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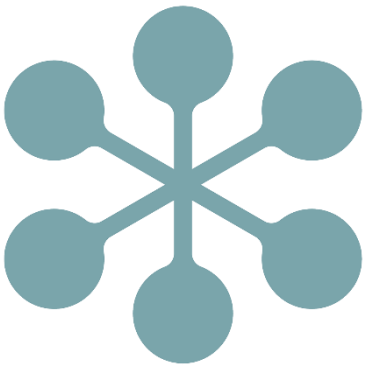
Evaluation of the Fred Hollows Foundation New Zealand's Pacific Programme

Final Evaluation Report

14 September 2026





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Executive Summary

Overview of the evaluation

This evaluation assessed the contribution of the Ministry of Foreign Affairs and Trade (MFAT)–Fred Hollows Foundation New Zealand (FHFNZ) Pacific Programme to strengthening eye health systems across the Pacific. The evaluation examined progress against the Outcomes Arrangement and assessed the Programme's contribution to strengthening the six WHO health system building blocks.

The evaluation drew on multiple sources of evidence, including programme documentation, monitoring and performance data, and key informant interviews across the Region.

Overall conclusion

Overall, the Programme has made a substantial contribution to strengthening Pacific eye health systems. The Pacific Programme is assessed as highly relevant, coherent and effective. Sustainability is progressing. However, sustainability remains uneven as countries continue the transition towards greater ownership, financing and integration of eye health within national systems.

The Programme has contributed significantly to strengthening the eye health workforce.

The Programme has established a sustainable regional training pipeline for eye care nurses and ophthalmologists, strengthening the capability, localisation and diversity of the Pacific eye health workforce. Strong retention rates, professionalised training and investment in clinical capability have increased workforce capacity, reduced reliance on visiting specialists, supported more decentralised service delivery and improved access to care across participating countries. Future gains will depend on addressing emerging system constraints, including training capacity, eye nurse shortages, workforce deployment and retention, and ensuring trained personnel have the positions, supervision, infrastructure and resources needed to practise effectively.

Service delivery has strengthened, although equity and sustainability risks remain.

The Programme has substantially strengthened eye health service delivery across the Pacific. Workforce development, outreach, stronger referral pathways and improved clinical governance have expanded access to care, improved service quality and continuity, and enabled more services to be delivered locally. Particularly in Fiji and Papua New Guinea, specialist and sub-specialist services are emerging, reducing reliance on overseas referrals, and increasing the capacity to manage more complex conditions. However, equity of service access remains uneven. Geography, transport costs, workforce shortages, infrastructure limitations, supply-chain challenges and rising outreach costs continue to affect service delivery. Future progress will depend on strengthening the systems that underpin equitable access.

Strong foundations have been established for a more evidence-informed eye health system.

The Programme has strengthened evidence generation, information use and health information systems across the Pacific. This work has improved understanding of eye health needs and supported more evidence-informed advocacy, planning, and decision-making. National ownership and use of eye health data are increasing, creating a stronger foundation for quality improvement and system development. Future investment should focus on strengthening routine information systems, integrating eye health into national reporting processes, improving workforce and patient tracking data, and building country-led data governance and digital capability.

Investments in equipment, consumables and infrastructure have expanded service capability, with sustainability now the key challenge.

The Programme has strengthened clinical capability through investments in specialist equipment, diagnostic technologies, consumables and infrastructure, improving service quality and supporting outreach. This investment has reduced reliance on overseas referrals and supported local service delivery. Sustainability is now the key challenge, with many countries still reliant on Programme support for infrastructure and equipment procurement, maintenance and replacement. This highlights the need for stronger integration of eye health equipment, consumables and infrastructure into routine government planning, financing and maintenance systems.

Leadership and governance are strengthening, although country ownership remains uneven.

The Programme has made a credible contribution to strengthening leadership, coordination and governance across Pacific eye health systems. Progress is most evident through the establishment of national eye health plans, strengthened eye health coordination functions, stronger Ministry engagement, growing clinical leadership, and increasing use of evidence to inform planning and decision-making. These developments have increased the visibility of eye health and strengthened its integration within national health systems. While planning and coordination have strengthened, progress towards full country ownership remains uneven. Future efforts should focus on embedding governance, accountability and implementation responsibilities within country-led systems.

Financing remains the weakest building block and the greatest sustainability risk.

The Programme has strengthened the foundations for more sustainable eye health financing through investments in workforce, infrastructure, planning, coordination, and evidence generation. The main sustainability risk is that many countries still rely on external funding to finance critical recurrent costs, including outreach, consumables, and workforce support.

Looking ahead

The next Outcomes Arrangement should sustain successful approaches, grow system capability and resilience, and support long-term Pacific ownership of eye health. Priority recommendations for the next phase are to:

1. **Invest in and support the pathway to sustainable Pacific ownership** through programming that strengthens national leadership, governance, financing, and planning, while responding to differing country contexts, capacities and stages of system maturity.
2. **Invest in and support the Pacific eye health workforce** through continued workforce development, retention, deployment, supervision, specialist training and pathways for trained personnel to practise effectively within national health systems.
3. **Invest in the systems that underpin sustainable eye care** through support for clinical governance, information systems, equipment and supply chains, sustainable financing, quality assurance and outcome monitoring, alongside the evidence needed to guide decision-making and assess long-term impacts.
4. **Invest in and demonstrate long-term outcomes** through stronger quality assurance, outcome monitoring, research and evaluation to assess progress towards improved eye health outcomes and reductions in avoidable blindness and vision impairment.

Introduction to the Pacific Programme

This report presents the evaluation findings of how well the Fred Hollows Foundation New Zealand's (FHFNZ) Pacific Programme is delivering on the shared MFAT–FHFNZ partnership.

This section provides an overview of the Pacific Programme's rationale, context, intended outcomes and the MFAT partnership.

Why the Programme exists?

A strong need exists for the Pacific Programme.

Avoidable blindness and vision impairment remain significant and inequitable challenges across the Pacific, with profound health, social and economic consequences. The Pacific has some of the highest global rates of preventable vision loss, driven mainly by cataract, uncorrected refractive error, and the rising burden of non-communicable diseases (NCDs), particularly diabetes and diabetic retinopathy, alongside population ageing (Burton, Ramke & Marques et al. 2023). These challenges are compounded by fragile health systems, limited specialist workforce capacity, geographic dispersion, and exposure to shocks such as climate events and pandemics (The Fred Hollows Foundation NZ, 2023).

Systemic pressures on eye care delivery and sustainability.

The operating context for eye care in the Pacific is shaped by long-standing structural pressures, including poverty, climate change impacts, a diverse and changing demographic profile, persistent gender inequality, and the normalisation of violence against women.

These pressures have been compounded in recent years by COVID-19, which exposed and exacerbated existing system vulnerabilities. Lockdowns, border closures and service redeployments disrupted eye care delivery, created substantial backlogs, and constrained training and supervision pathways.

At the same time, health systems have become increasingly fragile due to health worker attrition, pressure on health budgets, and rising NCD burdens. The Pacific Programme focuses on strengthening the systems that enable Pacific countries to plan, finance and deliver inclusive and sustainable eye care over the long term.

The Programme response.

MFAT, FHFNZ and Pacific Ministries of Health have partnered for more than 20 years.

Since 2002, the New Zealand Government, through MFAT and FHFNZ have partnered with Pacific Ministries of Health to reduce avoidable blindness and strengthen eye care systems. Over more than two decades, the partnership has supported the development of a regional eye care workforce, established enduring institutions such as the Pacific Eye Institute (PEI), and delivered large-scale eye care services across the region. This work culminated in the Strengthening Pacific Eye Care Systems programme (2016–2022) and laid the foundations for a more system-focused, outcomes-oriented approach.

MFAT and FHFNZ agreed on a five-year Outcomes Arrangement (2022–2027) that supports FHFNZ's longer-term strategy. The Outcomes Arrangement recognises that sustainable eye health outcomes

depend on system integration, local leadership, and partnership-based approaches rather than ongoing external support.

