant Change
CHEWS	Community Health Extension Workers	P.E.	Principal Evaluator
DQA	Data Quality Assurance	PWD	People with Disabilities
DQS	Data Quality Standard	RRS	Risk Rating Scale
FCT	Federal Capital Territory	RRM	Respondent Referral Matrix
FMoH	Federal Ministry of Health	RQ	Research Questions
FRCN	Federal Radio Corporation of Nigeria	SIB	Seeing is Believing
GoN	Government of Nigeria	SOW	Scope of Work
HANDS	Health Support and Development Program	KHS	Knowledge Harvesting Session
HMIS	Health Management Information System	TBA	Traditional Birth Attendants
HSS	Health Systems Strengthening	TOR	Terms of Reference
IDI	In-depth Interviews	OH	Outcome Harvesting
I.E.	Investigative Evaluator	OPDS	Organization of Persons with Disability
IEC	Information Education and Communication	OM	Outcome Mapping
LGA	Local Government Area	QR3	Qualitative Research Methodology
LOE	Level of Effort	WHO	World Health Organization
M&E	Monitoring and Evaluation		

Foreword

The qualitative end line research study explored perceptions of persons with disability towards the inclusiveness of health services in two areas of Nigeria (selected locations in Federal Capital Territory and Nasarawa state). This perception research study provided an end line survey for work on disability at the pilot facilities under the Seeing is Believing (SiB) programme. The purpose of the study further examined the perception of persons with disabilities regarding the inclusiveness of health services in their local area compared with baseline study findings, by identifying Most Significant Changes (MSC) attributed to the programme.

The Seeing is Believing (SiB) Comprehensive Child Eye Health in Nigeria (CCEHiN) programme, was implemented in Nigeria between December 2017 and January 2020, by a consortium comprising of the Brien Holden Vision Institute and CBM International as the lead organization and was funded by Standard Charter Bank through IAPB. Dr Juliana Nathaniel was the Programme Director that led the consortium.

Over a three-year period, the programme delivered comprehensive child eye health services to over 1.5 million vulnerable children aged 0-14 years old; making them accessible through promotion, prevention, medical care and rehabilitation/inclusive education. The SiB programme was implemented in eleven (11) States of the federation divided into four clusters as follows: Cluster 1: Oyo, Ogun and Osun States, Cluster 2: the Federal Capital Territory, Nasarawa and Plateau States, Cluster 3: Kano, Katsina and Jigawa States, and Cluster 4: Cross River and Akwa Ibom States.

The main objective for this study was to conduct an endline evaluation to find out how well the implementation of the Seeing is Believing programme was at achieving its objective on disability inclusion component of the programme in the selected locations of Nigeria.

The evaluation involved the following stakeholders: SiB Programme Director, implementing partners (including supported health facilities), Knowledge Management/Monitoring and Evaluation Manager, the Federal Ministry of Health – Eye Health Coordinator and the Cluster Co-coordinators. Intrinsic to programme implementation, they provided their perspective for the triangulation of the information collected during the secondary data review.

We hope that the key findings, conclusions and recommendations contained in the document will help to raise awareness about the effectiveness of the programme and advocate the increased need for sustainable approaches to Child Eye Health programme implementation.

L.S
Louise Shute
CBMUK Programme Manager

Acknowledgements

The pilot project on disability inclusion was implemented under the Comprehensive Child Eye Health in Nigeria (CCEHiN), Seeing is Believing (SiB) programme.

Our thanks goes to the Management and Staff of the two pilot sites, St Mary's Catholic Hospital Gwagwalada, under the FCT and General Hospital Doma Nasarawa State for accepting to pilot the project in their facilities. We appreciate Dr Israel Balogun, the CBM-SiB Technical Advisor on Disability Inclusion for his technical support and guidance. Our appreciation goes to all members of the Organization of Persons with Disabilities (OPDs) for their commitment and time towards identifying and referring children with disability, thus directing them to access care at the pilot sites.

We wish to acknowledge the efforts of the following persons: CBM-UK Programme Manager, Louise Shute and the CBM Country Director, Mr Bright Ekwernmadu. We also acknowledge the contributions of the former CBM-UK Programme Manager, Rebecca Molyneux and Mr Kingsley Adimabua, the former SiB Monitoring and Knowledge Management Manager for their technical support.

Prior to commencement of the project and at the end, SiB conducted studies on perception of persons with disability regarding inclusiveness of services in the two pilot sites. Our appreciation goes to the Principal Evaluators, Dr Olushola Alonge and Mr Augustus Emenogu and his team for conducting the baseline and endline studies respectively.

Finally, we appreciate the pilot communities and gatekeepers for providing the enabling environment required by the project to accomplish all related tasks. Most importantly, we appreciate the International Agency for the Prevention of Blindness and Standard Chartered Bank for providing technical and funding support to the programme.

Dr Juliana Nathaniel, Ph.D.
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Executive Summary

Background

The world is making progress in tackling poverty. However, persons with disabilities are left behind. One in six of us has a disability. That is more than one billion people around the world! 80 percent of whom live in low middle-income countries. Based on our Christian values and more than 100 years of professional expertise, we address poverty as a cause and a consequence of disability. We work in partnership to create an inclusive society for all.

CBM International has been working with partners in Nigeria since 1968, preventing blindness, improving health and helping people with disabilities go to school, earn a living, access health care/rehabilitation and secure respect in their communities. The Comprehensive Child Eye Health in Nigeria (CCEHiN) was launched to span a three-year period, from 2017 to 2020, as the Seeing is Believing (SiB) program. The SiB program sought to make comprehensive child eye health services available and accessible the through promotion, prevention, medical care and rehabilitation / inclusive education targeted at vulnerable children.

Research Purpose and Scope

The end line research study explored perceptions of persons with disability towards the inclusiveness of health services in two areas of Nigeria (selected locations in Federal Capital Territory and Nasarawa state). This perception research study also provides an end line survey for work on disability at the pilot facilities under the Seeing is Believing (SiB) programme. The purpose of the study further examined the perception of persons with disability regarding the inclusiveness of health services in their local area compared with baseline study findings, by identifying Most Significant Changes (MSC) attributed to the programme.

The study will focus on two project sites - Gwagwalada (FCT) and Doma (Nasarawa state) - where inclusive eye health services were piloted in secondary health facilities. The target groups for the study will include the following stakeholders:

- Community members.
- health facility staff (CHEWs, doctors and Nurses) and non-facility care providers (e.g. TBAs);
- Community gatekeepers and opinion leaders.
- Parents and caregivers of children (0-14 years) with disabilities.
- People with disabilities.
- Their peers without disabilities in the same age group.

The study addressed the following research questions:

- What are the perceptions of persons with disabilities regarding the inclusiveness of and access to public health services in the area?
- To what extent are persons with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?
- What level of knowledge, awareness and understanding do stakeholders in the pilot areas have about accessible and inclusive health services?
- What barriers are faced by persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?

- What factors support the access and inclusion of persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?
- What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services, in the two pilot secondary health facilities?

Sampling focused on the catchment areas for two secondary health facilities in Gwagwalada (FCT) and Doma (Nasarawa state), where inclusive eye health services were piloted under the Seeing is Believing (SiB) programme - Comprehensive Child Eye Health in Nigeria (CCEHIN). The findings of the research study will guide the planning, programming and policy formulation as well work to address barriers militating against access to services and inclusiveness of persons with disability.

Research Design and Methodology

A Qualitative Research (QR3) methodology was adopted for this research study following a three-tier approach to facilitate effective storytelling with data. Table 1 highlights information on planned evaluation tasks and associated QR3 methodology components. The research team conducted an initial review of CBM baseline perception survey of persons with disabilities towards healthcare in Nigeria. Specific emphasis was placed on content related to identified research questions outlined in section 1.5. This was used as a basis for the development of sub-research themes and associated probing questions for end line data collection.

Table 1. Research Themes and Questionnaires

Themes	Description	Questionnaires
Theme 1	PWD Perception of Access and Inclusiveness of Public Health Services	Program Beneficiary Questionnaire (PBQ), Health Facility Questionnaire (HFQ)
Theme 2	PWD Health Services Access	Health Facility Questionnaire (HFQ)
Theme 3	Stakeholder Awareness of Access and Inclusive Health Services	Community Stakeholder Questionnaire (CSQ)
Theme 4	Barriers to PWD Access and Inclusive Health Services	Health Facility Questionnaire (HFQ)
Theme 5	Support for PWD Access and Inclusive Health Services	Community Stakeholder Questionnaire (CSQ), Health Facility Questionnaire (HFQ)
Theme 6	Improving PWD Access and Inclusive Health Services	Community Stakeholder Questionnaire (CSQ), Health Facility Questionnaire (HFQ) and Program Beneficiary Questionnaire (PBQ)

This was followed by a deep dive literature review of current knowledge including substantive findings, as well as theoretical and methodological contributions to the research study focus. The desk review put forward a theoretical base for each research question to be examined by the perception study. These processes focused on reviewing research themes per Research Question (RQ) outlined in Table 1.

A review of preliminary findings and literature review provided the context for the implementation of the QR3 qualitative methodology employed by the research team in this study i.e. Outcome Harvesting (OH), Outcome Mapping (OM) and Most Significant Change (MSC).

The MSC research approach adopted a process review of findings by curating feedback from multiple respondents that could speak on the activities of the SiB program in the pilot sites.

After pilot testing data collection instruments, the research team finalized design of field questionnaires. Each research questionnaire had a collation of additional probing questions derived from each research question. At the completion of field data collection, the research team reviewed and collated feedback from respondents via the conduct of Individual In-depth Interviews (IDIs) in Abuja and Nasarawa States respectively.

Research Sampling Technique

The end line perception study employed a QR3 methodology approach to collect, analyze, and triangulate primary and secondary data sources from the outcome harvesting process. The Principal Evaluator constructed the sample frame from previous data set of the SiB program's proposed beneficiaries in each designated sample location i.e. each study location (Gwagwalada and Doma) served as the Primary Sampling Unit (PSU) and were purposely-selected pilot locations.

At the second stage, a representative sample was derived from the different categories of respondents i.e. health facility workers, program beneficiaries, PWD, community stakeholders. The principal evaluator applied a stratified random sampling procedure to select a representative sample of respondents from the sample frame, randomizing within both pilot locations in Doma and Gwagwalada. A respondent driven approach was applied to facilitate the conduct of Individual In-depth Interviews (IDIs) handled by the research team.

Data Collection Methods

This final perception research study used qualitative based methods to collect, analyze, and triangulate data to answer each research question specified in the research Terms of Reference (TOR). The research team adopted a four-step data collection process, which involved the following methods.

- **Desk Study Review**: The research team conducted a desk review of SiB primary and secondary data sources i.e. internal and external documents. This involved collating findings from the baseline survey for each research question in order to ascertain a reference point for comparison at the end line stage. Through first hand observations and updates to each research questions from two broad stand points.
    - **Learning from what works**: what was achieved from the activities planned, what worked well/what the success factors were, key lessons learned, key adaptations to leverage success/achieve greater SiB project outcomes to achieve greater results.
    - **Learning from what did not work**: what was not achieved from the activities planned, what did not worked well/what were the challenges/bottlenecks, key lessons learned, key adaptations/course corrections to address challenges/bottlenecks to achieve expected outcomes in relation to SiB program expected results.

- **Literature Review**: As part of the Outcome Harvesting (OH) process, the research team conducted a literature review to curate current knowledge including substantive findings, as well as theoretical and methodological contributions to the research study focus i.e. Perceptions of Disabilities towards Healthcare in Nigeria (FCT and Nasarawa). The literature review put forward a theoretical base for each research question for the perception study. Findings from the literature review are elaborated further in Section three (3) of the research study report.

- **Respondent Referral Survey (RRS):** The Respondent Referral Survey (RRS) method was adopted for data collection. This process involved the referral of new respondents for Individual In-depth Interview (IDIs) from each completed interview form across each respondent category. The approach ensured that the research team sourced the right information from respondents without influencing discussions during one-on-one interviews, which is critical to the integrity of the process. By triangulating curated information from QR3 Tier One Phase (Table 1), which informed the revision of data collection instruments, the research team was able to identify appropriate probing question for each respondent category during data collection. This informed the choice of the snowball respondent driven approach.

At the end of the QR3 methodology process, the research team engaged an STTA graphic designer to support the finalizations of knowledge products for dissemination to the CBM Nigeria team e.g. diary of quotes.

Research Limitations

The research team encountered several challenges during the research study. This informed the application of the Risk Mitigation Plan (RMP) to address the research limitations i.e.

- **Pilot testing data collection instruments:** The research team pilot tested selected data collection tools (HFQ, PBQ and CSQ) in Doma, Nasarawa State among non-sampled respondents. After pilot testing, the research team reviewed the Risk Mitigation Plan (RMP) to accommodate potential risks associated to field data collection i.e. data reliability and validity, use of primary and secondary data, privacy concerns, cultural and language barrier, logistics and non-responses from interviewees.

- **Non-domiciled Optometrists**: A challenge encountered by the research team was the geographical distance between the place of assignment of designated Optometrists and SiB selected health facilities in both pilot sites i.e. the Optometrists were domiciled in different facilities and had to consult once a week at respective pilot sites. This contributed to significant delays in service provision, especially for children and PWDs.
- **Non-resident beneficiaries**: Most of these beneficiaries had to be referred to the Ophthalmologists place of primary assignment within the state. It is therefore possible that, the beneficiaries list will not be completely updated at the pilot sites. Some other beneficiaries were not domiciled at sampled sites as they were referred during large outreaches at various locations and linked to the health facility. Most of the beneficiaries could not be easily located in (Gwagwalada) FCT and some parts of (Doma) Nasarawa State because of distance.
- **Time constraints:** Given the tight timeline to deliver on the perception research study, the research team opted to triangulate findings from multiple data sources (i.e. program beneficiaries, PWD, health facilities, and community stakeholders) due to the applied sample size of 40 IDIs. This offered useful insights into the outcome of the SiB program as narrated from multiple validation sources.
- **Securing government approvals**: It is common with government Ministries, Department and Agencies (MDAs) to require supervisor approvals before government workers can participate in any interview or survey. This was no different during the research survey, as engaged health facility workers and schoolteachers both sought permission from appropriate authorities before participating in conducted interviews. This situation imposed significant time delays during the respondent referral surveys. It was challenging securing interview appointments with the government personnel who

participated in the SiB project because approvals were needed from senior management staff, which took long hours.

- **Data Limitations:** Limited data on disability outlined in the baseline survey report as well as the absence of a midline assessment study. In order to answer the RQs, the research team considered where deeper evidence would be needed. Upon a preliminary review of SiB program documents and additional secondary data from completed desk study (i.e. literature review); the research team developed probing questions aligned to each research question.

Key Findings, Conclusion and Recommendations

RQ1: What are the perceptions of persons with disabilities regarding the inclusiveness of public health services?

Prior to the commencement of the SiB program, the accessibility of any of these services was believed to impact on the ability to access others. Respondents regarded education (increased awareness) as critical to understanding disability issues for community members, stakeholders and respective Health Facility Workers (HFWs). Thereby empowering PWDs, as their needs are acknowledged and adequate or adjustments made to improve inclusive public health services.

> *"Truly speaking, the SIB program is just like an appetizer, as if the people of the state have just been appetized and are waiting for more. The SIB program has come to create a certain type of awareness to people that, a program like this, if it can continue, it will prevent a lot of preventable blindness in children. So, one of the challenges is that the program is short-lived"* - **Jacob (SiB focal Person) Nasarawa State Ministry of Health, Lafia.**

The SiB project improved PWD access to inclusive health services by creating awareness in the community regarding health services. This was achieved using radio jiggles and community outreach activities. The inclusion of health services was not limited to health facilities but was extended to schools where a few disabilities were detected and referred to the health facilities. For example, all interviewed respondents (19 respondents: 12 male and 7 females, 8 PWD) at the end line acknowledged that their perception of disability inclusive public health services had improved and often referenced the inception of the SiB project.

This was in no small part to the improvement in Health Facility Worker (HFWs) treatment of PWD and available consultation services provided by and Optometrists collaborated by the research team through the review of available hospital records (i.e. Bin cards and Eye Health Attendance Registers) which showed that PWD were readily attended to by HFWs trained by the SiB program. A further review of collated respondent data across all respondent categories, showed that program beneficiaries and Health Facility Workers (HFWs) provided mainly positive perceptions of access and inclusive health services for PWD. While community stakeholders had some reservations on the present state of PWD access to inclusive public health services in Doma and the FCT.

Persons with disabilities in rural communities have significant barriers to accessing health care compared to persons without disabilities. The study confirmed that the SiB project reached persons with disabilities in rural areas with outreaches and linkage to supportive health facilities for health care services. Finances for transport from hard to reach terrain and distances to be covered were especially prominent as barriers to access to the health facility for disabled persons. The quantitative study also showed that barriers to health care access among children 0-14years. Lack of awareness and knowledge was shown to increase barriers to health care attributed to a lack of education and poverty. Socio-cultural status limited the acceptance of health care services and the referral of persons with disabilities.

Specifically, the SiB program also worked to improve positive experience of care by persons with disabilities (PwDs) and addressed gaps identified at baseline. Specifically, the following achievements were achieved i.e.

- 100 Health workers (50 per location) from the pilot facilities were trained on disability friendliness in order to address negative attitudes towards persons with disability (PwD).
- SiB programme produced disability friendly information Education and Communications (IEC) materials and distributed to the communities and the two pilot health facilities. This was to reinforce knowledge on how to engage with PwD and improve interaction with them to ensure delivery of quality services to them.
- SiB program ensured that training manuals incorporated relevant sections on disability.
- SiB program worked with the FMoH and stakeholders to develop disability friendly Health Management Information System (HMIS) data collection tools.