The Programme is a partnership-focused way of working.

The MFAT-FHFNZ Partnership is built on the belief that Pacific people and governments are best placed to lead their own development and decisions. The partnership work is with Pacific Governments to strengthen and support the transition to sustainable and locally-led eye-care systems. Their shared goal is stronger and more resilient health systems across the Region.

Appendix 1 presents the Theory of Change, which outlines how national health systems can be transformed to support resilient, sustainable, high-quality eye care. Pacific governments lead this process in partnership with in-country stakeholders. The approach aligns with the WHO Health System Building Blocks. Progress is intended to occur in three phases: build, strengthen, and sustain.

The five -year MFAT-FHFNZ partnership forms part of FHFNZ's broader Pacific Programme and contributes about 22% of its total budget (The Fred Hollows Foundation NZ, 2022)[1]. This collaboration allows both parties to maximise outcomes and impact by combining resources. MFAT's NZD 7.5 million supports the wider FHFNZ Pacific Programme.

The MFAT-FHFNZ Partnership has adopted a programmatic way of working with a clear focus on outcomes.

Programme activities are organised across three inter-linked outcome areas, supported by a managing-for-outcomes and adaptive management approach. The three outcome areas are:

- **Workforce training and academic support** focuses on sustaining and strengthening a quality, representative Pacific eye care workforce.
  - Activities funded under the MFAT partnership include scholarships and student support; clinical training, supervision and continuous professional development, and strengthening in-country training capacity. This work responds to persistent workforce shortages, limited supervisory capacity, and the need to embed skills within national systems rather than rely on expatriate support.
- **Service delivery and universal access** focus on improving the availability and reach of inclusive eye care services, particularly in response to COVID-19 backlogs and geographic inequities.
  - MFAT funding supports regional and national outreach, mobile clinics, integration with NCD services (particularly diabetic retinopathy screening), and targeted patient support to address barriers faced by remote communities, women, disabled people and other marginalised groups. Service delivery also provides opportunities for training, mentoring and support for broader health system strengthening. It is intentionally positioned as a way to protect previous gains while creating space for longer-term system strengthening.
- **Eye health information, planning and policy** underpins sustained impact.
  - Activities include strengthening national eye health coordination roles, supporting the development of inclusive national eye health plans and policies, undertaking evidence generation such as RAABs, and improving the availability and use of Gender Equality, Disability, and Social Inclusion (GEDSI) disaggregated data for decision-making. These investments directly address longstanding gaps in health information, planning and financing that limit governments' ability to integrate eye care within wider health systems and budgets.

[1] Going forward, MFAT's contribution is estimated at 8% of the FHFNZ's broader Pacific Programme's budget.

Across all outcome areas, the partnership is guided by principles of local leadership, GEDSI mainstreaming, safeguarding, and adaptive management.

The Programme goal is resilient, sustainable quality eye care in the Pacific.

Under Schedule 1 of the Outcomes Arrangement, MFAT and FHFNZ agreed on a clear hierarchy of outcomes to guide investment and accountability. Four long-term outcomes underpin this goal:

- **A quality and representative eye care workforce able to meet eye care needs across the Pacific.**
  This outcome reflects the recognition that workforce availability and capability are foundational constraints across the region, and that long-term service sustainability depends on locally trained and retained professionals rather than intermittent external provision.
- **People across the Pacific are better able to access inclusive, quality eye care.**
  This outcome responds to persistent inequities in access based on geography, gender, disability and socio-economic status, and recognises the importance of integrating eye care with primary health care and NCD systems to achieve universal health coverage.
- **More sustainable eye health systems, with eye care integrated into national policy, plans and budgets.**
  The rationale is that without integration into national planning and financing processes, eye care remains dependent on external assistance and vulnerable to disruption. Strengthening leadership, coordination, and policy alignment enables governments to progressively assume ownership and funding responsibility.
- **A localised, evidence-based framework for sustainable eye care guides investment in Pacific eye health.**
  This outcome seeks to ensure that investment decisions by governments and partners are informed by contextually relevant data, sustainability planning and shared accountability, rather than fragmented projects or parallel systems.

Short and medium-term outcomes sit beneath these long-term outcomes and provide a realistic pathway for demonstrating progress. MFAT and FHFNZ acknowledge that fully achieving system-level change extends beyond a five-year timeframe.

Appendix 2 lists the programme logic, including programme activities and short- and medium-term outcomes. An indicator table is also presented in Appendix 3.

Ten Pacific countries are supported by the Programme.

The Pacific Programme works directly across ten Pacific countries: Papua New Guinea, Solomon Islands, Vanuatu, Fiji, Tonga, Samoa, Kiribati, Nauru, Cook Islands and Tuvalu. FHFNZ also provides training and support to five additional Pacific Island countries and territories, including: Federated States of Micronesia, Republic of Marshall Islands, Niue, Timor-Leste and Tokelau.

These countries are culturally and linguistically diverse. They are also geographically remote, have limited infrastructure and resources, and are increasingly impacted by climate change. The following provides a high-level overview of the six Pacific countries that the Pacific Programme works directly with and are the focus of this evaluation.

Fiji (population 935, 285) comprises more than 330 islands covering over 18,000 square kilometres, with most people living on Viti Levu and Vanua Levu. The Ministry of Health and Medical Services delivers services through four divisions and 21 sub-divisions, including divisional hospitals, sub-divisional hospitals, health centres and nursing stations. Fiji's eye health systems are centred around

the Colonial War Memorial Hospital and the Pacific Eye Institute in Suva. Almost half of the country's eye care workers are based in Suva. The Pacific Eye Institute is a regional training hub for Pacific ophthalmologists and nurses, linking clinical service delivery with accredited postgraduate training, supervision and ongoing professional development for the wider Pacific workforce. Fiji's maritime geography creates ongoing access challenges for outer island communities.

Papua New Guinea (population 10,185,363) is the largest Pacific country by population and includes a large mainland, extensive highlands, coastal areas and islands. The population is spread across 22 provinces and four regions, making health service delivery complex and highly dependent on provincial systems, referral pathways, workforce availability and transport access. Eye health services are centred in Madang and Port Moresby. The new Centre for Eye Health is under construction in Port Moresby and will strengthen national training and service capacity.

Solomon Islands (population 858,288) is a dispersed archipelago in Melanesia, with communities spread across multiple provinces and many remote islands. The Ministry of Health and Medical Services is responsible for strengthening the national health system and delivering services through national divisions, provincial health services, health centres and rural facilities. Geographic dispersion and provincial capacity shape access to care. The country's locally led eye health system is based at the Regional Eye Centre at the National Referral Hospital in Honiara, which serves as the national referral, training, and outreach hub.

Samoa (population 222,382) consists of 18 islands across 3,000 km in the central South Pacific. Upolo and Savai'i are the main islands alongside several other smaller inhabited islands. Savai'i has five health facilities, Upolo has six health facilities, and the National Hospital. Samoa's eye health system is centred in the Tupua Tamasese Meaole Hospital Eye Clinic in Apia, supported by an eye health nurse in each health clinic and periodic specialist outreach.

Vanuatu (population 342,564) comprises 83 islands across six provinces in the southern Pacific Ocean, with most people living in rural areas and urban populations concentrated mainly in Port Vila and Luganville. The Ministry of Health operates through a decentralised system. Eye health services are centred in the Vanuatu National Eye Centre in Port Vila and the Santo Eye Clinic, the main eye care facility serving Espiritu Santo and northern Vanuatu. Geographic remoteness, workforce constraints, infrastructure limitations, data quality issues and exposure to climate shocks and earthquakes affect the delivery of consistent eye care and wider health services.

Tonga (population 106,858) is spread over 171 islands, 45 of which are inhabited across 700,000 km of the Southern Pacific Ocean. About 70% of the population lives on the main island of Tongatapu, where most of the health workforce is based. Tonga's eye health services are centred at Vaiola Hospital in Nuku'alofa, supported by eye health nurses in outer islands.

Evaluation purpose and approach.

The purpose of the evaluation was to assess how well the Fred Hollows Foundation New Zealand's (FHFNZ) Pacific Programme is delivering on the shared intent of the MFAT–FHFNZ partnership. The findings will inform future investment decisions and strengthen programme design and delivery.

Activities assessed in the evaluation.

The evaluation covered activities delivered under the Pacific Programme during the current partnership period (May 2022 to April 2027), including:

- Workforce development and training, including clinical, technical, and leadership capability building.
- Service delivery support, including outreach, surgical services, and quality improvement.
- Infrastructure and equipment investments, including support to national eye centres and training institutions.
- Systems strengthening, including governance, planning, data systems, and integration with national health systems.
- Regional coordination and partnerships, including engagement with Pacific Ministries of Health, regional bodies, and training institutions.
- Programme management, monitoring, learning, and adaptation, including how evidence shapes programme decisions.

Key evaluation questions.

Focus areas	Key evaluation questions
Partnership quality and delivery	1. How well have the Programme's approaches and delivery models worked in practice, and which have added the most value? 2. How strong, effective, and mutually beneficial has the partnership been for in-country stakeholders, and what factors have most influenced partnership quality? 3. What were the most important intended and unintended outcomes of the partnership, and how valuable were they to Pacific stakeholders?
System-strengthening contribution and programme learning	4. What system changes happened, and how significant were they? 5. How well has the Programme learned, adapted, and improved over time?
Outcomes for people and services	6. How well has the Programme contributed to its intended outcomes in ways that are inclusive and equitable, and aligned with GEDSI principles?
Future direction	7. What are the most important lessons about where and how FHFNZ should focus its resources and expertise to maximise long-term system resilience and sustainable eye care?

Data sources.

The evaluation findings draw on a document review and qualitative interviews with key stakeholders. The documents reviewed are listed in the bibliography.

A total of 60 stakeholders across the Programme took part in qualitative semi-structured interviews and small-group discussions. Face-to-face interviews were conducted in PNG, Fiji, and Samoa. Online interviews were also undertaken with Solomon Islands, Vanuatu and Tongan stakeholders and with FHFNZ and MFAT staff. Informed consent processes were completed for all interviews. With

stakeholders' permission, interviews were audio -recorded and transcribed for analysis. Interviews were completed in May and June 2026.

Table 1: Sample profile of stakeholders interviewed

Country	FHFNZ	MFAT	Academic	Clinical	Trainees	MOH	Total
New Zealand	9	1	-	-	-	-	10
PNG	5	2	5	4	3	2	21
Fiji	2	-	3	3	5	1	14
Samoa	1	-	-	2	7	-	10
Solomon Islands	1	-	-	1	-	-	2
Vanuatu	1	-	-	1	-	-	2
Tonga	-	-	-	1	-	-	1
TOTAL	**19**	**3**	**8**	**12**	**15**	**3**	**60**

Appendix 4 contains the list of participants by country.

Analysis approach.

The report is structured around the key evaluation questions, with evidence organised by the four focus areas: partnership quality, system-strengthening contribution (which includes outcomes for people), future direction and overarching evaluative judgements about the Pacific Programme:

- Partnership quality is assessed at three levels: MFAT, country and regional partnerships.
- System-strengthening contribution is assessed using the WHO Health System Building Blocks: Health Workforce; Service Delivery; Health Information Systems, Medical Products and Technologies; Leadership and Governance; Health Financing. Using the WHO Building Blocks incorporates the MFAT's outcomes and key evaluation questions while avoiding report duplication.
- Overarching evaluative judgements are made against the Development Assistance Criteria (DAC criteria) of relevance, coherence, effectiveness, efficiency, impact, and sustainability.
- Future directions identify areas where FHFNZ and MFAT can:
  - sustain what works
  - grow system capability and reach
  - enable the drive to sustainable Pacific ownership.

Within each domain, the analysis brings together findings from document review, monitoring data and stakeholder interviews to identify common themes, differences across countries and stakeholder groups, and the strength of available evidence.

This approach enables the evaluation to move beyond descriptive findings and make clear judgements about what has worked well, what has been more challenging, and the implications for future investment and programme design.

Evaluation limitations.

The evaluation drew on substantial quantitative evidence, including programme monitoring, workforce data and population-based surveys. Some findings, particularly those relating to system strengthening and policy influence, relied more heavily on qualitative evidence. Triangulation across data sources, stakeholder groups and countries strengthened confidence in the findings and evaluative conclusions.

Partnership quality



Partnership quality has strengthened

This section presents findings on how the partnership has strengthened over the last four years at three levels: in-country partnerships and regional partnership, and the strategic partnership with MFAT.

At country level, partnerships are generally strong, trusted and mutually beneficial.

In-country stakeholders consistently describe FHFNZ as a long-term partner that brings technical credibility, practical support, workforce development, service delivery capability and system-strengthening expertise. Partnerships have strengthened as FHFNZ increasingly works through Ministry systems, supports the implementation of national eye plans, builds local leadership and progressively shifts responsibility to local institutions.

Trust and mutual respect are the strongest and most consistent partnership features.

Over the last four years, trust has deepened across the Pacific region as FHFNZ remained present and supported through COVID recovery, workforce shortages, service delivery pressures and system-strengthening. FHFNZ is now seen less as an external provider and more as a long-term technical and systems partner.

Across countries, stakeholders consistently described trust and mutual respect as the foundation of effective partnerships:

- In Papua New Guinea, stakeholders described the partnership as one of the Programme's greatest strengths, anchored in long-standing collaboration between government, universities, hospitals and service providers.
- In Fiji, relationships between service providers, the university and Programme partners were described as collaborative and mutually beneficial.
- In Solomon Islands, the partnership was described as long-standing, highly valued and central to the development of national eye care services.
- In Samoa, Tonga and Vanuatu, stakeholders valued FHFNZ's understanding of local contexts and its sustained commitment to national priorities.

Clarity of roles and accountability remains variable.

Operational roles are generally well understood. FHFNZ supports workforce, technical assistance, outreach, equipment, data and planning. Local partners lead service delivery and national health system engagement. However, institutional roles and responsibilities are less clear in some countries.

In many Pacific countries, the close working relationship between FHFNZ and local staff makes boundaries difficult to distinguish.

> The work between CWM and Fred Hollows, it was very symbiotic might be the right word. It is quite closely linked together and hard to pull apart. (In-country partner)

Fiji illustrates this challenge most clearly. At an operational level, eye health training and service delivery are reciprocal. Trainee doctors and nurses help sustain eye health services. Experienced clinicians provide the supervision and mentoring for the next generation of eye care workers. However, unresolved governance arrangements, expired MOU agreements, and ambiguity around roles and responsibilities create uncertainties at the institutional level.

PNG has used MOUs and planning structures to strengthen role clarity. However, cost-sharing and long-term eye health care responsibilities remain unresolved. Samoa stakeholders similarly have highlighted the need for clearer roles in infrastructure, financing and long-term stewardship.

Regional partnerships are strengthening through Pacific-led collaboration.

At the regional level, partnership quality is evident in the growing ability of Pacific eye health professionals to connect, lead and address shared system challenges. The realities of small populations, geographic dispersion and specialist workforce shortages mean that sustainable eye health solutions cannot be achieved by countries working in isolation.

The Pacific Eye Care Society (PacEYES) is a regional professional network established in 2003 to support and represent Pacific eye health professionals. Its members include ophthalmologists, eye doctors, ophthalmic nurses, technicians and other eye care workers from across the Pacific. Through its biennial conference and ongoing professional networks, PacEYES supports professional development, knowledge exchange, leadership and regional coordination.