Persons with disabilities require an array of health care services and need support to meet their specific needs. However, there is great variability in how, where, and from whom persons with disabilities receive needed services. The persons with disabilities in hard to reach areas do not only need medical attention but social inclusion. People need to begin to have open minds regarding various forms of disability among older people, children and the need for immediate care. Extensive community centered Sensitization and Behavioral change Campaigns (SBCC) should be prioritized in each pilot site; through the engagement of relevant community stakeholders to ensure uptake and sustainability of actionable results.

RQ 2: To what extent are persons with disabilities, including children with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?

At the baseline, most of the healthcare personnel interviewed at the General Hospital Doma admitted to a lack of some hospital equipment, which they claim hindered service delivery. Similarly, healthcare personnel and PWD interviewed in Doma complained of inadequate manpower, particularly medical doctors. This inadequate manpower is believed to be a major cause of long queues for consultations. However, at the end line the research team noted that at both pilot sites, the SiB program successfully selected and trained health care workers and CHEWs on various health services for disabled persons including child eye health services.

Figure 1. Child Friendly Centre, St. Mary Hospital, Gwagwalada, Federal Capital Territory (FCT).

Findings from the research study shows that the SiB programme trained members of community-based Organization of Persons with Disability (OPDs) on eye health case identification. In addition, referral forms were provided to members of community-based Organization of Persons with Disability (OPDs) trained by SiB to facilitate ease of referrals. More clients are accessing services at health facilities now compared to the baseline. This was ascertained by the review of Health Facility registers.

The SiB program also provided hospital equipment for both pilot health facilities. Training activities extended to schools as teachers were also equipped with instruments for detecting visual impairments and routinely referred students to pilot health facilities in the FCT and Nasarawa. Ophthalmologists were assigned to each of these facilities and complicated cases needing surgeries were linked to tertiary facilities for surgeries.

Persons with disabilities present higher unmet healthcare needs particularly children who cannot express themselves. An increased understanding of the challenges among people with a disability do not incorporate conditions that will enable optimum care. Affordability of health services and transportation remain two main reasons why PWDs do not receive the required health care; they are unable to afford out of pocket expenses and are limited by the lack of appropriate transportation services except for SiB programme beneficiaries.

The Government has a role to play in the establishment of suitably accessible transportation options on a city-wide level. Further engagement with planning authorities in both pilot locations can serve as a first step in engaging relevant government agencies (e.g. Federal Capital Development Agency) to address this challenge. For example, the SiB program could potentially support these agencies to establish a disability unit in the departments of urban and regional planning and further advocate for increased budgetary funding from the National Assembly. This can be done through the engagement of specialized local Non-Profit Organizations (NGOs) that actively work on legislative engagement and advocacy activities with the National and State Assembly. This will ensure CBM Nigeria can leverage existing networks and coalitions of these local NGOs to amplify calls for responsive budgeting and closer supervision of designated government agencies to increase access to health services for children with disabilities and PWDs.

RQ 3: What level of knowledge, awareness and understanding do stakeholders in the pilot areas have about accessibility and inclusiveness of health services?

The awareness and understanding of health programs by stakeholders build responsibility for future programming by various NGOs towards inclusive health services. The knowledge of access to health services helps stakeholders to be accountable for strategic plans for future programming regarding health services. During the SiB project, community stakeholders showed a legitimate interest and displayed an understanding of disability inclusiveness as it relates to the provision of public health care services.

> "The SiB program provided services including glasses and correcting visual error free of charge and even surgeries. Some of these children required surgeries and they were transported to Jos and other centres and had surgeries for free. And this took away most of our restrictions in the state" - **Dr Ibrahim, Director Public Health**.

For example, the Director for Public health in Lafiya, Nasarawa displayed an outstanding knowledge of the SiB program implementation as he effortlessly outlined key achievements of SiB Nigeria in providing training for health workers in Doma pilot location. Respondents acknowledged that child eye services were incorporated in health facilities at both pilot locations due to the activities of the SiB project. Specifically, interviewed respondents from the State Ministry of Education (SMoE) in Nasarawa, clearly articulated the selection process adopted by CBM Nigeria in the choice of pilot locations i.e. the selection of schools by three (3) senatorial districts of the state and additional support provided for the training of teachers.

At the schools, teachers were trained to check children with low vision to be referred to the health facility for further treatment. Community Health Extension Workers (CHEWs) were also trained to provide care in their communities and make referrals of cases that were beyond their

capacity to the closest health facility. Respondents also confirmed that teachers were equipped with charts, refraction and low vision instruments to detect children with impairments. The SiB program supported referral of students from schools to health facilities through the provision of referral registers and the training of teachers. Additional support is still required by the health centres in the effective documentation and use of referral data in conducting follow-up services to PWD beneficiaries in both pilot locations. The presence of a visiting Ophthalmologist and Ophthalmic nurse at the health facility increased access to child eye health services; as PWD could access specialized public health services more readily. There were low vision devices and charts available at the facility, which helped in the improvement and distribution of telescopes and glasses among programme beneficiaries.

Interviewed respondents from the State Ministry of Health (SMoH) and State Ministry of Education (SMoE) were actively involved in advocating for inclusive health services regarding eye care and disability in both pilot locations. This shows the potential to engage reform champions in relevant government Ministries, Departments and Agencies (MDAs) to sustain action on disability centered policies.

Findings from the research study highlighted community centered engagement achievements of the SiB program. This included the following outcomes i.e.

- 200 members of Organization of Persons with Disability (OPDs) from cluster communities around the pilot health facilities were trained to raise awareness, identify person with disability that require health services and refer them to the pilot health facilities.
- SiB through its partner Health Support and Development Program (HANDS) conducted advocacy to Joint National Association of Persons with Disability (JONAPwD) and community gatekeepers to discuss the inclusion program and select OPD members that received training under the SiB program.
- SiB in conjunction with National Orientation Agency (NOA) and community partner HANDS created awareness on the Disability Inclusion program within cluster of communities around the health facilities.

On the other hand, community stakeholders' respondents did not show as much in-depth knowledge of disability inclusive health services. While the activities of trained CHEWS are laudable and indeed promoted access of PWDs to referral services for follow-on consultations, more still needs to be done to support as well as strengthen community-based initiatives. A dual approach of engaging government via MDAs as well as establishing foundational roots in communities would go a long way in increasing the knowledge awareness and understanding of stakeholders on issues related to accessibility/inclusiveness of health services for PWDs. This knowledge awareness pattern needs to be explored further through the conduct of a Knowledge Attitudes (KAP) and Practices (KAP) survey; which has been commissioned by CBM Nigeria.

Clearly, increasing stakeholders (i.e. community and government) involvement is the right approach to increase uptake of PWD public health services in each intervention community. A dual approach is therefore most suitable for SiB program consideration in any planned follow-on project.

RQ 4: What barriers are faced by persons with disabilities, including children with disabilities, in accessing health services in the two pilot secondary health facilities?
Findings from the end line research showed that there are two main categories of PWD barriers to accessing public health services in both pilot sites. Broadly speaking, these barriers can either be physical or institutional. Physical barriers such as uneven access to buildings

(hospitals, health centers), inaccessible medical equipment, poor signage, narrow doorways and internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities for persons with disability. First-hand observation by the research team confirmed that the SiB program worked to address physical barriers to PWD accessing public health services with the construction of ramps, expanding entry areas, linking health facility buildings and upgrading designated PWD toilets support furnishing.

Except for the pilot facilities, PWD echoed that attitude of some healthcare workers towards disabled persons is very poor and increases stigma and lack of acceptance. Leading from this, the research findings revealed that a lack of appropriate services for people with disabilities is a significant barrier to health care. For example, the lack of specialized services and adequately trained personnel is the most significant barrier to using health facilities after cost considerations by PWD. Prior to the commencement of the SiB program, the lack of appropriate services for people with disabilities was a significant barrier to health care services. The lack of specialized services and adequately trained personnel was identified as the most significant barrier to using health facilities after cost considerations by PWD.

To address physical barriers, the program constructed several structural modifications to the pilot health facilities:

- Ramps widened the doors of the facility and provided handles to increase accessibility of wheelchair user;
- Widened the toilets facilities for easy access to wheelchair users;
- Installed toilet hangers to help wheelchair users sit in a balanced position while using the toilets;
- The SiB program also produced 13 episodes of radio magazine program in English and domesticated it into local languages including Hausa to address issues of eye health including change perception about persons with disability. The radio program was broadcasted through the Federal Radio Corporation of Nigeria (FRCN) and at the local radio stations.

To address these communication barriers the SiB program put signage to direct persons with disabilities about where to obtain specific types of services at the health facilities and engaged in the use of sign language interpreters to address communication barriers. However, feedback from respondents during the end line research survey highlighted continued stigma and lack of acceptance of PWD within the community and the propagation of certain cultural and religious beliefs which encourage the acceptance of different forms of disability; which in turn hinders PWD from seeking prompt medical attention from designated public healthcare centers.

Program beneficiaries also noted that the attitude of HCWs is less discriminatory in recent times. This was attributed to on the job coaching of colleagues by trained CHEWs. People with disabilities always require skilled health care workers, which in most cases are inadequate based on training and skills to use the needed equipment. While non-domiciled Optometrists posed a challenge to the ready access of PWDs to health services at both pilot sites i.e. as the Optometrists were domiciled in different facilities and had to consult once a week at respective pilot sites. This contributed to significant delays in service provision, especially for children and PWDs.

This also affected the ability of the pilot facility to maintain reliable patient consultation records for PWD accessing public health services supported by the SiB program. For example, at some point, the beneficiary list was not updated because the Optometrist could no longer travel for weekly consultations due to incurred personal expenses. The SiB program should work closely

with the respective state as well as federal government agencies and ministries to facilitate the posting of qualified Optometrists to pilot health facilities or make transportation provision for them.

The SiB program may also explore collaborating with the National Youth Service Corps (NYSC) to prioritize the posting of young medical professionals to selected health facilities. Such a partnership would ideally extend to providing support for continuous training for Health Facility Workers (HFWs) and Ophthalmologists through the appropriate professional bodies in Nigeria. If Optometrists are not domiciled at the health facility, incurred transportation expenses will continue to frustrate attempts by the program to address barriers faced by PWDs in accessing health services.

EQR 5: What factors support or inhibit the access and inclusion of persons with disability including children with disability in accessing health services in the two pilot secondary health facilities?

Socio-cultural factors were identified as one of the major barriers to the inclusiveness of services. The concern was shared by a large proportion of respondents. Stigma and discrimination, including perceptions of persons with a disability as less human, were key factors hindering the integration required for inclusive service provision. Communication barriers arising from the inability of some of the healthcare workers to speak the local dialect, and a lack of personnel trained in sign language in the facility, were noted as a key challenge for inclusive service delivery. For example, some of the participants noted that the lack of political will by policymakers and Chief Executive Officers of government agencies remains a major barrier in the provision of inclusive services.

While low cadre officers may make efforts to ensure inclusive service delivery, the lack of commensurate support in terms of the availability of equipment, infrastructure and funding usually limit how much can be done. Concerns were also raised regarding the barriers resulting from the structural design of other health facility buildings and the difficulty this poses for persons with a disability to physically gain access.

A review of respondent feedback during the end line research showed that financial limitations increased the burden of PWDs as cultural beliefs continue to attribute witchcraft to disability. Lack of communication remains a challenge among HFWs although some specialized disability specific training was provided by the SiB program. During interaction with PwDs, a major challenge identified contributing to inability to access health care services was lack of resources including transport fare to the health facilities even when referred. This is understandable because most of the persons with a disability are unemployed and have no source of income except begging.

A glaring limiting factor remains the lack of government policies for inclusive health care services for disabled persons; even as movement around the facilities improved for PWDs, rural locations still experienced limited health care access. Interviewed respondents also highlighted the lack of equipment to support certain disabilities i.e. only refractive vision equipment, telescopes, sample lenses, visual acuity charts and basic medications were available in both pilot health facilities. A request was made for a Ophthalmoscope at both pilot health facilities. Specifically, ophthalmologist services werethat not available in General Hospital, Doma leading to long waiting hours and increased complications. As the ophthalmologist was not domiciled in the Doma and had to travel from Lafia each Friday for consultation with PWDs.

Figure 2. Constructed Ramps, General Hospital, Doma, Nasarawa.

The support needed by disabled persons is the provision of free transportation and other health services, which increases the response to seek proper health care from the facility. The support to include teachers who have improved awareness in schools is a good initiative that should be extended to various sectors regarding childcare. When it comes to access to health services, the societal changes have undergone lower levels of reported quality of life and perception of poorer health outcomes for persons with a disability.

Apart from the SiB intervention health facilities, the multiple reports of abuse towards people with disabilities in public health services include the refusal of services from certain health providers. These experiences have a negative influence on health-seeking behaviour and push persons with a disability away from services that are desperately needed. In addition, they contribute to the perception that the health system is selective, exclusive and does not care for people with disabilities.

On the other hand, the SIB programme successfully trained a total of 100 health care workers (50 in each pilot location). Beyond this, follow on monitoring should be strengthened to ensure that acceptable practices are being adhered to by trained HFWs. People with disabilities (hearing impairment) may require additional support within the public health service to communicate with healthcare providers.

It would therefore be beneficial if the SiB program worked alongside relevant government agencies and management of pilot health facilities to set up disability desk at each center to address any case of reported abuse; and provide appropriate training programs for other Health Facility Workers (HFWs). This would complement ongoing public relation campaigns supported by the program on national radio stations.

RQ 6: What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services in the two pilot secondary health facilities?

With the planned dissemination of respective end line research studies (i.e. perception study and KAP study) by CBM Nigeria, another opportunity to actively engage stakeholders presents a unique stage to communicate an urgent call to action by stakeholders. Securing government commitment is crucial and should be pursued immediately by engaging identified contact persons in each government ministry or agency. Building on this the dissemination of these research findings of this research study to appropriate stakeholders (community leaders, beneficiaries and HFWs) should ideally encourage conversation on recommended actions to sustain positive outcomes of the SiB program achieved in both pilot locations.

The setup of strategic plans for disabled people will go a long way in the inclusion of health care services. These strategic plans should include some skill acquisition, which limits the intuition of the disabled person feeling like a burden to their caregivers. Government support to a disabled person to know their rights will improve inclusiveness and access to health services. What is lacking is a robust exit strategy to sustain positive outcomes of the SiB program, which is tied to political will.

In articulating strategies to improve inclusiveness and access of PWD to public health services, respondents identified political will as a major requirement. As not enough has been done to leverage on the passage of the National Discrimination Against Persons with Disabilities (Prohibition) Act 2018 by the National Assembly in Nigeria. This is especially evident with the limited engagement of the Nasarawa State Disability Right Commission in promoting inclusive service delivery for PWDs.

Any follow up design consideration for the SiB program should consider the engagement of government through the use of advocacy and strategic communications tools to stimulate engagement of legislative committees at the federal and state assemblies to hold implementing agencies of government accountable to institutionalized provisions of the National Discrimination against Persons with Disabilities (Prohibition) Act 2018. Where necessary, the SiB program could further support the domestication of the National Discrimination against Persons with Disabilities (Prohibition) Act 2018 in pilot states.

The research study recommends that the SiB program take the following actions i.e.

- Establish a community-based rehabilitation program and entrepreneurial initiatives for PwD to help boost their economic base.
- Promotion of a conditional cash transfer scheme to enable them access health services in both pilot locations.
- With support from trained CHEW, the program should intensify outreach /mobile clinic activities targeted at communities including PwDs.

Based on the findings of the research study, it is recommended that CBM International conduct a Randomized Control Trial (RCT) pilot activity to examine the outcome of the Knowledge, Attitudes and Practices (KAP) and Perception studies. By comparing SiB programme outcomes in each cluster region (i.e. control health facilities and intervention health facilities) over a six (6) month period; additional contextual information can be collated and analyzed to highlight specific design options for follow-on activities.

Section 1. Introduction

1.1. Background and Context

CBM International is an International Christian Development Organization, committed to improving the quality of life of persons with disabilities in the poorest countries of the world. CBM provides grants sourced from private and institutional donors to local partners, who subsequently implement the grants based on contracts signed with CBM detailing implementation, accounting, and reporting standards. Nigeria is an oil rich nation, home to Africa's largest population of over 182 million people. However, high levels of poverty and joblessness persist. Development challenges include reducing the great inequality in access to quality health and education services and promoting social inclusion. People with disabilities in Nigeria are often excluded from society, and struggle to access even the most basic services like healthcare and education.

The emphasis throughout CBM Nigeria's work has been on local capacity development in poorer regions of the world. This increases service delivery in the fields of healthcare, education, rehabilitation and livelihood development as well as organizational development of partner organizations.

In this set-up, CBM Country Office (CO) perform control and monitoring procedures aimed at partner projects; control reports from implementing partners to CBM, including comparison with original source documents, project contract and cost plans; and ensure compliance with organizational and statutory requirements.

Figure 3. Map of Nigeria showing States.

Comprehensive Child Eye Health in Nigeria (CCEHiN) is a three-year (2017-2020) Seeing is Believing (SiB) programme that seeks to make comprehensive child eye health services available and accessible through promotion, prevention, medical care and rehabilitation / inclusive education targeted at vulnerable children.

The Seeing is Believing programme kicked off in December 2017 and would be concluded in December 2019. The SiB programme is being implemented in eleven (11) States i.e.

- **Cluster 1**: Oyo, Ogun and Osun States.
- **Cluster 2**: Federal Capital Territory (FCT), Nasarawa and Plateau.
- **Cluster 3**: Kano, Katsina and Jigawa.
- **Cluster 4**: Cross River and Akwa Ibom.

The SIB program objectives are listed below i.e.

- Develop skilled and adequate manpower to provide comprehensive child eye health services at various levels of health care in the targeted project areas.
- Improve the quality, accessibility and scope of eye health services to children.