Stakeholders described PacEYES as an important platform for sharing learning, strengthening professional relationships and working collectively on common eye health challenges. Several also highlighted its role in building a stronger Pacific eye health identity and supporting Pacific-led approaches to workforce and system development.

MFAT and FHFNZ relationships embody the partnership principles.

The MFAT–FHFNZ partnership is built on a foundation of trust, strategic alignment, strong governance, continuous learning, collaborative decision-making, and a shared commitment to Pacific ownership. Together, these elements create a partnership that moves beyond a traditional funder–recipient relationship towards a collaborative model focused on strengthening sustainable eye health systems and achieving long-term development outcomes across the Pacific.

The MFAT- FHFNZ partnership is built on trust, shared purpose and Pacific ownership.

Over the last four years, the MFAT–FHFNZ partnership has evolved from a post-COVID recovery arrangement into a more mature, outcomes-focused partnership. Early activity centred on restoring disrupted eye health services, rebuilding outreach programmes, and supporting workforce training. As delivery stabilised, the partnership shifted towards broader system strengthening, including national planning, evidence generation, and support for Pacific eye health workforces in a context of workforce migration, fiscal pressure, and system fragility.

Trust and mutual respect underpin a mature outcomes-based partnership.[2]

MFAT describes FHFNZ as a valued and mature partner, with strong delivery capability, high-quality reporting and open engagement. The Outcomes Arrangement has supported adaptive management and allowed the Programme to respond to country priorities rather than being constrained by fixed activity delivery.

> We acknowledge that Fred Hollows is a mature organisation. With the Fred Hollows Foundation, they already had a vision and a strategy and a theory of change, and we're purchased into it. We provide flexibility within an accountability framework. It's probably the best way to look at it. (MFAT)

From a FHFNZ perspective, the partnership provides more than funding. The relationship has evolved from a traditional funder–recipient arrangement into one where both organisations contribute complementary strengths. MFAT provides strategic backing, credibility, and the flexibility needed to support long-term health system strengthening. FHFNZ contributes technical expertise, regional relationships, and implementation capability.

> There was a shift from being a negotiated relationship – this is how we work together – to one of accompaniment. Now it is more, 'How can we help you do more of what you do?' That's a very distinct shift from being across the table. (FHFNZ)

The relationship is characterised by confidence in each partner's expertise, integrity, and intentions. MFAT trusts FHFNZ's technical capability and Pacific relationships. FHFNZ values MFAT's strategic support and long-term commitment.

MFAT and FHFNZ are aligned around a shared vision for sustainable eye health systems.

Both organisations are aligned around a shared goal of strengthening sustainable, locally owned eye health systems across the Pacific. The partnership is guided by long-term outcomes rather than short-term project delivery.

Over the last four years, the partnership has increasingly focused on building resilient and sustainable Pacific eye health systems. FHFNZ's annual reporting to MFAT demonstrates growth in national planning, eye care coordination roles, government-supported processes, and sustainability planning. These changes demonstrate that the partnership is increasingly strengthening country systems rather than operating as a parallel service-delivery model.

Accountability, transparency, and learning strengthen the partnership.

Regular reporting, annual reviews, partnership health checks and ongoing dialogue and co-design are at the heart of the partnership. These accountability and collaboration mechanisms provide a shared evidence base that helps MFAT and FHFNZ understand what is being delivered, identify emerging risks, and adapt the Programme in response to country and Pacific contexts.

[2] Further information on

MFAT's confidence in the partnership is underpinned by the quality of engagement, the use of evidence, and FHFNZ's willingness to openly discuss challenges and trade-offs. Learning and adaptation are central to the partnership model. Reflection processes have informed refinements to workplans, COVID recovery pressures, strengthened national planning and coordination roles, and a stronger focus on sustainability and Pacific ownership.

The high trust model also creates uncertainty about the optimal engagement. MFAT is confident taking a 'hands off' approach because of its confidence in FHFNZ capability and delivery. However, both organisations have reflected on the appropriate level of engagement to sustain and strengthen their partnership.

The strategic partnership remains less visible at country-post level.

MFAT posts, particularly in PNG, have reported limited visibility of how MFAT's Wellington-managed Outcomes Arrangement connects with in-country activity. This can reduce opportunities for MFAT Post to actively support the Pacific Programme and FHFNZ through their relationships with government counterparts and other stakeholders.

Evaluative judgement: Partnership quality has strengthened.

Partnership quality has strengthened over the last four years. The MFAT–FHFNZ relationship is mature, trusted and strategically aligned, with strong accountability and learning processes supporting adaption and continuous improvement. The relationship gives practical expression to their partnership principles. Both partners work in good faith, communicate openly, support Pacific-led development, and focus on sustainable outcomes.

At country level, FHFNZ is increasingly working through Ministry systems and local institutions, strengthening ownership, trust and mutual benefit. At regional level, the PacEYES initiative is emerging as valuable mechanisms for Pacific leadership, peer learning and workforce sustainability.

Partnership challenges are now primarily institutional rather than relational. Trust, commitment and collaboration are well established. The key challenge is ensuring that governance arrangements, responsibilities, resources and accountability mechanisms are sufficiently formalised to support long-term Pacific ownership. In Fiji, this tension is particularly evident in ongoing discussions about the future ownership, leadership and sustainability of regional training and coordination functions.

System-strengthening contribution



Health workforce: Workforce has strengthened

Under the WHO Health Systems Framework, a well-performing health workforce requires sufficient numbers of competent, motivated and appropriately distributed personnel to deliver health services. This section assesses how the Pacific Programme has contributed to strengthening the eye health workforce, including ophthalmologists and eye care nurses, across the Pacific.

This section also examines progress towards the long-term outcome of a quality and representative eye care workforce able to meet eye care needs across the Pacific.

The Programme has strengthened the Pacific eye care workforce.

Workforce training and academic support are the most significant contributions of the Programme to health-system strengthening. The Programme supports a suite of accredited training pathways for eye-care nurses and ophthalmologists designed to meet workforce needs across the Region.

- For nurses, this includes the one-year Postgraduate Diploma in Nursing Eye Care (PGDEC) delivered through the Pacific Eye Institute (PEI) and Fiji National University, and the one-year Advanced Diploma in Eye Care (ADEC) delivered through Madang Provincial Hospital and Divine Word University in PNG.
- For doctors, pathways include the one-year Postgraduate Diploma in Ophthalmology (PGDO), followed by the three-year Master of Medicine in Ophthalmology (MMED). Together, these programmes provide a four-year specialist training pathway leading to qualification as an ophthalmologist.

Since training began in 2006, the Programme has supported more than **400 graduates** across the Region, with an overall retention rate of approximately **75%**. Retention is particularly strong among ophthalmologists (**90%**).

Table 2. Workforce graduates supported by the Programme from July 2022 to June 2026

	Jul 22 - Jun 23	Jul 23 - Jun 24	Jul 24- Jun 25	Jul 25 – Jun 26	TOTAL
Nurses					
PGDEC	15 (13)*	8 (7)	10 (7)	9 (5)	42 (32)
ADEC	10 (4)	10 (7)	11 (6)	12 (5)	43 (22)
Doctors					
PGDO	1 (0)	3 (2)	7 (5)	4 (1)	15 (8)
MMED	3 (0)	2 (0)	3 (3)	0 (0)	8 (3)
TOTAL	**29 (17)**	**23 (16)**	**31 (21)**	**25 (11)**	**108 (65)**

Note: the brackets indicate the number of female graduates.

During the evaluation period, the Programme produced **108 graduates**, including **65 women** (Table 2). Most graduates were eye-care nurses (**85**), reflecting continued investment in workforce expansion at primary and secondary-care levels. A further **15** doctors (including **eight** women) completed postgraduate diploma training and **eight** (including **three** women) completed specialist MMED

training, qualifying as ophthalmologists. Together, these outputs contributed to continued growth in eye-health workforce capacity across the Pacific region.