- Embed child eye health in the policies and programme work of the Ministries of Health and Education.
- Pilot strategies for inclusive eye health.
- Establish the school eye health programme as a sustainable model to deliver eye health services to children.
- Improve the quality of early intervention and education of blind children and children with severe visual impairment.

The end line research study explored perceptions of persons with disability towards inclusiveness of health services in Nigeria and was conducted in the Federal Capital Territory (FCT) and Nasarawa State.

1.2. Purpose and Scope of Perception Study

The objective of this research study is to assess the perception of persons with disabilities and other relevant stakeholders about the inclusiveness of basic services (focusing particularly on health, also covering education and other services) for people with disabilities including children with disabilities and their peers without disabilities in comparison to baseline findings.

1.3. Research Objectives

The specific objectives of the end line research study to explore perceptions of persons with disability towards the inclusiveness of health services in Nigeria i.e.

- To understand the perceptions and experiences of persons with disability and other community members regarding the inclusiveness of health and other services, including the barriers to accessing services;
- To determine the level of satisfaction of persons with disability regarding inclusiveness of health and other services;
- To understand the perceptions and attitudes of health workers in pilot facilities regarding the inclusion of persons with disability in the pilot health facilities;
- To recommend interventions and strategies that should be put in place to make pilot facilities more inclusive of persons with disability, and to improve access of people with disabilities to health services;
- Understand the broader context for inclusion of persons with disabilities in society in the pilot areas (attitudes towards persons with disabilities, root causes of any discrimination encountered).
- To discern how much perception has changed (if any changes are observed) after programme implementation and noting any possible attribution to programme implementation.

1.4. Research Questions

Leading from the above listed research objectives, the following Research Questions (RQs) were outlined in the Terms of Reference (TOR) for the perception study i.e.

- **RQ1:** What are the perceptions of persons with disabilities regarding the inclusiveness of public health services?
- **RQ 2**: To what extent are persons with disabilities, including children with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?
- **RQ 3**: What level of Knowledge, awareness and understanding do stakeholders in the pilot areas have about accessible and inclusive health services?
- **RQ 4**: What barriers are faced by persons with disability, including children with disability, in accessing health services in the two pilot secondary health facilities?

- **RQ 5**: What factors support the access and inclusion of persons with disability including children with disability in accessing health services in the two pilot secondary health facilities?
- **RQ 6**: What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services in the two pilot secondary health facilities?

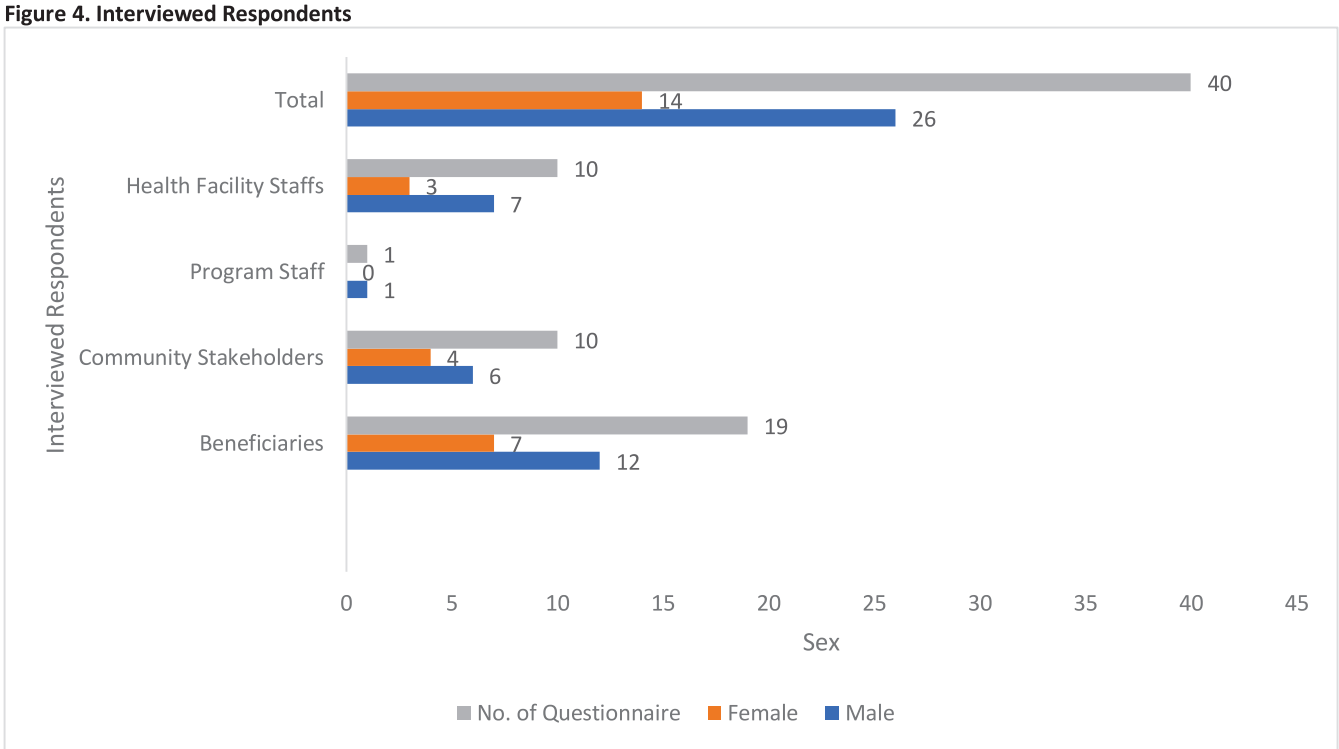
1.5. Demographic Characteristics of Respondents

A total of forty (40) respondents participated in the Respondent Referral Survey (RRS); while thirty-five (35) referred respondents could not be reached due to their absence or non-availability during field data collection. The distribution by sex indicates that, there were 26 (65%) male respondents and 14 (35%) female respondents who participated in the RRS. While among absent respondents, there were 22 (63%) male respondents and 13 (37%) female respondents.

Absent respondents could not be reached at the time of field data collection for different reasons i.e. refer to research limitations (Section 2.7).

Figure 4 and 5. display the demographic characteristics of RRS participants i.e. both interviewed and absence respondents.

Figure 4. Interviewed Respondents



Section 2. Literature Review

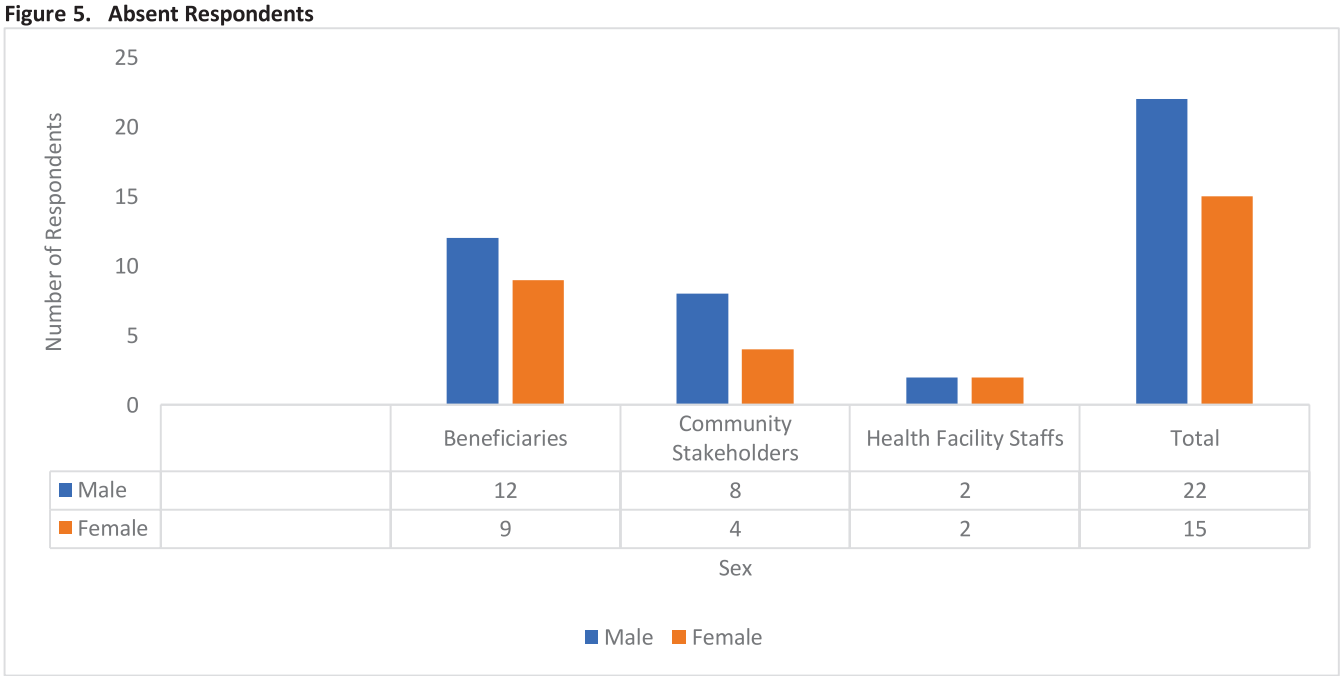
This section outlines the current knowledge including substantive findings, as well as theoretical and methodological contributions to the research study focus i.e. perceptions of disabilities towards Healthcare in Nigeria (FCT and Nasarawa). The desk review puts forward a theoretical base for each research question for the perception study.

2.1. PWD Perception of Access and Inclusive Public Health Services

Disability is thus not just a health issue but a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities, therefore, requires interventions to remove environmental and social barriers (WHO 2018). According to WHO (2017), the impact of unmet eye care needs in sub-Saharan Africa is compounded by barriers to accessing eye care, limited engagement with communities, a shortage of appropriately skilled health personnel, and inadequate support from health systems. The renewed focus on primary health care has led to support for greater integration of eye health into national health systems through donor implementing partners like CBM international.

The coverage of the programme demonstrates available evidence of the integration of eye health into primary health care in sub-Saharan Africa from health systems strengthening perspective. There has been a need to improve the strategy in programming for eye health care to increase the performance among various health facilities supporting children on better

Figure 5. Absent Respondents



vision.

The improvement of the primary health care system includes eye health which has been challenged by the fragile, fragmented and under-resourced systems within the health sector. The viability of the primary health care systems about eye health care varies between countries

and even between different areas in a country (WHO, 2017). It has been recommended that the coverage of eye health care within the health systems should be strengthened to enable most interventions to be delivered in an integrated way, where feasible.

Nigeria through CBM international has thus adopted policies using priority health interventions such as eye health care as an entry point to strengthen health systems (Health Systems Strengthening - HSS), based on a primary health care approach. The importance of the health systems strengthening approach has been recognized through eye health care program coverage.

Many persons with disabilities reported that they did not receive health care when they needed it and significantly fewer non-disabled reported the same (Ali et al, 2018). Persons with disabilities thus had higher rates of unmet health care needs. WHO (2017) detailed that the number of persons living with disabilities is growing as a result of factors such as population increase, ageing, and medical advances that preserve and prolong life. This has increased the demand for health services. Some persons with disabilities are more susceptible than the general population to secondary health conditions. As a result, persons with disabilities may have greater needs than the general population. Health promotion services for the prevention of further disability and the promotion of health in general are important in determining the quality of life and health status of those with disabilities.

2.2. PWD Access to Public Health Services

Generally only tertiary and some secondary services have specialist eye care services and equipment required to reliably diagnose and manage the major causes of vision impairment (Atun et al, 2015). These conditions, which include cataract, refractive error, diabetic retinopathy, and glaucoma, usually have a gradual onset. People may not experience or notice symptoms. Alternatively, they may use traditional medicine, self-medicate or develop coping strategies.

This may delay presentation to eye care services, leading to complications and even irreversible visual loss (Chibuga et al 2018). A person with these conditions could benefit from earlier identification, counselling, and referral to other health facilities before the introduction of eye health care by the Seeing is Believing (SiB) program. Delays in the presentation of other sight-threatening conditions, such as injuries, are often due to lack of finances and or ignorance at the community level that interventions are available. This can be compounded by the poor knowledge within the health care sector of appropriate management and the availability of specialist eye care services. These issues generate questions about how to facilitate equitable access to eye care at the most appropriate levels.

Information from other fields of health shows that few institutions offer mid-level both teaching or supervision skills and this supervisory role is rarely fulfilled in line with low vision services. Cascade training has to be well supported to be effective in offering specialized refraction services. In the past, only specific tertiary institutions offered specialized refraction and low vision services because of inadequate equipment.

Another concern was the absence of trained personnel to care for children with special eye needs in other primary and secondary institutions. There are few institutions offering eye health training session for general health staff were not encouraged to document short-term outcomes and impact within the community. In general, however, documented longer-term outcomes for

eye health training have been less encouraging among health facilities. Evidence from evaluations of the quality eye care services in various locations of these interventions is sparse.

Persons with disabilities experience significant barriers to accessing health care. Barriers, which can be particularly severe for those residing in rural areas, can include physically inaccessible medical clinics and hospitals (Mahmoudi & Meade, 2015). Persons with disabilities lack appropriate transport to enable them to seek medical care or rehabilitation services. There is also lack of communication and accommodation in health care settings for disabled people (Mulumba et al, 2016).

Some limitation for disabled children includes untrained personnel, inadequate staffing and negative attitudes of health care providers. As with all members of the general population, the health needs of persons with disabilities can vary broadly. The range of services available to the general population must also be accessible to persons with all types of disability (WHO, 2014). Care must also be taken to meet the health needs of those with invisible disabilities, particularly those with psychosocial disabilities and other mental health conditions. Ensuring optimal mental health is an integral part of health service provision but has received inadequate attention by policy makers and also by society in general (Mulumba et al, 2016). As a result, it imposes an enormous disease burden and an increasing obstacle to development in countries around the world.

2.3. Barriers to PWD Access and Inclusive Health Services

Initiatives to promote access to eye care for vulnerable people are important to reduce blindness worldwide. This includes the availability of quality care and community awareness on eye health issues. This is what the SiB project in Côte d'Ivoire has been working on. Indeed, before the onset of this program, no regional hospitals offered cataract surgeries. Most cataract surgeries in the country were done through surgical outreaches by nongovernmental teams, in the private sector at a very high cost, and in one tertiary hospital in the capital; however, overall, outputs were low. With the SiB project, surgical services were set up in four regional hospitals across the country; this included training, provision of equipment and consumables and awareness-raising activities in communities around eye care issues.

In addition to addressing the availability of care, the question of the user costs of eye surgery is also a major challenge. Therefore, as part of the project, a resource centre has been set up in some tertiary facilities. The objective of this resource centre is to guarantee the availability of quality consumables for cataract surgeries at a lower cost. The resource centre if established will be one of the project's major success stories which will be the project's partner hospitals and other health centres.

Despite this, the costs are still inaccessible for some patients. Therefore, pending the outcome of advocacy actions for a substantial reduction in the fees and other costs of surgery, a subsidy system has been put in place. Alongside this, CBM International is advocating for reduced costs of surgery with the Ministry of Health (MoH), including a review of the different pre-and post-operative costs related to surgery. Addressing the financing of cataract surgery requires a combination of efforts to ensure that as many people as possible have access to affordable care.

Before the SiB program, there was no guiding policy in place regarding eye health care at the Federal level. The documentation on Health Management Information System (HMIS) tools and data entry on Demographic Health Information System (DHIS) was not specific to eye health care limiting the availability of information for decision making.

Problems of disability are largely manifested in social contexts and social relations, rather than in an individual's medical condition. Scheer et al in 2015 detailed the context of health, stigma and prejudice as additional barriers that are faced by persons with disabilities. Most of these include:

- physical barriers that prevent access for persons with disabilities to health clinics and hospitals;
- informational barriers that prevent access for persons with disabilities to health literacy and information on health promotion, prevention and protection;
- attitudinal barriers which give rise to discrimination that can have severe implications for the rights of persons with disabilities, particularly, for those with psychosocial disabilities; and
- institutional barriers that include legislation, practices and processes that prohibit access to health services for persons with disabilities and services for people with physical, sensory or intellectual disabilities have also been the subject of criticism in relation to communication and cultural barriers (Ali et al, 2018).

Lack of physical access, including transportation and/or proximity to clinics and, within clinics, lack of ramps, adapted examination tables, and similar facilities reduce access for persons with disability. Lack of information and communication materials including sign language interpretation are included in the barriers for disabled people (UN, 2017). Some other barrier includes lack of private offices to discuss confidential health and social matters. The washrooms and rest room facilities in most health centres are not made inconsideration of people with disability (Tomlison et al, 2017).

So many health workers lack awareness, knowledge and understanding of the needs of disabled persons and this leads to negative attitudes, prejudice and imposed stigma. Untrained health care workers toward disabled people lack coordination in the affairs related to persons with disability. There is a large gap in funding and health care insurance for persons with disability (Tomlison et al, 2017).

2.4. Support for PWD Access and Inclusive Health Services

The WHO considered integration as a key strategy for eye health care of primary health facilities in 2013. Integration remains a cornerstone of initiatives to revitalize primary health care. The WHO further indicated that integration of management and delivery of health services can receive a continuum of preventive and curative services concerning eye health care. There is however no documentation on the nature of integration to increase the effectiveness of the approach within the health care system.

In 2013, the WHO also recommended a primary health care approach by including appropriate management of eye conditions at the primary care level with cascading levels of referral for more complex conditions. The VISION 2020 focuses on priority blinding conditions with the goal of the elimination of avoidable blindness and visual impairment by the year 2020.

Primary eye care as an integral part of primary health care was recommended as a key strategy that included the promotion of eye health and the provision of basic preventive and curative treatment for common eye disorders (Frenk, 2019). The role of a primary eye care provider was outlined blind and vision impaired, advice about referral and give advice on any treatment and make sure spectacles are available. The concept of integration of eye health into primary health care thus enjoys an enabling policy environment, but there is little information about the implementation of these policies.