Over the last four years, MMED enrolments have increased from **four trainees in 2022–23** to **fifteen trainees in 2025–26.** This growth indicates a growing ophthalmologist workforce pipeline that is likely to contribute to workforce gains in future years.

The Programme is supporting women's participation in the eye-health workforce

The Programme's scholarship and student-support model appears to reduce barriers to participation by covering tuition fees, travel, accommodation, equipment and living costs. These forms of support are particularly important for students from remote locations and those with significant family responsibilities.

Despite these gains, participation in training continues to involve substantial personal and family commitments. Women nursing students described the challenges associated with relocating for study and extended periods away from partners, children and wider family networks. These barriers may disproportionately affect women given their caregiving responsibilities in many Pacific contexts. Several students suggested that satellite training sites and blended learning models could help reduce these barriers while maintaining access to supervision and practical experience.

Continued attention to gender-responsive workforce development will be important to ensure that gains in workforce capacity are sustained and that women have equitable opportunities to progress into specialist and leadership roles within eye health.

Eye health training has evolved and professionalised.

Nurse training pathways have strengthened the professionalisation of eye care for nurses.

In Fiji, the recent recognition of the Postgraduate Diploma in Nursing Eye Care marks an important shift from eye care nursing being treated as a poorly recognised speciality toward a clearer professional pathway for nurses. The change has not altered the core competencies of the programme. However, it strengthens the legitimacy of the nursing qualification. The implications for eye care nurses are that once the Nursing Council recognises the scope of practice, eye care nurses may have designated roles in eye clinics, which would protect their specialist role and support better workforce planning. Further, formal recognition could make the programme more attractive to nurses by giving them a clearer professional pathway and stronger confidence that the qualification will lead to meaningful specialist practice.

In PNG, the nursing eye care qualification shifted from a Postgraduate Diploma in Eye Care to an Advanced Diploma in Eye Care. This change was linked to a decision to stop training community health workers and instead focus on already-qualified health professionals. Nurses now need to hold a nursing diploma, and health extension officers need a bachelor's degree, before entering the one-year Advanced Diploma. This change makes the training more clearly aligned with existing professional qualifications, supports diploma-qualified nurses to specialise in eye care, and protects the quality and professional standing of the eye care nursing role.

In PNG, the Programme uses a layered training approach to extend the eye health reach, given the shortages of ophthalmologists. A three-day primary eye care course, delivered by eye care graduates and clinicians, trains nurses and other frontline health workers to recognise common eye conditions, identify people with cataract, trauma, or refractive error, and refer them for specialist treatment. The

training supports earlier diagnosis, improves access to care closer to home, and helps identify candidates for future specialist eye care training.

Ophthalmology training is strengthening and institutionalising.

In Fiji, the ophthalmology training programme has become increasingly embedded within Fiji's national education and health workforce systems. Responsibility for the postgraduate ophthalmology programme has shifted from the Pacific Eye Institute to Fiji National University, increasing its formal recognition and aligning it with other postgraduate medical specialities. This university integration has raised the profile of ophthalmology within both undergraduate and postgraduate medical education. Further, it creates a clearer pathway into specialist training and increases exposure to the discipline among medical students. Stakeholders also pointed to stronger institutional ownership, with ophthalmology now incorporated into university planning processes, including the development of a teaching hospital and specialist training facilities such as a wet laboratory. Together, these developments indicate a transition from a stand-alone training programme to one that is more firmly embedded within Fiji's tertiary education system and long-term health workforce planning.

Doctor training in PNG has also been strengthened through a more structured, module-based ophthalmology curriculum, standardised online examinations across training sites, and the introduction of workplace-based assessment to monitor clinical and surgical competency over time. These changes, supported by FHFNZ through trainers, equipment, consumables, workshops and outreach-based clinical exposure, have helped make the training pathway more consistent, practical and aligned to PNG's priority causes of avoidable blindness.

Workforce capability is strengthened through scholarships, practical training, and ongoing professional support.

The Programme's scholarship and student-support model enables participation.

Students reported that they would have been unable to undertake training without support for tuition fees, travel, accommodation, equipment and living costs. Many students are mid-career professionals from remote locations and described the significant personal sacrifices involved in leaving jobs, families, and communities to study. Both nurses and doctors in training noted that peers in other specialties were impressed by the level of support they received, not only financially but also through the Programme's pastoral care.

> My other colleagues in the other fields are quite envious of me... they don't have an NGO like that backing them up. (MMED student)

Clinical exposure and supervised practice are essential to workforce development.

Students consistently described the training experience as highly practical, supportive, and directly relevant to their clinical roles. Across nursing and ophthalmology training pathways, students valued the combination of classroom learning, supervised clinical practice, outreach experience and hands-on exposure to patients. Training was described as building clinical competence, confidence, and readiness to practise in often isolated, resource-constrained and geographically dispersed Pacific settings.

Doctors in training highlighted the quality of supervision. They appreciated the opportunity to learn alongside experienced clinicians and the ability to immediately apply theory in clinical settings. Many reported that the training expanded their scope of practice, career aspirations and ability to deliver eye-care services on return to their communities.

Access to outreach services emerged as a particularly important enabler of ophthalmology training. In many Pacific settings, patient volumes and surgical caseloads at tertiary facilities alone are insufficient to provide trainees with the breadth and volume of clinical experience required to achieve competency and meet diploma and Master of Medicine training requirements. Outreach clinics expose trainees to a larger number and wider range of eye conditions and provide opportunities to undertake supervised surgical procedures. They help ensure graduates develop the practical skills needed for independent practice. Outreach therefore contributes simultaneously to service delivery, workforce development and training quality.

Post-graduate professional support maintains professional competence and may overcome barriers to practice.

The Programme provides workforce-support visits, clinical attachments, mentoring, supervision and continuing professional development opportunities that help graduates consolidate skills in practice. Stakeholders described these activities as particularly important for practitioners working in isolated or resource-constrained settings, where access to specialist support and peer networks is often limited. In PNG, ongoing nursing support includes refresher training and mentorship delivered through outreach activities. Engaging local eye health nurses in outreach helps maintain and strengthen their skills after deployment to provincial settings.

Student feedback also identified opportunities to strengthen the training model.

Regional students based in Fiji described accommodation costs and access to affordable housing as significant challenges. Some nursing students noted difficulties associated with prolonged separation from partners, children and wider family networks. Several students suggested that satellite-campus and blended-learning approaches could reduce these barriers and maintain access to quality supervision and practical experience. Fiji-based nursing students highlighted the absence of health entitlements creating additional financial pressures and uncertainty.

Clinical supervision and infrastructure can impede workforce development.

Several factors limit the programme's ability to expand despite strong demand and ongoing workforce shortages across the Pacific. Recruiting and selecting students has become more complex as demand has increased. Fiji National University prioritises academic merit and minimum entry requirements. In contrast, FHFNZ has historically considered country need and sponsorship priorities. In addition, the Programme agreement specifies an even split between Fiji and regional students. However, this has not always been achieved when regional workforce needs have been prioritised.

In Fiji, growing demand for ophthalmology training is constrained by training capacity and recruitment challenges.

Demand for ophthalmology training exceeds available places, creating a growing backlog of qualified applicants. Fiji National University can train only ten ophthalmology students each year (12 with satellite training), meaning unsuccessful applicants often defer and reapply alongside new candidates. Training capacity is constrained by limited supervision resources. Although six consultant ophthalmologists support the programme, three are currently undertaking fellowship training and have reduced availability for student supervision.

Other constraints to ongoing workforce development lie within the health system environment. The main barriers are limited operating theatre access, constrained opportunities for supervised surgical experience, and broader infrastructure limitations.

Workforce capacity, particularly among eye nurses, is emerging as a key constraint to service expansion.