Poor knowledge and skills are broadly attributed to inadequate or inappropriate training, inadequate supervision, or lack of support to implement the eye health skills learned. There is however little evidence as to what the most effective interventions would entail in the implementation of eye health care by primary health facilities. A systematic review by Atun et al (2015) however found insufficient evidence to determine whether managerial supervision has a substantive, positive effect on the quality of primary health care in low and middle-income countries.

Access to healthcare for persons with disabilities extends well beyond the accessibility factors (Danquah et al, 2015). Differences in access to health and social services may arise due to unavailability of services which may be scarce or simply not provided to disabled persons. It is important both to enhance the capacity of persons with disabilities to access the healthcare system and also to ensure that the system is able to respond in an appropriate and timely manner to their needs.

2.5. Improving PWD Access and Inclusive Health Services

Although service delivery was a huge component of CBM's SiB program, its success rests on the fact that the program integrated all six (6) components needed to strengthen health systems; advocacy, information, and awareness-raising, strengthening human resources, improving service delivery, strong programme management, and building infrastructure and technology. Having well trained and committed staff was essential to the success of the SiB programme. Partners initially struggled with hiring trained staff and had to invest in the expansion of the residency programme to build in-house capacity to conduct high volume surgeries. Higher patient volumes contributed significantly to better-trained staff, enhancing hospital reputation and increasing revenues.

The program demonstrated that quality eye care services do not have to be expensive. The business model of having tiered pricing makes services affordable for all patients and this business model can be replicated in other centres. Even after the end of the SiB program, the hospitals are still able to charge fees as low as N10,000 for cataract surgeries by examining areas of inefficiency that drive up cost within their systems, emphasizing on delivering quality and patient-focused services and having a high volume of patients.

Community mobilization and awareness of eye services were essential to the uptake of eye care services although the programme was offering free or highly subsidized services. Some partners struggled initially to attract patients despite offering free surgeries. They had to understand the specifics of their target groups to design appropriate interventions and mobilization strategies. Plans were tested and modified, and several approaches had to be combined to effectively mobilize community members to attend outreaches. Programme targets were only met because of the massive investment of time and resources, which, led to successfully mobilizing communities.

The SiB programme showed that with training and a clear referral network, government structures can be utilized adequately to identify cataract cases for surgery as evidenced in the use of primary health care staff and community drug distributors in Jigawa state. The use of highly trained mid-level Ophthalmic personnel made it possible to successfully carry out tasks that normally would be the responsibility of specialized eye health personnel. This model has been used successfully elsewhere and CBM's SiB programme provides evidence that the model has been replicated successfully in Nigeria.

CBM Nigeria partners were able to engage private individuals and corporations in their work which led to funding for free surgeries. To do this successfully, advocacy efforts, messages, and tools needed to be tailored to each target group. Although this type of fundraising was not part of the initial program design those fundraising efforts have helped sustain the outreach work and subsidized surgeries.

Persons with disabilities, especially those with severe disabilities, often require home and community based services. These services and other support help people with disabilities of all ages to live in the community to optimize their health, functioning, and well-being while enabling them to live in their homes and participate in their communities. Such services may include a variety of health services, such as home health care, durable medical equipment, case management, personal care, caregiver and client training, and health promotion and disease prevention (Rose et al, 2016). Home and community based services also include human services that support the daily living needs of people with disabilities, such as personal care (e.g. dressing, bathing, toileting), transportation; home safety assessments, repairs, and modifications; information and referral services; and legal services (Pharr, 2014).

Section 3. Research Methodology

This section outlines the adopted steps and tools employed by the research team in conducting the research evaluation. By following this process, the research team determined a robust analysis matrix and established an appropriate level of quality to finalize the research study on perceptions of persons with disabilities towards healthcare in two areas of Nigeria.

3.1. Resign Design: QR3 Qualitative Methodology

To meet the stipulated evaluation research objectives and provide useful insights from the above-mentioned Research Questions (RQs); this research study employed the QR3 methodology adopting a three-tier approach (Table 1) i.e. incorporating a harmonized qualitative methodology of Outcome Harvesting (OH), Outcome Mapping (OM) and Most Significant Change (MSC). Each QE3 qualitative methodology is presented below.

3.1.1.Outcome Harvesting (OH)

This method will be used to collect evidence of what the SiB program has changed (perception outcomes) and then the research team will work backwards to determine whether and how the SiB program contributed to documented changes. The OH process involved the conduct of desk studies of SiB program documents (i.e. internal data sources) and a deep dive of external data sources through literature review. As a follow-on to this process, the research team conducted daily Knowledge Harvesting Sessions (KHS) during field data collection.

3.1.2.Outcome Mapping (OM)

This evaluation method was chosen because it will assess the SiB Theory of Change (ToC) corresponding to changes in behavior (perception) of beneficiaries, community stakeholders and Health Facility Workers (HFWs) which worked directly with CBM Nigeria. Key to the mapping of SiB programme outcomes (as per research questions) is the alignment and triangulation of collated feedback from the respondent driven surveys (i.e. IDIs) from different categories of interviewees.

Curated responses were reviewed against documented baseline perception survey findings across each research theme i.e. Research Questions (RQs).

Figure 6. Outcome Mapping (OM).

3.1.3.Most Significant Change (MSC)

The Most Significant Change (MSC) method collected and analyzed personal accounts, stories of change among program stakeholders and beneficiaries. The MSC research approach adopted a process review of findings by curating feedback from multiple respondents. Based on targeted probing questions, the research team reviewed collated feedback from different categories of respondents via the conduct of Individual In-depth Interviews (IDIs) in Abuja and Nasarawa States respectively.

Highlighted findings from these stories were collected and triangulated against information presented in SiB programme reports. At this stage, the research team ascertained the MSC associated to the Perception of Persons with Disabilities towards Healthcare in sampled locations in the FCT and Nasarawa i.e. on a comparison basis showing a before and after scenario of key program outcomes based on each RQ.

Figure 7. Most Significant Change (MSC).

At the final analysis stage of the QR3 methodology, all research findings (visuals, data and narrative contents) were used to explain SiB programme outcomes for each research question.

The research team then focused on clearly showcasing examples where the SiB programme successfully delivered on its core objectives as aligned to each RQ through the course of implementation.

This was done through a step by step comparison of MSC verified per research question i.e. changes from the baseline perception survey.

3.2. Research Sampling Technique

The end line perception study employed a QE3 methodology approach to collect, analyze, and triangulate primary and secondary data sources from the outcome harvesting process. Sampling focused on the catchment areas for two secondary health facilities in Gwagwalada (FCT) and Doma (Nasarawa state), where inclusive eye health services were piloted under the SiB program - CCEHIN. A mix of rural and urban locations within the catchment areas of the two health facilities were sampled.

The Principal Evaluator constructed the sample frame from previous data set of the SiB program's proposed beneficiaries in each designated sample location i.e. each study location (Gwagwalada and Doma) served as the Primary Sampling Unit (PSU) and were purposely selected pilot locations. At the second stage, a representative sample was derived from the different categories of respondents i.e. Health facility workers, program beneficiaries, PWD, community stakeholders. The principal evaluator applied a stratified random sampling procedure to select a representative sample of respondents from the sample frame, randomizing within both pilot locations in Doma and Gwagwalada. A respondent driven approach was applied to facilitate the conduct of Individual In-depth Interviews (IDIs) handled by the research team.

Following this process, the principal evaluator finalized the review of data collection tools and updated the research matrix aligning data points for each research question across the scope of the perception study. Refer to Annex 4. List of Facilities and Contact Persons at Doma (Nasarawa) and Gwagwalada (FCT) and Annex 6 for QE3 Research Matrix.

3.3. Research and Analysis Plan

The design of a robust evaluation and analysis plan is critical to the completion of this perception research study. The research team harmonized desk study findings to conduct a deep dive session. This brainstorming session was conducted to develop additional research questions and map out casual linkages attributed to each RQ.

3.3.1. Developing Sub-Research Questions

The first step in developing a research analysis plan for the perception research study is the development of sub-research themes for each RQ. This is tailored to the strategic objectives of the SiB program to identify suitable probing questions to be incorporated into the design of suitable data collection instruments. Table 4 outlines associated sub-research themes per RQ. Refer to Annex 6 for QR3 Research Matrix (outlines information of developed research themes, sub-research questions and corresponding probing questions).

3.3.2.Mapping Casual Linkages

The development of a robust qualitative analysis plan was focused on mapping casual linkages across each research question in order to identify the specific respondents to direct each line of inquiry. This was done to aggregate suitable research themes from relevant respondents (i.e. program staff, community stakeholders, health facility staffs and program beneficiaries). The Principal evaluator reviewed baseline survey instruments to identify overlapping questions and identified alternative probing questions not captured in the QR3 research matrix. At the end of this process, the research team was able to finalize the design of suitable data collection instruments. Refer to Annex for sample data collection instruments deployed by the research team.

Table 2. Developing Sub-Research Questions

Research Questions	Sub-Research Questions
RQ1: What are the perceptions of persons with disabilities regarding the inclusiveness of public health services?	To what extent did the SiB program improve perception of PWD on access and inclusiveness of health services?
	How can health care facilities improve PWD access to public health services?
RQ2: To what extent are persons with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?	Was there an increase in Health workers delivering C.E.H.S to PWDs at the health facility?
	To what extent did the program increase institutional coverage of PWD inclusive services?
RQ3: What level of knowledge awareness and understanding do stakeholders in the pilot areas have about accessible and inclusive health services?	How can health care facilities improve PWD access to public health services?
	How have health institution services promoted inclusiveness for persons with disabilities?
RQ4: What barriers are faced by persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?	What challenges and opportunities exist to sustain the SiB implementation model?
	How responsive were health institutions to the needs of the community and PWD?
RQ5: What factors support the access and inclusion of persons with disability, including children with disability, in accessing health services in the two pilot secondary health facilities?	In what way(s) did C.E.H.S consultations improve for PWD?
	How can beneficiaries and PWD be better linked to improved C.E.H.S?
RQ6: What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services in the two pilot secondary health facilities?	How successful were pilot strategies for PWD inclusive eye health care?
	How have health institution services promoted inclusiveness for persons with disabilities?
	What program outcomes for PWD justified expenditure from the program design?

3.3.3. Respondent Referral Matrix (RRM)

The Respondent Referral Matrix (RRM) outlines the referral pathways for each interviewed respondent engaged by the research team during actual field data collection. The RRM was used by the research team to tag and track the rate of responses from each category of respondents; as well as, study the trend of response for each deployed data collection instrument. The RRM also presents a visual illustration of the demographic characteristics of sampled respondents (interviewed and absent) via the use of a color code to facilitate the prompt identification of referral pathways and patterns for each respondent group. It further serves as a means of highlighting the existing awareness levels of community stakeholders based on their corresponding referral connections.

Refer to Annex 12 for Referral Respondent Matrix (RRM).

3.3.4.Data Analysis and Quality Assurance

The QE3 research methodology was aligned to addressing each research question for effective storytelling with data. When you combine the right visuals and narrative content with the right

data, you have a data story that can influence and drive change. This addresses the "so what?" for every research i.e. setting out a viable action plan to implement the findings for the research study as well as facilitate sustainable uptake by respective stakeholders.

The data cleaning and analysis process involved the review of conducted data collection activities by digesting what happened and determining how it could relate to corrective actions. Through the application of descriptive analysis, a train of research findings was developed to show linkages between RQs and baseline survey findings to ascertain the quality of SiB programme outcomes.

Table 3. Data Quality Standards

DQA Standards	Definition
Completeness	The proportion of stored data against the potential of "100% complete.
Uniqueness	Nothing will be recorded more than once based upon how that thing is identified. It is the inverse of an assessment of the level of duplication.
Timeliness	The degree to which data represent reality from the required point in time.
Validity	Data are valid if it conforms to the syntax (format, type, range) of its definition.
Accuracy	The degree to which data correctly describes the "real world" object or event being described.
Consistency	The absence of difference, when comparing two or more representations of a thing against a definition.

By triangulating different feedback sources from respondents, the evaluation team will be able pinpoint relevant information to answer each RQ as a comparison from preliminary baseline survey findings. The research team adopted a Data Quality Assurance (DQA) checklist showing definition standards.

This was used to complement the Risk Mitigation Strategy (RMS) to address encountered challenges during field data collection. Analyzed data was then reviewed to highlight pivot points in order to create a bridge between programme implementation and decision-making. The research team conducted two (2) field data collection at each sampled location in FCT and Nasarawa respectively. Upon the completion of data collection from all categories of respondents and triangulation of responses, the research team reviewed all data points for quality standards i.e. completeness, uniqueness, timeliness, validity, accuracy and consistency (Table 6).

3.4. Design of Data Collection Instruments

The research team reviewed CBM Nigeria baseline survey tools (i.e. employed for the previous baseline perception study) to gather qualitative data that answer each of the six (6) Research Questions (RQs). The research team deconstructed each of the RQs into corresponding research themes with corresponding set of probing questions to guide field data collection activities. In other words, the research team developed supplementary probing questions for each RQ contained within a harmonized QR3 Research Matrix i.e. Refer to **Annex 6**.

This was used to develop draft research questionnaires for different key informants prior to pilot testing and field deployment with beneficiaries and stakeholders. These finalized questionnaires incorporated lines of enquiry from instruments deployed during the baseline survey. However, the finalized tools were customized to address each research question outlined in the research TOR document (Annex 1).

The following questionnaires were developed and deployed for data collection by the research team i.e.

- Community Stakeholder Questionnaire (CSQ);

- Program Beneficiary Questionnaire (PBQ); and
- Health Facility Questionnaire (HFQ).

3.5. Data Collection Methods

This section provides information on data collection methods employed by the research team. Specifically, the perception survey adopted three (3) data collection methods during the conduct of the research study.

3.5.1.Desk Study Review

This final perception research study used qualitative based methods to collect, analyze, and triangulate data to answer each research question specified in the Research Terms of Reference (TOR). The research team adopted a four-step data collection process which involved the following methods.

- **Desk Study Review**: The research team conducted a desk review of SiB primary and secondary data sources i.e. internal and external documents. This involved collating findings from the baseline survey for each research question in order to ascertain a reference point for comparison at the end line stage. Through firsthand observations and updates to each research questions from two broad stand points.
    - **Learning from what works**: what was achieved from the activities planned, what worked well/what the success factors were, key lessons learned, key adaptations to leverage success/achieve greater SiB project outcomes to achieve greater results.
    - **Learning from what did not work**: what was not achieved from the activities planned, what did not worked well/what were the challenges/bottlenecks, key lessons learned, key adaptations/course corrections to address challenges/bottlenecks to achieve expected outcomes in relation to SiB programme expected results.

3.5.2.Literature Review

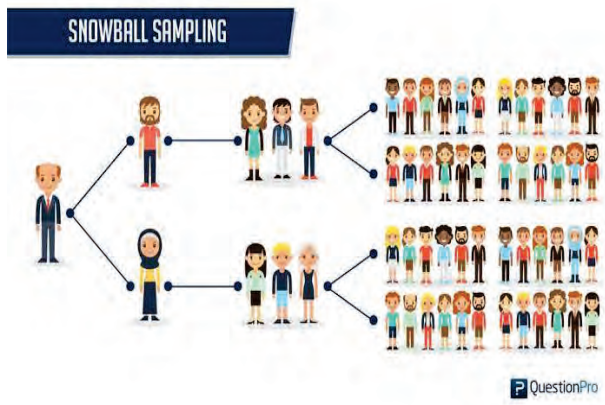
As part of the Outcome Harvesting (OH) process, the research team conducted a literature review to curate current knowledge including substantive findings, as well as theoretical and methodological contributions to the research study focus i.e. Perceptions of Disabilities towards Healthcare in Nigeria (FCT and Nasarawa). The literature review put forward a theoretical base for each research question for the perception study i.e. provide further context on best practices to inform the effective delivery of disability inclusive health services. Findings from the literature review are elaborated further in section three (3) of the study report per research question.

3.5.3.Respondent Referral Surveys (RRS)

The Respondent Referral Survey (RRS) method was adopted for data collection. This process involved the referral of new respondents for Individual In-depth Interview (IDIs) from each completed interview form across each respondent category. The approach ensured that the research team sourced the right information from respondents without influencing discussions during one-on-one interviews, which is critical to the integrity of the process.

By triangulating curated information from QR3 Tier One Phase (Table 1), which informed the revision of data collection instruments, the research team was able to identify appropriate probing question for each respondent category during data collection. This informed the choice of the snowball respondent driven approach.

Figure 8. Respondent Referral Survey (RRS)



For example, at the end of each conducted IDI, each interviewee was asked to recommend persons for follow-on interviews. This highlighted lines of communication among respondents (i.e. formal and informal relationships); and further provided the basis for interrogating the associated influence/interest interactions per respondent group aligned to each RQ.

To ensure effective documentation of all narrative content from conducted interviews, the research team directly interviewed respondents and procured the services of a STTA Videographer to film specific interviews with selected stakeholders (beneficiaries, health facility contacts and stakeholders). Footage from these interviews were reviewed and incorporated into a final short video (KM product) as part of final deliverables for the perception research study.

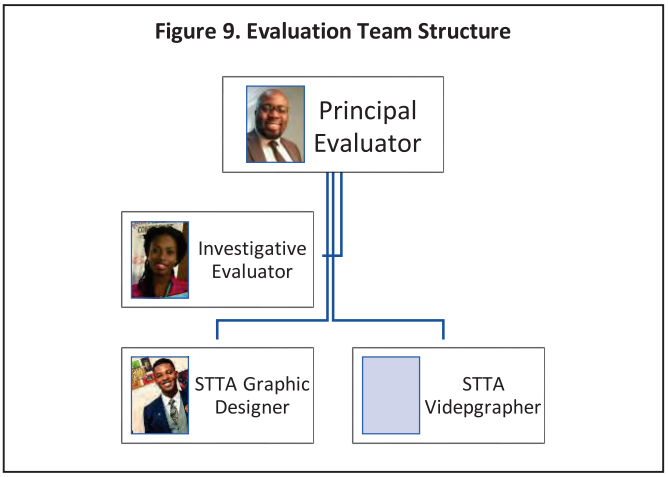
3.6. Research Responsibility

The end line research study was comprised of a two (2) member core team, comprising of a Principal Evaluator (P.E) and Investigative Evaluator (I.E) with two (2) supporting STTA personnel (i.e. STTA Graphic Designer and STTA Videographer).

3.6.1.One-Team Partnership Approach.

The end line research study team drew on their individual strengths and resources to increase the reliability, validity and usefulness of perception assessment data to CBM Nigeria. Both evaluators worked collaboratively as a single unit, co-locating and under unified management of the Principal Evaluator. The Principal Evaluator's role centered on the provision of management, technical and contractual direction.

Figure 9. Evaluation Team Structure



With a primary focus on engaging CBM Nigeria technical team as part of the research methodology approach. While the Investigative Evaluator will handle engagements with SiB program beneficiaries (i.e. Ministry of Health (MoH) officials, Supported Health Facilities and Schools, and Eye Health Coordinators).

This approach ensured comprehensive professional review and technical oversight across board. Pilot testing of instruments was conducted in pilot locations among non-sampled

respondents to avoid recall bias by respondents. All research team members worked together, coordinating across responsibilities and functions, through weekly conference calls.

To ease communication, the principal investigator set up a WhatsApp group to facilitate timely feedback among team members and discuss any potential challenge encountered.

3.6.2. Research Team Structure

3.6.2.1. Principal Evaluator roles and responsibilities

The P.E. served as the research team leader leading and managing all study activities and being the primary liaison with Nigeria-based CBM International staff. The P.E. had primary responsibility for ensuring the quality and timely delivery of all research task(s) and oversaw, supported and coordinated the work by the research team. With guidance from CBM Nigeria, the P.E. approved all field visit plans, drafted deliverables, reviewed and approved all reports prior to their submission.

3.6.2.2. Investigative Evaluator role and responsibilities.

The I.E. handled all public health related engagements especially regarding child eye health and interactions with external stakeholders. The I.E. worked alongside the P.E. in conducting primary and secondary data review and made contributions towards the drafting of the end line research study reports (i.e. inceptions, zero, first and final drafts).

3.7. Research Limitations

The research team encountered several challenges during the research study. This informed the application of the Risk Mitigation Plan (RMP) to address these research limitations i.e.

- **Pilot testing data collection instruments:** The research team pilot tested selected data collection tools (HFQ, PBQ and CSQ) in Doma, Nasarawa State among non-sampled respondents. After pilot testing, the research team reviewed the Risk Mitigation Plan (RMP) to accommodate potential risks associated to field data collection i.e. Data Reliability and Validity, Use of Primary and Secondary Data, Privacy Concerns, Cultural and Language Barrier, Logistics and Non-responses from interviewees.
- **Non-domiciled Optometrists**: A challenge encountered by the research team was the geographical distance between the place of assignment of designated Optometrists and SiB selected health facilities in both pilot sites i.e. the Optometrists were domiciled in different facilities and had to consult once a week at respective pilot sites. This contributed to significant delays in service provision, especially for children and PWDs. At some point, the beneficiary list was not documented at the pilot site because the Ophthalmologist could no longer travel for weekly consultations due to personal expenses incurred.
- **Non-resident beneficiaries**: Most of these beneficiaries had to be referred to the Ophthalmologist place of primary assignment within the state. It is, therefore, possible that the beneficiaries list may not be completely updated at the pilot sites. Some other beneficiaries were not domiciled at sampled sites site as they were referred during large outreaches at various locations and linked to the health facility. Most of the beneficiaries could not be easily located in (Gwagwaalada) FCT and some parts of (Doma) Nassarawa State because of distance.
- **Time constraints:** Given the tight timeline to deliver on the perception research study, the research team opted to triangulate findings from multiple data sources (i.e. programme beneficiaries, PWD, health facilities, and community stakeholders) due to the applied sample size of 40 IDIs. This offered useful insights into the outcome of the SiB program as narrated from multiple validation sources.

- **Securing government approvals**: It is common with government Ministries, Department and Agencies (MDAs) to require supervisor approvals before government workers can participate in any interview or survey. This was no different during the research survey, as engaged health facility workers and schoolteachers both sought permission from appropriate authorities before participating in conducted interviews. This situation imposed significant time delays during the respondent referral surveys. It was challenging securing interview appointments with the government personnel who participated in the SiB project because approvals were needed from senior management staff, which took long hours.
- **Data Limitations:** Limited data on disability outlined in the baseline survey report as well as the absence of a midline assessment study. In order to answer the RQs, the research team considered where deeper evidence would be needed. Upon a preliminary review of SiB program documents and additional secondary data from completed desk study (i.e. literature review); the research team developed probing questions aligned to corresponding to each research question.

3.7.1.Mitigation Strategies

Prior to the commencement of field data collection, the Principal Evaluator developed a Risk Mitigation Plan (RMP) itemizing potential challenges and risks associated with data quality for field activities. This ensured timely reporting and effective assessment of field data collection by respective evaluators. The RMP also highlighted respective mitigation strategies and probability ratings for each identified risk. For this reason, the RMP will consists of two sections: i.e. Risk Rating Scale (RRS); and Risk Mitigation Strategy (RMS). The RRS assigned corresponding risk ratings captured in the RMP. The impact of each identified risk was scaled according to the probability of its occurrence across a four-code color scheme (i.e., low, medium, high, and critical).

Figure 10. Risk Rating Scale (RRS)

RISK SCALE	RISK PROBABILITY				
		REMOTE	OCCASSIONAL	PROBABLE	FREQUENT
	SIGNIFICANT	CRITICAL	CRITICAL	CRITICAL	CRITICAL
	MATERIAL	HIGH	HIGH	CRITICAL	CRITICAL
	MARGINAL	MEDIUM	MEDIUM	HIGH	HIGH
	NEGLIGIBLE	LOW	LOW	MEDIUM	MEDIUM

Refer to **Annex 7.** for the Risk Management Strategy (RMS).

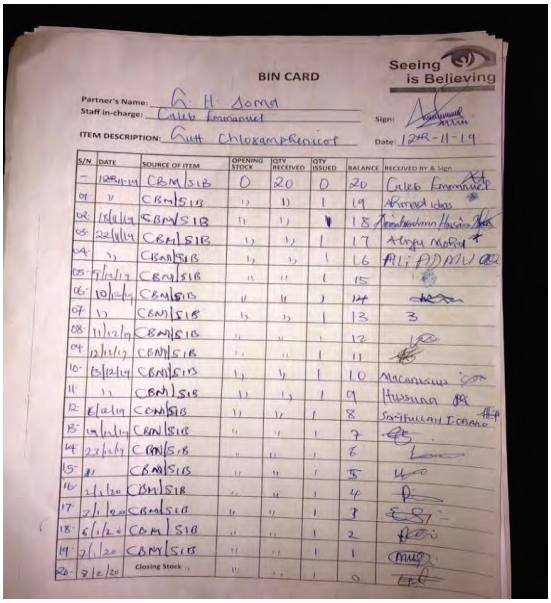
Section 4. Research Findings

The evaluation outlined key findings per research questions through the application of the QR3 methodology i.e. Outcome Mapping (OM), Outcome Harvesting (OH) and Most Significant Change (MSC). To deduce key findings, the research team presented reviewed information from primary and secondary data sources (i.e. the baseline survey and harvested literature review findings) and then triangulated both data points against collated field data provided by interviewed respondents in both pilot locations.

4.1. PWD Perception of Access and Inclusive Public Health Services

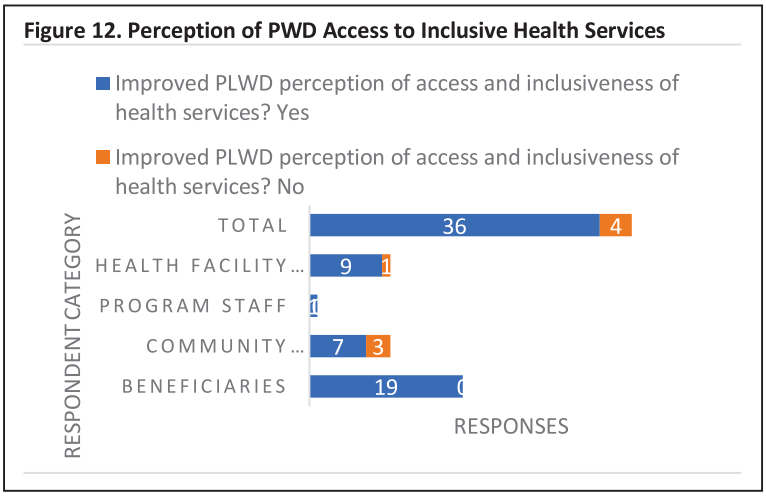
This section presents the findings as regards the factors in the environment that limit access to services and the inclusion of persons with a disability, such as the accessibility of the surroundings, or the attitudes of friends, family or staff towards persons with health conditions. The International Classification of Functioning, Disability and Health (ICF) recognizes that environmental factors could constitute barriers for persons with a disability and this could in turn impact on access to services.

Figure 11. Bin Card, General Hospital, Doma, Nasarawa.



Prior to the commencement of the SiB program, the accessibility of any of these services was believed to impact on the ability to access others. Respondents regarded education (increased awareness) as critical to understanding disability issues for community members, stakeholders and respective Health Facility Workers (HFWs). Thereby empowering PWDs, as their needs are acknowledged and adequate or adjustments made to improve inclusive public health services.

The SiB program improved PWD access to inclusive health services by creating awareness in the community regarding health services. This was achieved using radio jingles and community outreach activities. The inclusion of health services was not limited to health facilities but was extended to schools where a few disabilities were detected and referred to the health facilities. For example, all interviewed respondents (19 respondents: 12 male and 7 females, 8 PWD) at the end line acknowledged that their perception of disability inclusive public health services had improved; and often referenced the inception of the SiB program.



This was in no small part to the improvement in Health Facility Worker (HFWs) treatment of PWD and available consultation services provided by Optometrists and collaborated by the research team through the review of available hospital records (i.e. Bin cards and Eye Health Attendance Registers) which showed that PWD were readily attended to by HFWs trained by the SiB program.

A further review of collated respondent data across all respondent categories, showed that program beneficiaries and Health Facility Workers (HFWs) provided mainly positive perceptions of access and inclusive health services for PWD, while community stakeholders had some reservations on the present state of PWD access to inclusive public health services in Doma and the FCT.

Findings from the research study show that Referral forms were provided to members of community-based Organization of Persons with Disabilities (OPDs) trained by SiB to facilitate ease of referrals. As it is evident that more clients are now accessing services at health facilities now compared to the baseline. This was ascertained by the review of Health Facility registers.

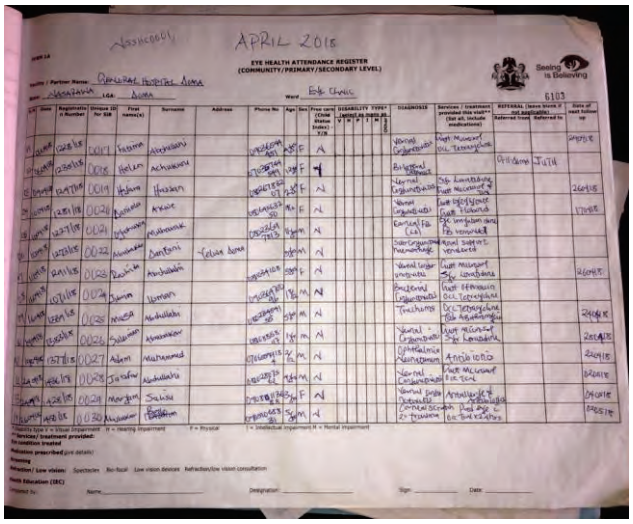
The SiB program also worked to improve positive experience of care by persons with disabilities (PwDs) and addressed gaps identified at baseline. Specifically, the following were achieved i.e.

- 100 Health workers (50 per location) from the pilot facilities were trained on disability friendliness in order to address negative attitudes towards persons with disability (PwD).
- SiB program produced disability friendly Information Education and Communications (IEC) materials and distributed to the communities and the two pilot health facilities. This was to reinforce knowledge on how to deal with PwD and improve interaction with them to ensure delivery of quality services to them.
- SiB program ensured that training manuals incorporated relevant sections on disability.
- SiB program worked with the FMoH and stakeholders to develop disability friendly Health Management Information System (HMIS) data collection tools.

4.2. PWD Access to Public Health Services

At the baseline, participants in the qualitative research expressed their level of satisfaction about inclusive delivery of education from the viewpoint of availability of special schools, learning aids and instructional materials that could facilitate persons with disabilities' teaching and learning. Most participants based their satisfaction with the delivery of inclusive health services based on the attitudes of healthcare workers, availability of relevant equipment and adequacy of healthcare personnel. Most of the healthcare personnel interviewed at the General Hospital Doma admitted to a lack of some hospital equipment, which they claim hinders their service delivery.

Figure 13. Eye Health Attendance Register, General Hospital, Lafia.



Similarly, both healthcare personnel and persons with a disability interviewed in Doma complained of inadequate manpower, particularly medical doctors. This inadequate manpower is believed to be a major cause of long queues for consultations.

At the end line the research team noted that at both pilot sites, the SiB program successfully selected and trained health care workers and CHEWs on various health services for disabled persons including child eye health services. The SiB program also provided hospital equipment for both sampled health facilities.

Training activities extended to schools as teachers were also equipped with instruments for detecting eye disability and routinely referred students to pilot health facilities in Nasarawa. An Ophthalmologist was assigned to each of these facilities and complicated cases needing surgeries were linked to tertiary facilities for surgeries.

4.3. Stakeholder Awareness of Access and Inclusive Health Services

The Director for Public health in Lafiya, Nasarawa displayed an outstanding knowledge of the SiB program implementation as he effortlessly outlined key achievements of SiB Nigeria in providing training for health workers in Doma pilot location. Respondents acknowledge that Child eye services were incorporated in at both pilot locations due to the activities of the SiB project. Specifically, interviewed respondents from the State Ministry of education (SMoE) in Nasarawa, clearly articulated the selection process adopted by SiB Nigeria in the choice of pilot locations i.e. the selection of schools by three (3) senatorial districts of the state and additional support provided for the training of teachers.

At the schools, teachers were trained to check children with low vision to be referred to the health facility for further treatment. Community Health Extension Workers (CHEWs) were also trained to provide eye services in their communities and refer cases that are beyond their capacity to the closest health facilities.

Figure 14. Interview with the Health Coordinator, Mrs. Beatrice Bishi, Ministry of Education, Lafia, Nasarawa.

Respondents also confirmed that teachers were equipped with charts, refraction and love vision instrument to detect children with issues. The SiB program supported school referral of students from schools to health facilities through the provision of referral registers and training of teachers. Additional support is still required by the health centres in the effective documentation and use of referral data in conducting follow-up services to PWD beneficiaries in both pilot locations.

The presence of a visiting Ophthalmologist and Ophthalmic nurse at the health facility increased access to child eye health services as PWD could access specialized public health services more readily. There were low vision devices and charts available at the facility which helped in the improvement and distribution of telescopes and glasses among programme beneficiaries.

4.4. Barriers to PWD Access and Inclusive Health Services

Prior to the commencement of the SiB programme, the lack of appropriate services for people with disabilities was a significant barrier to health care services. The lack of specialized services and adequately trained personnel was identified as the most significant barrier to using health facilities after cost considerations by PWD. However, feedback from respondents during the end line research survey highlighted continued stigma and lack of acceptance of PWD within the community and the propagation of certain cultural and religious beliefs, which encourage the acceptance of different forms of disability; which in turn hinders PWD from seeking prompt medical attention from designated public healthcare centers.

Figure 15. Waiting Area, General Hospital, Doma, Nasarawa State

Programme beneficiaries also noted that the attitude of HFWs with no prior training was not as discriminatory as in recent times. This was attributed to on the job coaching of colleagues from CHEWs.

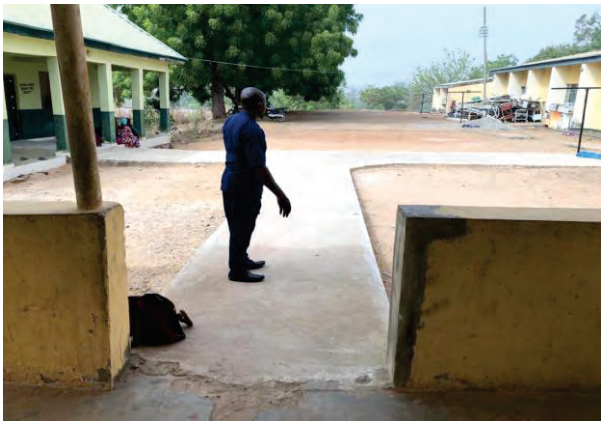
For example, non-domiciled Optometrists posed a challenge to the ready access of PWDs to health services at both pilot sites i.e. as the Optometrists were domiciled in different facilities and had to consult once a week at respective pilot sites. This contributed to significant delays in service provision, especially for children and PWDs.

This also affected the ability of the pilot facility to maintain reliable patient consultation records for PWD accessing public health services supported by the SiB program. For example, at some point, the beneficiary list was not updated because the Optometrist could no longer travel for weekly consultations due to incurred personal expenses.