Despite growing interest in ophthalmology and increasing numbers of doctors entering training in Papua New Guinea, stakeholders reported that the current workforce is not keeping pace with service needs. Stakeholders emphasised that expanding the ophthalmology workforce will require parallel investment in eye nurse recruitment, training, and deployment. One ophthalmologist described a mismatch between the number of eye nurses available and the growing number of ophthalmologists working in eye care in Port Moresby.

These constraints have important implications for PNG's new Centre for Eye Health. The facility will significantly increase infrastructure capacity, creating demand for additional clinical and support staff to operate services effectively. Without corresponding growth in the eye care workforce, there is a risk that infrastructure expansion will outpace the system's capacity to deliver services. Continued investment in ophthalmologists, eye nurses and their deployment across provincial hospitals will be critical to ensuring the new facility can achieve its intended impact.

Fiji is also in the process of revitalising and expanding its health infrastructure, including new hospitals, and teaching facilities that will require additional ophthalmologists. Stakeholders noted that workforce planning must account for future service expansion and attrition within the eye health workforce.

Training capacity constraints are driving innovation.

Training capacity constraints have prompted the Programme to pilot a satellite training model, supported by FHFNZ, to expand ophthalmology training beyond the central campus in Suva. The model enables trainees to complete part of their training at approved clinical sites in their home countries, with the current pilots including a trainee based in Solomon Islands and Samoa. The satellite training also increases students surgical experience, both in terms of patient numbers and familiarity with health service to which they will return post training. Stakeholders viewed the approach positively and saw potential for it to increase training capacity, reduce the backlog of applicants, and better meet both Fiji's workforce requirements and regional demand for ophthalmologists.

The model aligns with the Programme's longstanding regional workforce mandate, which has prioritised countries with the greatest workforce shortages. By creating additional training pathways, the satellite model has the potential to strengthen the regional ophthalmology workforce while supporting Fiji's domestic needs. Stakeholders noted successful implementation will depend on maintaining training quality through protected learning time, strong oversight from Fiji National University and PEI, and continued investment in teaching and supervision capacity at satellite sites.

Employer support enables training to translate into service delivery.

Across Fiji and PNG, specialist eye care training is designed for health professionals already employed within the health system. Entry requirements typically include professional registration, employer endorsement, and a clear pathway for graduates to return to service. This approach reflects the Programme's focus on strengthening the existing workforce and ensuring that training investments contribute directly to increased service capacity. The effectiveness of this model depends on strong

alignment between training, workforce planning, and employer commitment. Employers play a critical role in releasing staff for training, maintaining salaries and positions during study, and providing appropriate roles on graduation so newly acquired skills can be applied in practice.

For nurses, employer support is often the determining factor in whether training can occur. In Fiji, the one-year, face-to-face training model requires nurses to be released from their workplace and their roles covered during their absence. Workforce shortages can limit an employer's ability to do this, preventing some eligible applicants from taking up training opportunities. In PNG, employers must formally release nurses to undertake the one-year Advanced Diploma in Eye Care and continue paying their salaries throughout the programme. This support is particularly important given the financial and family responsibilities many trainees carry. In both countries, employer commitment helps ensure graduates return to eye care roles where their skills can strengthen local services.

The same principle applies to ophthalmology training. Stakeholders noted that specialist training delivers the greatest value when graduates return to environments with the infrastructure, equipment, clinical workload, and service mandate needed to use their skills. In PNG, employer endorsement is a prerequisite for ophthalmology training and provides assurance that graduates will return to identified positions where their expertise is needed. The benefits of training are further strengthened by broader health system support, including supervision, protected learning time, outreach opportunities, theatre access, equipment, consumables, and clear deployment pathways.

However, sustaining government support for trainees throughout the full four-year ophthalmology training programme is becoming more challenging in some countries. Several governments are unable to continue salary support beyond the early stages of training. For example, Tonga provides full support for the first two years (PGDO and MMed) but more limited support thereafter. This creates financial uncertainty for trainees and may reduce the accessibility and sustainability of specialist training pathways. Together, these factors highlight that workforce development depends not only on access to training, but also on the financial and health system support needed for trainees to complete their training and apply their skills effectively on return.

Workforce investment has enabled greater localisation and decentralisation of services.

Workforce investments have contributed directly to greater localisation and decentralisation of eye-care services across the Region. Increased numbers of trained eye-care personnel are enabling countries to provide services closer to communities and reduce reliance on visiting specialists.

Samoa provides a strong example, with trained eye nurses increasingly delivering services in district hospitals and helping extend care beyond central facilities. More than 20 personnel are now involved in district-level eye-care delivery, including nine nurses providing eye-care services as part of their permanent roles.

Similar patterns are evident across the Pacific. In Solomon Islands, eye nurses are deployed across provincial locations, helping expand access beyond Honiara. Stakeholders in PNG described a growing provincial eye-health workforce that is extending access to eye care beyond major urban centres. In Tonga, eye-care personnel are working across the country, including the outer islands. In Vanuatu, eye nurses are supporting services in provincial hospitals and a growing cadre of future ophthalmologists is progressing through postgraduate training pathways.

These developments demonstrate that workforce investments have strengthened country ownership of service delivery and contributed to a transition away from reliance on externally delivered services.

> We also trained two nurses, so when he (the ophthalmologist) graduates, there are already two nurses waiting for him to support. (Clinician)

Workforce gains are vulnerable to attrition and redeployment.

In smaller Pacific countries, resilience is often constrained by limited ophthalmologist depth and dependence on one or two key individuals. Tonga illustrates this challenge most clearly. While eye-nurse capacity has expanded substantially, services remain dependent on a single practising ophthalmologist. Similar vulnerabilities exist in Samoa and Vanuatu, where ophthalmologist capacity remains limited, and services are exposed to risks associated with retirement, migration, leave and workforce turnover.

In PNG, eye health care is impeded by the redeployment of nurses. In PNG, both ophthalmologist and eye-health nurse numbers are increasing. However, the work of ophthalmologists is being blocked due to eye-health nurses being reassigned within health facilities to other clinical priorities. This redeployment reduces the number of personnel available to provide eye-care services. Stakeholders noted that mechanisms such as Memoranda of Understanding and engagement with local health facilities are being used to support the retention of eye-health nurses in their designated roles.

Attrition, retirement, migration, and movement into non-clinical roles remain ongoing risks across the Region. Solomon Islands continues to face workforce gaps requiring replacement training to maintain service coverage. Without sustained attention to retention, deployment and succession planning, workforce gains are likely to remain uneven across countries.

The future workforce will require a stronger focus on skill mix, specialisation and deployment.

The next phase of workforce development will require greater attention to workforce composition, advanced clinical skills, sub-specialisation, and deployment models that maximise access to specialist expertise across the Pacific.

Fiji has begun developing sub-speciality capacity through vitreoretinal and glaucoma fellowships, and stakeholders identified diabetic retinopathy as an emerging priority area. Several suggested that targeted short-course training in retinal screening, laser treatment and intravitreal injections could provide a cost-effective way to address specific service gaps. Stakeholders emphasised that advanced training must be accompanied by appropriate deployment, equipment, infrastructure, and employer support if new skills are to translate into improved service delivery.

Stakeholders in PNG similarly viewed the current ophthalmology training pathway as a foundation for future workforce development rather than an endpoint. The Master of Medicine programme provides strong preparation for managing cataract and other common causes of avoidable blindness. More complex conditions continue to require referral because sub-speciality expertise and advanced technologies remain limited. Future workforce development is therefore likely to focus on fellowship-level training for qualified ophthalmologists, initially through overseas programmes. Over time, this could build local sub-speciality capacity, reduce reliance on overseas referrals, and strengthen PNG's role in regional eye care, training, and research.

Stakeholders also highlighted the importance of developing a broader eye health workforce. Optometry was identified as a potential area for future investment, particularly to support refraction services, ongoing patient management and increasing service demand. In PNG, stakeholders also saw opportunities to expand the role of community health workers in health promotion, screening, referral and patient navigation, particularly in remote and underserved communities.