4.5. Support for PWD Access and Inclusive Health Services

Concerns were also raised regarding the barriers resulting from the structural design of the health facility buildings and the difficulty this poses for persons with a disability to physically gain access. A review of respondent feedback during the end line research showed that financial limitations increased the burden of PWD as cultural beliefs continue to attribute witchcraft to disability. The lack of communication remains a challenge among HFWs although the SiB program provided some specialized disability specific trainings.

Figure 16. Constructed Ramps, General Hospital Doma, Nasarawa.



A glaring limiting factor remains the lack of government policies for inclusive health care services for disabled persons; even as movement around the facilities improved for PWDs, rural locations still experienced limited health care access. Interviewed respondents also highlighted the lack of equipment to support certain disabilities i.e. only refractive vision equipment, telescopes, sample lenses and visual charts were available in both pilot health facilities.
Specifically, ophthalmologist services were not available in one of the implementing facilities leading to long waiting hours and increased complications. As the ophthalmologist was not domiciled in the Doma and had to travel from Lafia each Friday for consultation with PWDs. The research team confirmed from first-hand observation that the SiB program supported the construction of ramps to aid movement of disabled persons in Doma General Hospital around the labour and ANC wards.

Ramps and extended doors were also built around the entrance of the hospital and the convenience to aid wheelchair movement. Handrails were made available to ease movement of PWDs. Interviewed respondents also highlighted the lack of equipment to support certain disabilities i.e. some services were not available in implementing facilities leading to long waiting hours and increased complications. Concerns were also raised regarding the barriers resulting from the structural design of other health facility buildings in Nigeria and the difficulty this poses for persons with a disability to physically gain access.

4.6. Improving PWD Access and Inclusive Health Services

During the baseline survey, respondents identified the need for healthcare personnel to be re-oriented to improve their attitudes in delivering services to PWD. Furthermore, there were calls for specialized training for healthcare personnel that will enable the delivery of services to PWD.

Typically, these efforts should extend to structural improvements in the design of health facility buildings as part of measures to improve access to services. Both healthcare personnel and community respondents believed that reducing the cost of healthcare will improve access. One participant with a disability argued that "there should be free medical care for the disabled."

At the same time, healthcare personnel interviewed at the General Hospital Doma admitted to a lack of some hospital equipment, which they claim hinders their service delivery. Similarly, both healthcare personnel and PWD interviewed in Doma complained of inadequate manpower, particularly medical doctors. This inadequate manpower is believed to be a major cause of long queues for consultations.

Figure 17. Constructed Toilet Handrails, General Hospital Doma, Nasarawa.

The intervention of the SiB project is a good strategy that involves health facilities linked with schools for early detection in children. A sustainable plan of an exit of the SiB project by the government would have encouraged continuity. Some of the health facilities assigned for the surgery were far away and, in some cases, clients had to wait several weeks to be attended to because of the demand from other referral sites.

Access to clients was easy based on needs. The cost and type of services offered were relative to the complaints of the patients at the time of the visit. The number of health workers available to patients at the facility is still a work in progress that needs attention.

One of the approaches was community engagement through outreach to notify people of the presence of an optic unit within the facility. A lot of eye health campaign was done within the community to increase awareness. So many people were trained including Health Workers, CHEWS and teachers who could at their level detect some eye problems and refer immediately.

Section 5. Conclusion and Recommendations

The research team examined documented research findings in order to draw conclusions for each research question. This provided a basis for deducing the Most Significant Change (MSC) per research question to proffer actionable recommendations that meet the objectives of the perception study.

5.1. RQ1: What are the perceptions of persons with disabilities regarding the inclusiveness of public health services?

Persons with disabilities in rural communities have significant barriers to accessing health care compared to persons without disabilities. The study confirmed that the SiB project reached persons with disabilities in rural areas with outreaches and linkage to supportive health facilities for health care services. Finances for transport from hard to reach terrain and distances to be covered were especially prominent as barriers to access to the health facility for disabled persons. The quantitative study also showed that barriers to health care access among children 0-14years. Lack of awareness and knowledge were shown to increase barriers to health care attributed to a lack of education and poverty. Socio-cultural status limited the acceptance of health care services and the referral of persons with disabilities.

Persons with disabilities require an array of health care services and need support to meet their specific needs. However, there is great variability in how, where, and from whom persons with disabilities receive needed services. The persons with disabilities in hard to reach areas do not only need medical attention but social inclusion also. People need to begin to have open minds regarding various forms of disability among older people, children and the need for immediate care. Extensive community centered Sensitization and Behavioral Change Campaigns (SBCC) should be prioritized in each pilot site; through the engagement of relevant community stakeholders to ensure uptake and sustainability of actionable results.

5.2. RQ2: To what extent are persons with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?

Persons with disabilities present higher unmet healthcare needs particularly children who cannot express themselves. An increased understanding of challenges among people with a disability do not incorporate conditions that will enable optimum care. Affordability of health services and transportation remain two main reasons why PWDs do not receive the required health care because they are unable to afford out of pocket expenses; and are limited by the lack of appropriate transportation services.

Figure 18. Child Care Services Building, St. Mary Hospital, Gwagwalada, FCT.

Government has a role to play in the establishment of suitable disability suited transportation options on a city-wide level. Further engagement with planning authorities in both pilot locations can serve as a first step in engaging relevant government

agencies (e.g. Federal Capital Development Agency) to address this challenge.

For example, the SiB program could potentially support these agencies to establish a disability unit in the departments of urban and regional planning and further advocate for increased budgetary funding from the National Assembly.

This can be done through the engagement of specialized local Non-Profit Organizations (NGOs) that actively work on legislative engagement and advocacy activities with the National and State Assembly.

This will ensure CBM Nigeria can leverage existing networks and coalitions of these local NGOs to amplify calls for responsive budgeting and closer supervision of designated government agencies to increase access to health services for children with disabilities and PWDs.

5.3. RQ3: What level of knowledge awareness and understanding do stakeholders in the pilot areas have about accessible and inclusiveness health services?

The awareness and understanding of health programs by stakeholders build responsibility for future programming by various NGOs towards inclusive health services. The knowledge of access to health services helps stakeholders to be accountable for strategic plans for future programming regarding health services. During the SiB project, community stakeholders showed a legitimate interest and displayed an understanding of disability inclusiveness as it relates to the provision of public health care services.

Interviewed respondents from the State Ministry of Health (SMoH) and State Ministry of Education (SMoE) were actively involved in advocating for inclusive health services regarding eye care and disability in both pilot locations. This shows the potential to engage reform champions in relevant government Ministries, Departments and Agencies (MDAs) to sustain action on disability centered policies.

Findings from the research study highlighted community centered engagement achievements of the SiB program. This included the following outcomes i.e.

- 200 members of Organization of Persons with Disability (OPDs) from cluster of communities around the pilot health facilities were trained to raise awareness, identify person with disability that require health services and refer them to the pilot health facilities.
- SiB through its partner Health Support and Development Program (HANDS) conducted advocacy to Joint National Association of Persons with Disability (JONAPwD) and community gatekeepers to discuss the inclusion program and select OPD members that received training under the SiB program.

Figure 19. Interview with Optometrist, Mr. Caleb, General Hospital, Lafia, Nasarawa

- SiB in conjunction with National Orientation Agency (NOA) and community partner HANDS created awareness on the Disability Inclusion program within cluster of communities around the health facilities.

On the other hand, community stakeholder respondents did not show as much in-depth knowledge of disability inclusive health services. While the activities of trained CHEWS are laudable and indeed promoted access of PWDs to referral services for follow-on consultations; more still needs to be done to support as well as strengthen community-based initiatives.

A dual approach of engaging government via MDAs as well as establishing foundational roots in communities would go a long way in increasing the knowledge awareness and understanding of stakeholders on issues related to accessibility/inclusiveness of health services for PWDs. This knowledge awareness pattern needs to be explored further through the conduct of a Knowledge Attitudes (KAP) and Practices (KAP) survey; which has been commissioned by CBM Nigeria.

Clearly, increasing stakeholders' (i.e. community and government) involvement is the right approach to increase uptake of PWD public health services in each intervention community. A dual approach is therefore most suitable for SiB program consideration in any planned follow-on project.

5.4. RQ4: What barriers are faced by persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?

Findings from the end line research showed that there are two main categories of PWD barriers to accessing public health services in both pilot sites. Broadly speaking, these barriers can either be physical or institutional. Physical barriers such as uneven access to buildings (hospitals, health centers), inaccessible medical equipment, poor signage, narrow doorways and internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities for persons with disability. First-hand observation by the research team confirmed that the SiB program worked to address physical barriers to PWD accessing public health services with the construction of ramps, expanding entry areas, linking health facility buildings and upgrading designated PWD toilets support furnishing.

Specifically, to address physical barriers, the program constructed several structural modifications to the pilot health facilities:

- Ramps widened the doors of the facility and provided handles to increase accessibility of wheelchair user;
- Widened the toilets facilities for easy access to wheelchair users;
- Installed toilet hangers to help wheelchair users sit in a balanced position while using the toilets;
- The SiB program also produced 13 episodes of radio magazine program in English and domesticated it into local languages including Hausa to address issues of eye health including change perception about persons with disability. The radio program was broadcasted through the Federal Radio Corporation of Nigeria (FRCN) and at the local radio stations.

The attitude of some healthcare workers towards disabled persons is very poor, which increases stigma and lack of acceptance. Leading from this, the research findings showed a lack of appropriate services for people with disabilities is a significant barrier to health care. For example, the lack of specialized services and adequately trained personnel is the most

significant barrier to using health facilities after cost considerations by PWD. To address these communication barriers the SiB program put signage to direct persons with disability about where to obtain specific types of services at the health facilities and engaged in the use of sign language interpreters to address communication barriers.

People with disabilities always require skilled health care workers, which in most cases are inadequate based on training and skills to use the needed equipment. For example, non-domiciled Optometrists posed a challenge to the ready access of PWDs to health services at both pilot sites i.e. as the optometrists were domiciled in different facilities and had to consult once a week at respective pilot sites. This contributed to significant delays in service provision, especially for children and PWDs.

Figure 20. Beneficiary Interview, St. Mary Hospital, Gwagwalada, FCT.

This also affected the ability of the pilot facility to maintain regular patient consultation records, for PWD accessing public health services supported by the SiB program. For example, at some point, the beneficiary list was not updated because the optometrists could no longer travel for weekly consultations due to incurred personal expenses.

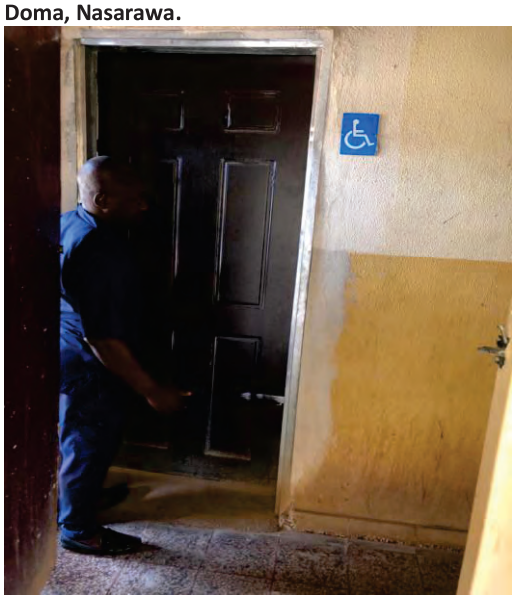
The SiB program should work closely with the respective state as well as federal government agencies and ministries to facilitate the posting of qualified optometrists to pilot health facilities.

The program may also explore collaborating with the National Youth Service Corps (NYSC) to prioritize the posting of young medical professionals to selected health facilities. Such a partnership would ideally extend to providing support for continuous training for Health Facility Workers (HFWs) and ophthalmologists through the appropriate professional bodies in Nigeria. If Ophthalmologists are not domiciled at the health facility, incurred transportation expenses will continue to frustrate attempts by the program to address barriers faced by PWD in accessing health services.

5.5. RQ5: What factors support the access and inclusion of persons with disability including children with disability in accessing health services in the two pilot secondary health facilities?

The support needed by disabled persons is the provision of free services which increases the response to seek proper health care from the facility. The support to include teachers who have improved awareness in schools is a good initiative that should be extended to various sectors regarding childcare. When it comes to access to health services, the societal changes have undergone lower levels of reported quality of life and perception of poorer health outcomes for persons with disability.

Figure 21. Designated PWD Toilet, General Hospital Doma, Nasarawa.



During interaction with PwDs, a major challenge identified contributing to inability to access health care services was lack resources including transport fare to the health facilities even when referred. This is understandable because most of the persons with disability are unemployed and have no source of income except begging.

The multiple reports of abuse towards people with disabilities in public health services include the refusal of services from certain health providers. These experiences have a negative influence on health-seeking behaviour and push persons with a disability away from services that are desperately needed. In addition, they contribute to the perception that the health system is selective, exclusive and does not care for people with disabilities.

On the other hand, the SIB programme successfully trained a total of 100 health care workers (50 in each pilot location). Beyond this, follow on monitoring should be strengthened to ensure that acceptable practices are being adhered to by trained HFWs. People with disabilities may require additional support within the public health service to communicate with healthcare providers. People with disabilities may require additional support within the public health service to communicate with healthcare providers.

It would therefore be beneficial if the SiB program worked alongside relevant government agencies and management of pilot health facilities to set up disability desk at each center to address any case of reported abuse; and provide appropriate refresher training programs for Health Facility Workers (HFWs). This would complement ongoing public relation campaigns supported by the program on national radio stations.

5.6. RQ6: What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services in the two pilot secondary health facilities?

With the planned dissemination of respective end line research studies (i.e. perception study and KAP study) by CBM Nigeria, another opportunity to actively engage stakeholders presents a unique stage to communicate an urgent call to action by stakeholders. Securing government commitment is crucial and should be pursued immediately by engaging identified contact persons in each government ministry or agency. Building on this the dissemination of these research findings of this research study to appropriate stakeholders (community leaders, beneficiaries and HFWs) should ideally encourage conversation on recommended actions to sustain positive outcomes of the SiB program achieved in both pilot locations.

The setup of strategic plans for disabled people will go a long way in the inclusion of health care services. These strategic plans should include some skill acquisition, which limits the intuition of the disabled person feeling like a burden to their caregivers. Government support to a disabled person to know their rights will improve inclusiveness and access to health services. What is lacking is a robust exit strategy to sustain positive outcomes of the SiB program, which is tied to political will.

In articulating strategies to improve inclusiveness and access of PWD to public health services, respondents identified political will as a major requirement. As not enough has been done to leverage on the passage of the National Discrimination Against Persons with Disabilities (Prohibition) Act 2018 by the National Assembly in Nigeria. This is especially evident with the limited engagement of the Nasarawa State Disability Right Commission in promoting inclusive service delivery for PWDs.

Any follow up design consideration for the SiB program should consider the engagement of government through the use of advocacy and strategic communications tools to stimulate engagement of legislative committees at the federal and state assemblies to hold implementing agencies of government accountable to institutionalize provisions of the National Discrimination Against Persons with Disabilities (Prohibition) Act 2018. Where necessary, the SiB program could further support the domestication of the National Discrimination Against Persons with Disabilities (Prohibition) Act 2018 in pilot states.

As a key recommendation, the research study recommends that the SiB program take the following actions i.e.

- Establish a community-based rehabilitation programs and entrepreneurial initiatives for PwD to help boost their economic base.
- Initiate a conditional cash transfer scheme for persons with disability to enable them access health services in both pilot locations and other health facilities.
- With support from trained CHEWs and OPDs, the program should intensify outreach /mobile clinic activities targeted at communities including PwDs.

Based on the findings of the research study, it is recommended that CBM trough the SiB programme should conduct a Randomized Control Trial (RCT) pilot activity to examine the outcome of the Knowledge, Attitudes and Practices (KAP) and Perception studies. By comparing SiB program outcomes in each cluster region (i.e. control health facilities and other intervention health facilities) over a six (6) month period; additional contextual information can be collated and analyzed to highlight specific design options for follow-on activities.

Annexes

Annex 1.Terms of Reference – Perception Research Study

Introduction
Seeing is Believing (SiB) was a three-year (2017-2020) Comprehensive Child Eye Health in Nigeria
(CCEHiN) programme, that seeks to make comprehensive child eye health services available and
accessible through promotion, prevention, medical care and rehabilitation/inclusive education targeted at vulnerable children. The SiB programme was implemented in eleven (11) States of the
Federation divided into four clusters as follows:

- Cluster 1: Oyo, Ogun and Osun States;
- Cluster 2: Federal Capital Territory, Nasarawa and Plateau States;
- Cluster 3: Kano, Katsina and Jigawa States; and
- Cluster 4: Cross River and Akwa Ibom States.

The goal of the programme was to contribute to the reduction of avoidable blindness and visual impairment through the provision of comprehensive child eye health services to over 1.5 million children aged 0-14 in selected states of Nigeria. Quality of care is critical for client's satisfaction and sustained use of health care services. Disability inclusive eye health programming provides holistic services that takes cognizance of all members of a community whether they have a disability or do not have a disability. It caters for all ranges and different types of disability. Working in two pilot secondary health facilities, the SiB Project ensured barriers were identified and removed if possible, and that disability-specific processes were adequately put in place.

Purpose of Assignment
This perception research study will provide an end line survey for work on disability at the pilot facilities under the Seeing is Believing (SiB) program. The purpose of the study is to examine the perception of persons with disability regarding the inclusiveness of health services in their local area and compare with a baseline study, by identifying Most Significant Changes (MSC) attributed to the program. The findings of the research study will guide the planning, programming and policy formulation as well work to address barriers militating against access to services and inclusiveness of persons with disability.

This research study will also evaluate how well the SiB program addressed the identified barriers that affect access to services and inclusiveness of persons with disability in the pilot sites.

Objectives of the research study:
The objective of this research study will be to assess the perception persons with disabilities and other
relevant stakeholders about the inclusiveness of basic services (focusing particularly on health, also
covering education and other services) for people with disabilities including children with disabilities
and their peers without disabilities in comparison to baseline findings.