Evaluative judgement: The Programme has made a substantial contribution to strengthening the Pacific eye-health workforce.

The Programme has made a substantial contribution to strengthening the eye health workforce across the Pacific. Through sustained investment in accredited training pathways, scholarships, workforce support and professional development, the Programme has helped establish a regional pipeline of ophthalmologists, eye-care nurses, and other eye-care personnel. The Programme has also contributed to the professionalisation and institutionalisation of eye-health training, particularly through strengthened nursing qualifications and increasing integration of ophthalmology training within national education and health systems.

Scholarships, financial assistance, and pastoral support are helping reduce barriers to participation in specialist eye-health training, particularly for women and students from remote locations. However, participation in training continues to involve significant personal and family commitments, especially for those with caregiving responsibilities and those required to relocate for study. More flexible delivery models, including satellite training and blended-learning approaches, may help sustain and further strengthen equitable participation.

Despite these achievements, workforce constraints remain. Demand for training exceeds available places, eye nurse shortages are emerging as a bottleneck in some settings, and workforce deployment, retention and role protection continue to affect service delivery. The next phase of workforce development will require continued investment in training capacity, workforce planning, deployment, retention, and advanced clinical skills to ensure that workforce gains translate into sustainable improvements in access to eye care across the Pacific.

Service delivery: Access and local delivery are strengthening

WHO identifies service delivery as a core building block of a well-functioning health system, encompassing services that are accessible, equitable, safe, high quality and responsive to population needs. This section assesses how the Pacific Programme has strengthened eye-health service delivery across the Pacific, including progress towards the long-term outcome that people across the Pacific are better able to access inclusive, quality eye care.

This section also examines progress towards the long-term outcome of people across the Pacific are better able to access inclusive, quality eye care.

Service reach has increased.

The Programme has made a substantial contribution to strengthening eye-health service delivery across the Region (Table 3).

Table 3: Service delivery reach from July 2022 to June 2026

	Jul 22-Jun 23	Jul 23-Jun 24	Jul 24-Jun 25	Jul 25-Jun 26	TOTAL
Outreach activities supported	23	135	102	58	318
Eye-care consultations	12,221 (57%)*	44,298	58,171 (52%)	58,144 (54%)	172,000+
Surgeries delivered	1,584 (54%)	3,634	4,654 (50%)	4,273 (50%)	14,000+

** Brackets denote the percentage of women reached, where disaggregated data was reported in monitoring reports.*

Over the last four years, the Programme supported **318 outreach activities**, delivered more than **172,000 eye-care consultations**, and facilitated more than **14,000 surgeries**.

Over the last four years, consultation and surgery volumes have increased. This increase reflects expanded workforce capacity, stronger country-led service-delivery systems and efforts to address service backlogs that accumulated during and following COVID-19.

In 2026, the Pacific Programme and its partners surpassed **100,000 sight-restoring surgeries** delivered since FHFNZ began its work in the Pacific.

Between July 2025 and June 2026, outreach activities declined to 58 compared with 102 in the previous year. The reduction appears to reflect a combination of programme and contextual factors and is discussed further below.

Outreach and decentralised models are expanding access.

A major achievement has been the expansion of access through outreach, mobile and decentralised service-delivery models. Outreach remains essential for reaching geographically dispersed populations and overcoming barriers associated with distance, transport costs and isolation. At the same time, countries are increasingly integrating eye care into district hospitals, provincial facilities, and community-based services, bringing care closer to where people live.

In PNG, outreach remains critical for reaching remote communities accessible only by boat, plane, or extended road travel. In Solomon Islands, Vanuatu and Tonga, outreach remains fundamental to servicing outer-island and remote populations. Samoa has increasingly delivered services through district hospitals, reducing dependence on Tupua Tamasese Meaole Hospital. Fiji has expanded access through outreach clinics, mobile services, and decentralised referral pathways.

Workforce development and service delivery reinforce one another.

Trained eye nurses embedded within local facilities are strengthening referral pathways, preparing patients before outreach visits and enabling outreach teams to work more efficiently when they visit remote communities. Increased numbers of ophthalmologists and eye nurses are also enabling many countries to provide services throughout the year rather than relying primarily on visiting specialist teams.

> We had nurses who are stationed in certain health centres or health facilities around the country, and when we go and currently do these outreaches in those places, we have these nurses who have already prepared the patients for us. (Clinician)

The impact of this transition is particularly evident in Vanuatu, where increasing local workforce capacity contributed to clearing a cataract backlog of more than 400 patients and reducing waiting times from months to weeks.

> When I first joined, the number of outreaches really depended on the visiting team. We had around 400-plus cataract backlog here. By 2023, we almost cleared up that backlog. (Clinician)

Samoa's district-based service model means primary eye care is increasingly delivered through district hospitals, while cataract surgical outreach is extending specialist services to communities beyond the main hospital. In Tonga, outreach has evolved into a systematic service-delivery model supported by dedicated outreach teams and mobile eye-health services.

Clinical governance strengthens quality and patient safety.

Clinical governance is becoming more established.

Clinical governance capacity is strengthening across the Pacific, although its maturity varies considerably between countries. Formal clinical governance is strongest in Fiji and PNG, where quality assurance processes such as clinical audits, cataract outcome monitoring, infection prevention reviews and documentation audits are increasingly used to inform service delivery and workforce development.

In other countries, governance arrangements remain less formalised. However, strong professional leadership is evident through national eye centres, eye departments, district service models and regional professional networks.

Supervision and assessment are improving service quality and safety.

Clinical governance is evident throughout the training pathway. Stakeholders consistently described supervision as both a teaching and patient-safety mechanism. Close clinical supervision, workplace-based assessment, structured feedback and standardised examinations help ensure trainees develop competence before practising independently.

In Fiji, eye-care nursing students receive intensive clinical supervision through small-group teaching and practical placements. Ophthalmology trainees benefit from close supervision in clinics, outreach settings and theatres. In PNG, the nursing and ophthalmology programmes use supervised clinical practice and workplace-based assessment to monitor competency development, identify learning needs and strengthen quality assurance throughout training.

Ongoing mentoring supports service quality and patient safety after graduation.

Stakeholders highlighted the importance of post-graduation support in maintaining service quality and professional competence. In PNG, graduates receive follow-up visits, mentoring, skills assessments and support to establish or strengthen eye-care services in provincial settings. In Fiji, specialist mentoring and exposure to sub-speciality services help graduates continue developing advanced clinical skills after qualification. These mechanisms recognise that workforce development continues after graduation and ensure training translates into safe, effective and sustainable service delivery.

> If we are going to be training more, then we need to have more supervisors. If we're looking at effectiveness and safety and quality, then we need to have a one-to-one supervisor and patient and student. (Clinical lead)

A stronger culture of quality and safety is emerging.

Strengthening clinical governance is contributing to a stronger culture of quality improvement and patient safety. Stakeholders described increasing use of incident reporting, infection prevention and control initiatives, patient feedback mechanisms, clinical governance training and regional learning forums. In Fiji, clinicians reported a shift towards openly discussing errors and near misses as opportunities for learning and improvement. In PNG, improvements in infection prevention and control were cited as examples of how governance processes are influencing clinical practice.

Service continuity is improving.

Alongside increased service coverage and service quality and safety, continuity of care is also strengthening. Clearer referral pathways, improved follow-up systems, increasing specialist capacity and stronger links between primary, secondary, and tertiary services are helping countries deliver more coordinated eye-care services. Clinicians described stronger referral and triage systems that enable patients requiring specialist intervention to be identified earlier and connected with appropriate services.

> Some of the patients are beyond their care, so they flag it up for us to come into the outreaches and see these patients. (Clinician)

Samoa has strengthened district-to-specialist referral pathways, shared patient information systems and follow-up arrangements, helping reduce the risk of patients being lost between screening, treatment, and review. Fiji is strengthening linkages between primary care, diabetes services and ophthalmology.