The specific objectives of the study are to:

- To understand the perceptions and experiences of persons with disability and other community
- members regarding the inclusiveness of health and other services, including the barriers to accessing
- services.
- To determine the level of satisfaction of persons with disability regarding inclusiveness of health and other services.
- To understand the perceptions and attitudes of health workers in pilot facilities regarding the inclusion of persons with disability in the pilot health facilities.
- To recommend interventions and strategies that should be put in place to make pilot facilities more inclusive of persons with disability, and to improve access of people with disabilities to health services.
- Understand the broader context of inclusion of persons with disabilities in the society, at the pilot areas (attitudes towards persons with disabilities and root causes of any discrimination encountered).
- To discern how much point 1-5 has changed (if any changes are observed) after programme implementation and noting any possible attribution to programme implementation.

Scope of Work

- The study will focus on two project sites - Gwagwalda (FCT) and Doma (Nasarawa state) - where
- inclusive eye health services were piloted in secondary health facilities.

The target groups for the study will include the following stakeholders:

- community members.
- health facility staff (CHEWs, doctors and Nurses) and non-facility care providers (e.g. TBAs);
- community gatekeepers and opinion leaders.
- parents and care givers of children (0-14 years) with disabilities.
- people with disabilities.
- their peers without disabilities in the same age group.

The sample size will endeavour to be representative of the diversity of the population in the catchment
areas; the methodology to achieve a representative sample should be clearly outlined in the research
protocol. The study is expected to respond to but not limited to the following research questions:

- What are the perceptions of persons with disabilities regarding the inclusiveness of and access to public health services in the area?
- What are the perceptions of persons with disabilities regarding the inclusiveness of and access to the two pilot secondary health facilities?
- To what extent are persons with disabilities, including children with disability, accessing health services at the two pilot secondary health facilities?

- What level of knowledge, awareness and understanding do stakeholders in the pilot areas have about accessible and inclusive health services?
- What barriers are faced by persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?
- What factors support the access and inclusion of persons with disability, including children with disability, in accessing health services, in the two pilot secondary health facilities?
- What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services, in particular in the two pilot secondary health facilities?

Methodology:
The consultant(s) is/are expected to present, in detail, their approach, methodology and tools, with an
action plan and timeframe that addresses the expected outputs, with reference to the overall and
specific objectives as well as a budget. A mixed methods study is envisioned, comprising of a review of
hospital records, quantitative survey and qualitative research.

The research protocol will use representative sampling as appropriate, considering both quantitative
(survey) and appropriate qualitative approaches. Two sets of tools will be developed; a questionnaire
to administer the quantitative component of the survey and qualitative tools. These tools may be as
used in the baseline for easy comparative evaluation where appropriate.

Qualitative research is expected to include:

- People with disabilities within the community, including parents (of both genders), children and
- young people:
- Key opinion leaders in the communities, community gatekeepers, group leaders, religious leaders.
- Health facility manager/lead.

Analysis:

- The findings of the survey will, where possible, be disaggregated by type of disability, age, sex, rural/urban, and other standard socioeconomic characteristics.
- Ways of working:
- Research tools will be developed in collaboration with the research committee from the Seeing is Believing team (Programme Manager, Programme Director, Knowledge Management and M&E Manager) The baseline tool was developed by studying existing tools and questionnaires developed for International Agencies for the Prevention of Blindness (IAPB), other national household surveys, Washington group questionnaires and WHO developed tools.
- The consultant will conduct the research in an ethical manner, that is sensitive with regards to different cultures, local customs, religious beliefs and practices, personal interaction and gender roles, disability, age and ethnicity.

- Requirements for participant informed consent and confidentiality will be maintained, including children participating in the research. Ethical clearance will be sought as required.

Work Schedule:
The consultancy will primarily be responsible to plan, design, manage, conduct and report on the
research.

The consultant will be responsible for the following tasks:

- Review existing literature.
- Develop research protocol, including methodology, tools and analysis plan.
- Adjust and finalize the research protocol.
- Recruit and conduct training of enumerators.
- Pre-test research tools (quantitative and review of hospital records)
- Data collection and entry
- Data cleaning, processing and analysis of data
- Drafting of the Preliminary Research Report
- Present the draft research report to research committee
- Integrate the feedback and comments received from research committee and finalise research
- report

Final deliverables:

- Power Point Presentation including speaker notes
- Research Report with annexes
- Data Sets

Consultant's Work Plan and Official Travel Involved:

- The consultant(s) is required to make his/her own return travel arrangements from Place of recruitment-Duty Station-Place of recruitment on the most direct route.
- Travel costs will be reimbursed to the consultant upon submission of invoice and travel documents.
- All related (internal/external) official travel of the consultancy will be organized by the consultant and costs reimbursed accordingly.
- The consultant(s) is also required to organize his travel schedule. Research committee, wider SiB team and partners will support him/her in arrangements.

Consultant's Workplace:

- The consultant will be based either at home, in the field or at the CBM country office in Abuja/Jos
- Field office.

Qualifications or Specialized Knowledge/Experience Required:
Qualifications

- Six years of professional work experience relevant to research and/or disability inclusion.
- Experience of conducting KAP studies is desirable.
- Advanced degree in a relevant social science.
- A consultant with multi-disciplinary background such as disability, statistics, research, and analysis, social sciences and development is preferable.

Experience

- The suitable consultant(s) should have experience in designing, conducting, and managing studies related to disability, children's issues and/or social development.
- Proven experience in conducting qualitative and quantitative research is required, including household surveys
- Experience of consulting with people with disabilities, and experience in conducting research with children are desirable.
- Experience in producing high-quality reports and analysis.
- Work experience in international organizations is an asset.

Languages

The consultant(s) must have good interpersonal communication and negotiation skills.
Excellent
English report writing and editing skills and additional knowledge of Hausa language is an asset.

Competencies

- Good facilitation and qualitative research skills.
- Understanding of human rights-based approaches to programming and results-based management principles is required, in particular related to child rights and disability rights.
- Ability to bring together diverse stakeholders.
- Effective oral and written communication skills.
- Ability to work in an international and multicultural environment.
- Sensitivity towards different cultures, local customs, religious beliefs and practices, personal interaction and gender roles, disability age and ethnicity.
- Strong quantitative analysis skills.
- Good attention to detail.

Method of Application

To Apply, Send a detailed CV, cover letter, a detailed proposal and samples of previous evaluations
done to: **edward.ighodalo@cbm.org** **with** **Juliana.Nathaniel@cbm.org** in copy.
Mail Subject: Perception Study

Annex 2. Research Study Work Plan

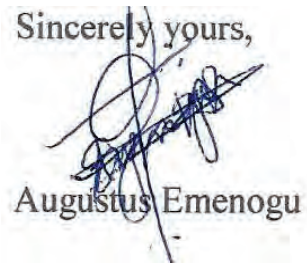
SN	Description of Activities	WK1						W2						W3						W4						W5					
Research Tasks		M	T	W	T	F	Sat	M	T	W	T	F	Sat	M	T	W	T	F	Sat	M	T	W	T	F	Sat	M	T	W	T	F	Sat
1	Review Terms of Reference	x																													
2	Conduct Desk Study and Literature Review (Deep Dive)	x	x	X	x	x																									
3	Develop Research Matrix and Analysis Plan						x	x																							
4	Finalize design of Data Collection Instruments							x	x	x																					
5	Development of Inception Report										x	x	x	x	x	x															
6	Respondent Referral Surveys – Field data collection													x	x	x	x	x	x	x											
7	Data Analysis and Quality Assurance																	x	x	x	x										
8	Development and Submission of Draft Evaluation Report																			x	x	x	x								
9	Review and submission of final Perception Research Study report																						x	x	x	x					
10	Dissemination Meeting																										x				

Annex 3.Ethical Principles Declaration

The consultant is required to respect the following Ethical Principles:

- **Comprehensive and systematic inquiry**: Consultant should make the most of the existing information and full range of stakeholders available at the time of the review. Consultant should conduct systematic, databased inquiries. He or she should communicate his or her methods and approaches accurately and in enough detail to allow others to understand, interpret and critique his or her work. He or she should make clear the limitations of the review and its results.
- **Competence**: Consultant should possess the abilities, skills, and experience appropriate to undertake the tasks proposed and should practice within the limits of his or her professional training and competence.
- **Honesty and integrity**: Consultant should be transparent with the contractor/constituent about: any conflict of interest, any change made in the negotiated project plan and the reasons why those changes were made, any risk that certain procedures or activities produce misleading review information.
- **Respect for people**: Consultant respect the security, dignity and self-worth of the respondents, program participants. Consultant has the responsibility to be sensitive to and respect differences amongst participants in culture, religion, gender, disability, age and ethnicity.

I hereby declare that I will always respect these ethical principles. I undertake to inform the CBM International of any change in these circumstances, including if an issue arises during the End line Perception Study Evaluation.



Principal Evaluator
Email: augustus.316@gmail.com
Mobile: +2348065295046

Annex 4.Conflict of Interest (CoI) Declaration

Have you or your partner any financial or other interest in the subject matter of the meeting or work in which you will be involved, which may be considered as constituting a real, potential or apparent conflict of interest?

Yes: ☐ No: x If yes, please give details in the box below.

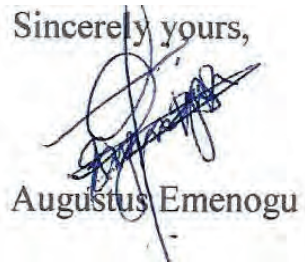
Is there anything else that could affect your objectivity or independence in the performance of your duties on the conduct of the Perception Study Evaluation for CBM International, or the perception by others of your objectivity and independence?

Yes: ☐ No: x If yes, please give details in the box below.

Is there anything else that you wish to disclose and that you believe may compromise your capacity to exercise objectivity or impair your ability to conduct the Perception Study Evaluation for CBM International or other Partnership mechanism? If so, please indicate this below:

Not Applicable

I hereby declare that the disclosed information is correct and that no other situation of real, potential or apparent conflict of interest is known to me. I undertake to inform the CBM International of any change in these circumstances, including if an issue arises during the conduct of the Perception Study Evaluation or work itself.



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Annex 5.List of Interviews (Interviewed and Absent)

Table 5. List of Interviews (Interviewed Respondents)

S/N	Respondent Category	Questionnaire Type	Respondents (FCT)		Respondent (Doma)		No of Questionnaire administered
			M	F	M	F	
1.	Beneficiary	Program Beneficiary Questionnaire (PBQ)	6	3	6	4	19
2.	Stakeholder	Community Stakeholder Questionnaire (SQ)	3	1	3	3	10
3.	Program Staff	Program Staff Questionnaire (PSQ)	0	0	1	0	1
4.	Health Facility Staff	Health Facility Questionnaire (HFQ)	4	1	3	2	10
Total			13	5	13	9	40

Table 6. List of Interviews (Absent Respondents)

S/N	Respondent Category	Questionnaire Type	Absent Respondents (FCT)		Absent Respondents (Doma)		No of Non-Administered Questionnaires
			M	F	M	F	
1.	Beneficiary	Program Beneficiary Questionnaire (PBQ)	4	3	8	6	21
2.	Stakeholder	Community Stakeholder Questionnaire (SQ)	2	1	6	3	12
3.	Program Staff	Program Staff Questionnaire (PSQ)	0	0	0	0	0
4.	Health Facility Staff	Health Facility Questionnaire (HFQ)	0	0	2	2	4
Total			6	4	16	11	37

Annex 6.QR3 Research Matrix

Research Questions	Sub-Research Questions	Probing Questions	Research Questionnaires
Theme 1: PWD Perception of Access and Inclusive Health Services			**Respondent Category**
What are the perceptions of persons with disabilities regarding inclusiveness and access to public health services in the area?	To what extent did the SiB program improve perception of PWD on access and inclusiveness of health services?	*How was the health facility selected?*	Program Beneficiary Questionnaire (PBQ)
		What benefits did you receive from the program?	Program Beneficiary Questionnaire (PBQ)
		Did the benefits meet your needs to increase coverage of C.E.H.S?	Program Beneficiary Questionnaire (PBQ)
		What challenge did you encounter in accessing comprehensive C.E.H.S at the facility?	Program Beneficiary Questionnaire (PBQ)
		What was done to improve the skills of health care workers within the facility for C.E.H.S?	Program Beneficiary Questionnaire (PBQ)
	How can health care facilities improve PWD access to public health services?	*Could you explain to me what your understanding of equal access to health care is?*	Program Beneficiary Questionnaire (PBQ)
		What factors according to you make people more vulnerable to poor health care access?	Program Beneficiary Questionnaire (PBQ)
		Which patients struggle to access the services at the facility?	Program Beneficiary Questionnaire (PBQ)
		Do you believe the health facility has adequate manpower to provide C.E.H.S?	Program Beneficiary Questionnaire (PBQ)
Theme 2: PWD Health Services Access			
To what extent are persons with disabilities, including children with disability, accessing health services at the two	Was there an increase in Health workers delivering C.E.H.S to PWDs at the health facility?	*What new C.E.H.S were linked to PWD surgeries in the health facility?*	Health Facility Questionnaire (HFQ)
		Were disability surgery outreaches conducted and linked to the health facility?	Health Facility Questionnaire (HFQ)
		How often was this organized?	Health Facility Questionnaire (HFQ)
		Do you have cataract surgery personnel at the facility?	Health Facility Questionnaire (HFQ)

Research Questions	Sub-Research Questions	Probing Questions	Research Questionnaires
pilot secondary health facilities?		*Did facility staff receive additional cataract surgery training?*	Health Facility Questionnaire (HFQ)
	To what extent did the program increase institutional coverage of PWD inclusive services?	*How were health institutions selected?*	Health Facility Questionnaire (HFQ)
		In the past, did these institutions offer specialized refraction and vision services?	Health Facility Questionnaire (HFQ)
		What is your perception/opinion on your inclusiveness of specialized refraction and low vison services in the community and health facility?	Health Facility Questionnaire (HFQ)
		What factors support the access and inclusion of persons with disability (including children with disability), in accessing health services? Probe for these factors: age, sex, education, employment, attitudes, rural/urban location, etc.	Health Facility Questionnaire (HFQ)
Theme 3: Stakeholder Awareness of Access and Inclusive Health Services			
What level of knowledge awareness and understanding do stakeholders in the pilot areas have about accessible and inclusive health services?	How can health care facilities improve PWD access to public health services?	*Could you explain to me what your understanding of equal access to health care is?*	Community Stakeholder Questionnaire (CSQ)
		What factors according to you make people more vulnerable to poor health care access?	Community Stakeholder Questionnaire (CSQ)
		Which patients struggle to access the services at the facility?	Community Stakeholder Questionnaire (CSQ)
		Do you believe the health facility has adequate manpower to provide C.E.H.S?	Community Stakeholder Questionnaire (CSQ)
		What additional opportunities are present for further engagement in the community?	Community Stakeholder Questionnaire (CSQ)
		How can health facilities increase participation of government and the community in the provision of inclusiveness services?	Community Stakeholder Questionnaire (CSQ)
	How have health institution services promoted inclusiveness for persons with disabilities?	*What services and provisions have been embedded for persons with disabilities in the health institution and/or in your community? Probe for these services.*	Community Stakeholder Questionnaire (CSQ)
		What community support services were established for persons with disabilities? Probe for these services.	Community Stakeholder Questionnaire (CSQ)

Research Questions	Sub-Research Questions	Probing Questions	Research Questionnaires
		What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services (in the health facility located in this community)? Probe for these interventions and strategies.	Community Stakeholder Questionnaire (CSQ)
Theme 4: Barriers to PWD Access and Inclusive Health Services			
What barriers are faced by persons with disability, including children with disability, in accessing health services in the two pilot secondary health facilities?	What challenges and opportunities exist to sustain the SiB implementation model?	*What challenges hindered program implementation?*	Community Stakeholder Questionnaire (CSQ) and Health Facility Questionnaire (HFQ)
		Was there an exit strategy in place?	Health Facility Questionnaire (HFQ)
		What barriers hindered persons with disability (including children with disability), from accessing health services? Probe for these barriers: social, cultural, beliefs, financial, health staff/facility, etc.	Health Facility Questionnaire (HFQ)
		What additional opportunities are present for further engagement in the health facilities?	Health Facility Questionnaire (HFQ)
		How can health facilities increase participation of government and the community in the provision of inclusiveness services?	Health Facility Questionnaire (HFQ)
	How responsive were health institutions to the needs of the community and PWD?	*What are the outstanding capacity needs and funding challenges of health institutions?*	Health Facility Questionnaire (HFQ)
		What might challenge the ability of health institutions to continue C.E.H.S?	Health Facility Questionnaire (HFQ)
		How can health institutions Improve C.E.H.S implementation approach?	Health Facility Questionnaire (HFQ)
Theme 5: Support for PWD Access and inclusive Health Services			
What factors support the access and inclusion of	In what way(s) did C.E.H.S consultations improve for PWD?	*What new C.E.H.S were accessed at the health facility?*	Program Beneficiary Questionnaire (PBQ)
		What was done to improve C.E.H.S consultations?	Program Beneficiary Questionnaire (PBQ)

Research Questions	Sub-Research Questions	Probing Questions	Research Questionnaires
persons with disability including children with disability in accessing health services in the two pilot sites?		*Was there an increase in the clientele request for C.E.H.S consultations?*	Program Beneficiary Questionnaire (PBQ)
	How can beneficiaries and PWD be better linked to improved C.E.H.S?	*What additional C.E.H.S could the facility provide?*	Program Beneficiary Questionnaire (PBQ)
		Were there any challenges in accessing C.E.H.S?	Program Beneficiary Questionnaire (PBQ)
		Are there any changes you would make to improve access to this facility for people with disabilities?	Program Beneficiary Questionnaire (PBQ)
Theme 6: Improving PWD Access and Inclusive Health Services			
What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services in the two pilot secondary health facilities?	How successful were pilot strategies for PWD inclusive eye health care?	*How accessible is the facility where you work for patients (physical, costs, time, type of services, equipment, number of health care workers)*	Health Facility Questionnaire (HFQ)
		What in your opinion can be done to improve access to health services if improvement is needed?	Health Facility Questionnaire (HFQ)
		What approaches were successful in the implementation of pilot strategies for inclusive eye health services? What specific evidence can you provide?	Health Facility Questionnaire (HFQ)
		How can the formulation of pilot strategies be improved?	Health Facility Questionnaire (HFQ)
		What challenges were encountered in the implementation of pilot strategies?	Health Facility Questionnaire (HFQ)
	How have health institution services promoted inclusiveness for persons with disabilities?	*Do you have any experience in providing health care to people with disabilities?*	Health Facility Questionnaire (HFQ)
		How often do you encounter people with disabilities in your work?	Health Facility Questionnaire (HFQ)
		If no experience, why do you think that is the case?	Health Facility Questionnaire (HFQ)
		What types of disabilities did you have experience in providing health care to?	Health Facility Questionnaire (HFQ)
		Were any of those individuals' children with disabilities?	Health Facility Questionnaire (HFQ)

Research Questions	Sub-Research Questions	Probing Questions	Research Questionnaires
		How does follow-up of people with disabilities take place if they miss clinic appointment?	Health Facility Questionnaire (HFQ)
	What program outcomes for PWD justified expenditure from the program design?	*Was the budgetary plan in line with the program delivery design?*	Health Facility Questionnaire (HFQ)
		Were the right resources available for the implementation of C.E.H.S in facilities?	Health Facility Questionnaire (HFQ)
		In what ways have health facilities been accountable for the available resources?	Health Facility Questionnaire (HFQ)
		4. Are there any pending counterpart funding commitments for C.E.H.S?	Health Facility Questionnaire (HFQ)

Annex 7.Risk Mitigation Strategy (RMS)

Potential Risk	Mitigation Strategy	Risk Rating
Security	In Northern Nigeria, security preparedness requires a daily assessment of violence, threats and road closings. Few roads in the region are safe for consistent travel and cell phone and internet connections are unreliable. As remain tight; the research team will take strict preventive safety measures e.g. maintaining contact and maintaining a diary of security emergency contacts. The research team will work with local security agencies for assistance when visiting conflict-prone areas as needed.	Low
Data Reliability	Misrepresentation by Field Data Collectors -Due to the use of paper based data collection instruments, field data collectors may at times, deliberately misrepresent data to promote the release of additional funds/aid packages to their communities; especially when they are domiciled in sampled locations. To address this concern, the research team (i.e. the principal evaluator and investigative evaluator will both handle field data collection personally to avoid such cases). This will also eliminate the need to conduct rigorous training to field data collectors will conduct rigorous training of field data collectors within the restricted timeframe. The research team will organize meetings with target persons to facilitate ready access to respondents during field data collection. These meetings will also offer an opportunity to receive feedback on specific challenges encountered in the field.	Medium
Use of Primary and Secondary Data	The triangulation of data will be driven by the research team using primary data provided by the SiB program (i.e. desk study) and secondary data derived from literature review (i.e. deep dive) for referenced data sources.	Low

Potential Risk	Mitigation Strategy	Risk Rating
Data Validity	The Risk Mitigation Plan (RMP) will guide field data collection and documentation. The research team will also maintain updated data quality worksheets to ensure effectively data assurance and cleaning.	Critical
Privacy Concerns	As a component of protection against security and privacy concerns, the research team will adhere to "Do No Harm" protocols during all data collection activities. This includes informed consent as well as minimizing collection of personally identifiable information (PII).	Medium
Cultural and Language Barrier	The research team member possesses local language skills suited to the sampled locations in Nasarawa and Abuja respectively. If a situation arises where the local dialects differ then the team will engage a community member as a translator. The Principal evaluator will ensure language challenges are minimized and will conform to existing culturally sensitive issues during the conduct of field data collection activities.	Low
Logistics	In addressing logistics concerns, the research team will seek the mobile phone contacts of contact persons from CBM Nigeria staff and will in turn secure contacts of beneficiaries from the designated health facilities. Each Individual In-depth Interview (IDI) will serve as referral to associated respondents that could be easily reached and also be conversant with the subject matter being researched by the research team. be developed.	Critical
Non-response	Data collection and survey instructions will be developed to guide field activities across the different sites. The research team will work to emphasize the role of gender in data collection related to specific locations and thematic groupings.	Medium

Annex 8.Health Facility Questionnaire (HFQ)

Health Facility Questionnaire (HFQ)			
Questionnaire Code: (HFQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location (Specify)			
Consent	The enumerator on behalf of the respondent confirms the consent. Consent should be recorded (Yes/No).		

Interview Prompt

[At the start of the interview, please say the following]

"It is a pleasure to meet you. My name is [Insert Name]. We are here to collect your views on the implementation of the Seeing is Believing (SIB) Program. We work as part of an independent research team engaged by CBM International, that is working to obtain information and perception of disability and inclusiveness of health services on behalf of the Project's sponsors.

The purpose of this interview is to gather information on the services offered at this location and to better understand health facility needs. The interview is estimated to last 55 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get.

We will not ask personal questions, only about the services you receive from the CBM International. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future. Are you willing to participate in the interview?

Do No Harm Principle

Evaluators will adhere to these three Protection Principles:

Evaluators will not further expose people to physical hazards, violence or other rights abuses.
Evaluators will not undermine any beneficiary's capacity for self-protection.
Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.

Instructions

The Health Facility Questionnaire (HFQ) is divided into Six (7) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on Disability and Inclusiveness of Health Services. The STTA Videographer will take photos when instructed.

Section 1: Demographic Information

Section 2: PWD Perception of Access and Inclusiveness of Public Health Services
Section 3: Barriers to PWD Access and Inclusive Health Services
Section 4: Improving PWD Access and Inclusive Health Services

Please note that children should not be photographed, nor can they provide informed consent.

Section One:	Demographic Information	
SN	Questions and Options	Responses
1	Age (*record age at last birthday*) _____	(Insert Response)
2	Gender 1 = Male 2= Female	(Insert Response)
3	Cadre of Health worker 1=Nurse, 2=CHEW, 3=CHO, 4=Doctor, 5= Pharmacist, 6= Lab Scientist, 7= Medical records officer, 8=others specify	(Insert Response)
4	Number of years of work at place of assignment	(Insert Response)
5	Health facility type 1=Primary health facility, 2= Secondary health facility, 3= tertiary health facility	(Insert Response)
6	Do you have any form of disability? 1= Yes, 2= No	(Insert Response)
Section Two:	PWD Perception of Access and Inclusiveness of Public Health Services	
SN	Questions and Options	Responses
7	*What new C.E.H.S were linked to PWD surgeries in the health facility?*	(Insert Response)
8	*Were disability surgery outreaches conducted and linked to the health facility?*	(Insert Response)
9	*How often was this organized?*	(Insert Response)
10	*Do you have cataract surgery personnel at the facility?*	(Insert Response)
11	*Did facility staff receive additional cataract surgery training?*	(Insert Response)
12	*How were health institutions selected?*	(Insert Response)
13	*In the past, did these institutions offer specialized refraction and vision services?*	(Insert Response)
14	*What is your perception/opinion on your inclusiveness of*	(Insert Response)

	specialized refraction and low vison services in the community and health facility?	
15	*What factors support the access and inclusion of persons with disability (including children with disability), in accessing health services?* *Probe for these factors: age, sex, education, employment, attitudes, rural/urban location, etc.*	(Insert Response)
Section Three:	Barriers to PWD Access and Inclusive Health Services	
SN	Questions and Options	Responses
16	*What challenges hindered program implementation?*	(Insert Response)
17	*Was there an exit strategy in place?*	(Insert Response)
18	*What barriers hindered persons with disability (including children with disability), from accessing health services?* *Probe for these barriers: social, cultural, beliefs, financial, health staff/facility, etc.*	(Insert Response)
19	*What additional opportunities are present for further engagement in the health facilities?*	(Insert Response)
20	*How can health facilities increase participation of government and the community in the provision of inclusiveness services?*	(Insert Response)
21	*What are the outstanding capacity needs and funding challenges of health institutions?*	(Insert Response)
22	*What might challenge the ability of health institutions to continue C.E.H.S?*	(Insert Response)
23	*How can health institutions Improve C.E.H.S implementation approach?*	(Insert Response)
Section Four:	Improving PWD Access and Inclusive Health Services	
SN	Questions and Options	Responses
24	*How accessible is the facility where you work for patients (physical, costs, time, type of services, equipment, number of health care workers)*	(Insert Response)

25	*What in your opinion can be done to improve access to health services if improvement is needed?*	(Insert Response)
26	*What approaches were successful in the implementation of pilot strategies for inclusive eye health services? What specific evidence can you provide?*	(Insert Response)
27	*How can the formulation of pilot strategies be improved?*	(Insert Response)
28	*What challenges were encountered in the implementation of pilot strategies?*	(Insert Response)
29	*Do you have any experience in providing health care to people with disabilities?*	(Insert Response)
30	*How often do you encounter people with disabilities in your work?*	(Insert Response)
31	*If no experience, why do you think that is the case?*	(Insert Response)
32	*What types of disabilities did you have experience in providing health care to?*	(Insert Response)
33	*Were any of those individuals' children with disabilities?*	(Insert Response)
34	*How does follow-up of people with disabilities take place if they miss clinic appointment?*	(Insert Response)
35	*Was the budgetary plan in line with the program delivery design?*	(Insert Response)
37	*Were the right resources available for the implementation of C.E.H.S in facilities?*	(Insert Response)
38	*In what ways have health facilities been accountable for the available resources?*	(Insert Response)
39	*Are there any pending counterpart funding commitments for C.E.H.S?*	(Insert Response)

Annex 9.Program Beneficiary Questionnaire (PBQ)

Program Beneficiary Questionnaire (PBQ)			
Questionnaire Code: (PBQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location (Specify)			
Consent	The enumerator on behalf of the respondent confirms the consent. Consent should be recorded (Yes/No).		

Interview Prompt
[At the start of the interview, please say the following] "It is a pleasure to meet you. My name is [Insert Name]. We are here to collect your views on the implementation of the Seeing is Believing (SIB) Program. We work as part of an independent research team engaged by CBM International, that is working to obtain information and perception of disability and inclusiveness of health services on behalf of the Project's sponsors. The purpose of this interview is to gather information on the services offered at this location and to better understand health facility needs. The interview is estimated to last 55 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get. We will not ask personal questions, only about the services you receive from the CBM International. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future. Are you willing to participate in the interview?

Do No Harm Principle
Evaluators will adhere to these three Protection Principles: Evaluators will not further expose people to physical hazards, violence or other rights abuses. Evaluators will not undermine any beneficiary's capacity for self-protection. Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.

Instructions		
The Program Beneficiary Questionnaire (PBQ) is divided into three (3) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on Disability and Inclusiveness of Health Services. The STTA Videographer will take photos when instructed. Section 1: Demographic Information Section 2: PWD Perception of Access and Inclusive Health Services Section 3: Community Responsiveness Please note that children should not be photographed, nor can they provide informed consent.		
Section One:	Demographic Information	
SN	Questions and Options	Responses
1	Age (*record age at last birthday*) _____	Insert Response
2	Gender 1 = Male 2= Female	Insert Response
3	What is the Nature of Benefit received from the SiB program?	Tick as Appropriate Training Received Consultation Referred/Conducted Cataract Surgery Accessed Specialised Retraction or Low Vision Services Other_____ (Please specify)
4	How long have you benefitted from SiB program?	Tick as Appropriate Less than 6 Months More than 9 Months One Year Over One Year Other_____ (Please specify)
5	Point of Service Type 1=Primary health facility, 2= Secondary health facility, 3= tertiary health facility	Insert Response
6	Do you have any form of disability? 1= Yes, 2= No	Insert Response
Section Two:	PWD Perception of Access and Inclusive Health Services	
SN	Questions and Options	Responses
7	*How was the health facility selected?*	Insert Response

8	*What benefits did you receive from the program?*	Insert Response
9	*Did the benefits meet your needs to increase coverage of C.E.H.S?*	Insert Response
10	*What challenge did you encounter in accessing comprehensive C.E.H.S at the facility?*	Insert Response
11	*What was done to improve the skills of health care workers within the facility for C.E.H.S?*	Insert Response
12	*Could you explain to me what your understanding of equal access to health care is?*	Insert Response
13	*What factors according to you make people more vulnerable to poor health care access?*	Insert Response
14	*Which patients struggle to access the services at the facility?*	Insert Response
15	*Do you believe the health facility has adequate manpower to provide C.E.H.S?*	Insert Response
Section Three:	Support for PWD Access ad Inclusive Health Services	
SN	Questions and Options	Responses
16	*What new C.E.H.S were accessed at the health facility?*	Insert Response
17	*What was done to improve C.E.H.S consultations?*	Insert Response
18	*Was there an increase in the clientele request for C.E.H.S consultations?*	Insert Response
19	*What additional C.E.H.S could the facility provide?*	Insert Response
20	*Were there any challenges in accessing C.E.H.S?*	Insert Response
21	*Are there any changes you would make to improve access to this facility for people with disabilities?*	Insert Response

Annex 11. Community Stakeholder Questionnaire (CSQ)

Community Stakeholder Questionnaire (SQ)			
Questionnaire Code: (CSQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location (Specify)			
Consent	The enumerator on behalf of the respondent confirms the consent. Consent should be recorded (Yes/No).		

Interview Prompt

[At the start of the interview, please say the following]

"It is a pleasure to meet you. My name is [Insert Name]. We are here to collect your views on the implementation of the Seeing is Believing (SIB) Program. We work as part of an independent research team engaged by CBM International, that is working to obtain information and perception of disability and inclusiveness of health services on behalf of the Project's sponsors.

The purpose of this interview is to gather information on the services offered at this location and to better understand health facility needs. The interview is estimated to last 45 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get.

We will not ask personal questions, only about the services you receive from the CBM International. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future. Are you willing to participate in the interview?

Do No Harm Principle

Evaluators will adhere to these three Protection Principles:

Evaluators will not further expose people to physical hazards, violence or other rights abuses.
Evaluators will not undermine any beneficiary's capacity for self-protection.
Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.

Instructions
The Stakeholder Questionnaire (SQ) is divided into five (5) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on Disability and Inclusiveness of Health Services. The STTA Videographer will take photos and videos when instructed. Section 1: Demographic Information Section 2: Stakeholder Awareness of Access and Inclusive Health Services Please note that children should not be photographed, nor can they provide informed consent.

Section One:	Respondent Information	
SN	Questions and Options	Responses
1	Age (*record age at last birthday*) _____	Insert Response
2	Gender 1 = Male 2= Female	Insert Response
3	Stakeholder Type 1=Religious Leader, 2=Community Leader, 3=Youth Leader, 4=Federal Government Official, 5= Local Government Official, 6= State Government Official, 7= Women Leader, 8=others specify	Insert Response
4	Number of years of work at place of assignment?	Insert Response
5	Health Facility Engagement 1=Primary health facility, 2= Secondary health facility, 3= tertiary health facility	Insert Response
6	Do you have any form of disability? 1= Yes, 2= No	Insert Response
Section Two:	**Stakeholder Awareness of Access and Inclusive Health Services**	
SN	Questions and Options	Responses
7	*Could you explain to me what your understanding of equal access to health care is?*	Insert Response
8	*What factors according to you make people more vulnerable to poor health care access?*	Insert Response
9	*Which patients struggle to access the services at the facility?*	Insert Response
10	*Do you believe the health facility has adequate manpower to provide C.E.H.S?*	Insert Response

11	*What additional opportunities are present for further engagement in the community?*	Insert Response
12	*How can health facilities increase participation of government and the community in the provision of inclusiveness services?*	Insert Response
13	*What services and provisions have been embedded for persons with disabilities in the health institution and/or in your community?* *Probe for these services.*	Insert Response
14	*What community support services were established for persons with disabilities? Probe for these services.*	Insert Response
15	*What interventions and strategies should be put in place to improve inclusiveness and access of persons with disabilities to health services (in the health facility located in this community)?* *Probe for these interventions and strategies.*	Insert Response
16	*What challenges hindered program implementation?*	Insert Response

Annex 12. Respondent Referral Matrix (RRM)

Respondent Categories	Respondent Sex	Respondent Referral Matrix (RRM)																					
Program Beneficiaries	X	YY	XX	YY	YY	YY	YY	YY	XX	YY	YY	YY	YY	XX	XX	XX	XX	XX	XX	NR	XX	XX	XX
	y	YY	XX	XX	XX	XX	YY	XX	YY	XX	XX	YY	YY	YY	XX	XX	YY	NR	NR	XX	XX	XX	XX
Community Stakeholders	X	NR	NR	NR	YY	NR	NR	YY	NR	YY	NR	XX	XX	YY	XX	XX	XX	NR	NR	NR	NR	NR	NR
	y	NR	XX	XX	XX	NR	XX	YY	YY	XX	NR	YY	XX	XX	NR	YY	XX	XX	NR	NR	NR	NR	NR
Health Facility Workers (HFWs)	X	XX	XX	YY	NR	NR	YY	YY	NR	NR	YY	NR	NR	NR	NR	NR	NR	XX	NR	NR	NR	NR	NR
	y	NR	XX	NR	NR	NR	XX	NR	XX	NR	NR	NR	YY	NR	XX	XX	NR	NR		XX	NR	NR	NR

Symbol/Code	Description
XX	Male Referral
YY	Female Referral
X	Male Respondents
y	Female Respondents
NR	Non-Referral
	Interviewed Respondents
	Absent Respondents

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