Specialist eye care services are emerging at PEI.

The Pacific Eye Institute in Fiji is increasingly delivering specialist and sub-specialist services that extend beyond cataract and general ophthalmology care. Stakeholders reported the development of vitreoretinal and glaucoma services, expanding capacity for diabetic retinopathy screening and treatment, and growing use of advanced interventions such as retinal laser therapy and intravitreal injections. These developments reflect the maturation of the Pacific Eye Institute. This shift towards managing more complex eye conditions locally reduces the reliance on overseas referrals and improves access to specialist care for Pacific populations.

Equity is a stronger focus, but access remains uneven.

The Programme has increasingly recognised that achieving equitable access requires more than expanding service availability. Across countries, targeted efforts are helping address financial, geographic, disability-related and social barriers that can prevent people from accessing eye-care services.

Stakeholders described a range of approaches including patient transport assistance, accommodation support, referral coordination, collaboration with disability organisations and measures that assist women and socially excluded patients to safely access care. In PNG, these supports were viewed as particularly important in enabling women and other underserved populations from remote communities to receive treatment. Similar approaches are evident elsewhere across the Pacific.

Geography remains one of the most significant constraints on service use. In Solomon Islands, patients may be identified through outreach programmes. These patients still face substantial challenges accessing surgery because of transport costs, accommodation expenses, caregiving responsibilities and the practical realities of inter-island travel. Similar barriers were described in Vanuatu, Tonga and PNG.

Many communities continue to rely on outreach services because routine eye-care services remain difficult to access. While outreach has improved access considerably, distance, poverty and transport limitations continue to influence who ultimately receives treatment.

Further service delivery depends on strong enabling systems.

As eye-care services expand and mature, infrastructure, workforce, supply systems and outreach financing are becoming the primary constraints to further growth. Several countries are now experiencing capacity pressures.

In Samoa, decentralised service delivery is beginning to exceed the available clinical space and equipment at district hospitals. In Tonga, the lack of a dedicated ophthalmology theatre limits surgical throughput despite growing demand. In PNG, shortages of eye nurses risk constraining the potential benefits of the new Centre for Eye Health Excellence.

Stakeholders also reported ongoing shortages of consumables, spectacles, medicines, surgical supplies and specialised equipment, with many services continuing to rely on Programme support to maintain continuity of care. Outreach remains essential for reaching remote and underserved communities, yet rising transport costs, fuel shortages, weather disruptions and climate-related events are increasing the cost and complexity of service delivery.

Together, these challenges suggest that future improvements in access and service coverage will depend increasingly on investments in workforce deployment, infrastructure, equipment, supply-chain systems and sustainable outreach models, rather than service expansion alone.

Evaluative judgement: Service delivery has strengthened, with equity and sustainability risks.

The Programme has made a substantial contribution to strengthening eye health service delivery across the Pacific. The Programme has contributed to workforce development, outreach and decentralised service models, stronger referral pathways and improved clinical governance. These activities have expanded access to care, improved service quality and continuity, and supported the emerging shift towards more sustainable, country-led service delivery. Specialist and sub-specialist services are also emerging, particularly in Fiji, reducing reliance on overseas referrals and increasing local capacity to manage more complex eye conditions.

However, equitable and sustainable access remains constrained by factors beyond service delivery. Geography, transport barriers, infrastructure limitations, workforce shortages, supply-chain constraints and rising outreach costs continue to affect access to care, particularly in remote and outer-island settings. Many countries also remain dependent on external support to address equipment, consumable and specialist workforce gaps.

Future gains will depend on strengthening the systems that support service delivery. Infrastructure, clinical supervision, equipment, consumables, supply chains and outreach financing are becoming the main constraints to further service growth. The next phase should focus on consolidating service gains, expanding specialist care, and investing in the enabling systems needed to sustain equitable access across the Pacific.

Health information systems: the evidential base is stronger

This section assesses whether the Pacific Programme is using evidence to improve eye health planning, management, accountability, quality and health outcomes. This section also examines progress towards the long-term outcome of a localised, evidence-based framework for sustainable eye care guides investment in Pacific eye health.

Eye-health planning and investment are increasingly informed by local evidence and data.

Across the Region, the Programme has strengthened the generation and use of evidence to support eye-health planning, priority setting, advocacy and investment. Countries are increasingly drawing on surveys, research, monitoring information and system assessments to understand population need, identify service gaps, advocate for resources and inform decisions relating to workforce, service delivery and infrastructure. This represents a significant shift from reliance on anecdotal information towards more structured and evidence-informed decision-making.

Table 4 summarises key evidence-generation activities supported during the evaluation period. These activities have provided governments, programme managers and clinical leaders with information on the prevalence of vision impairment, unmet need, workforce requirements, infrastructure gaps and future priorities.

Table 4: Evidence-generation activities supported from July 2022 to June 2026

Activity	Country partners
Rapid Assessments of Avoidable Blindness (RAABs)	Vanuatu, Samoa, Tonga. (Fiji delayed).
Small Island State methodology pilot	Cook Islands in progress.
Eye Care Situational Analysis Tool (ECSAT)	Solomon Islands and Vanuatu Also planned for Tonga and Samoa

The strongest examples are evident in countries that have undertaken RAABs, the Small Island State Survey and ECSAT assessments. These exercises have strengthened understanding of eye-health needs. They also provide a stronger evidence base for planning and advocacy. ECSAT assessments have supported system-level analysis across governance, financing, workforce, service delivery, medicines and technologies, information systems and leadership.

> The RAAB study showed that there is a lot of blindness that needs a lot of work. We have used the survey results in a lot of our meetings. The Ministry came in to recognise the importance of eye health. (Clinician)

Evidence is increasingly used to strengthen the visibility of eye health within national health planning and decision-making processes. Vanuatu, Samoa and Tonga are using research findings and assessment data to support planning, advocacy and stronger government recognition of eye-health priorities.

In Vanuatu, evidence has informed the inclusion of eye-health indicators within national health planning processes, including measures relating to cataract outcomes, access and refractive error services. In PNG, stakeholders highlighted increasing use of programme data to support workforce planning, budget advocacy and justification for eye-health positions.

Research methods are being adapted for small-island contexts.

The Programme has contributed to the development of more appropriate approaches for generating population-level evidence in small Pacific countries. Traditional RAAB methodologies were developed for populations exceeding 100,000 people and are difficult to apply in small island developing states.

In partnership with the University of Auckland, the Programme is piloting a modified survey methodology in the Cook Islands that is better suited to smaller populations and geographically dispersed communities. If successful, the approach could be applied in countries such as Tuvalu, Tokelau and Nauru, helping address long-standing evidence gaps in settings where conventional survey methods are difficult to implement.

Information is increasingly being used to support planning and accountability.

Countries are increasingly using evidence not only to understand need, but also to support planning, prioritisation, and accountability. Stakeholders described growing use of survey findings, monitoring data and system assessments to inform workforce planning, resource allocation and service priorities. In Vanuatu, evidence generated through the RAAB has strengthened the visibility of eye health within government planning processes. In PNG, programme data are increasingly being used to support workforce planning, budget advocacy and justification for eye-health positions.

These developments reflect a broader shift from collecting information primarily for reporting purposes towards using information as a management and planning tool.

Country ownership of information is becoming increasingly important.

A growing emphasis on country ownership and stewardship of information is emerging across the Region. Stakeholders consistently emphasised that health information should remain under country control, with governments determining how data are stored, accessed, shared and used. FHFNZ acknowledges this principle and actively works to support country partners to strengthen national ownership and use of their information.

Discussions between FHFNZ and country partners are increasingly discussing data sovereignty, governance, ethics, consent and stewardship. This reflects a broader shift towards Pacific-led ownership of evidence, and a shared commitment to ensuring information systems support national priorities and decision-making, rather than external reporting requirements.

The Programme has also invested in strengthening country capability to collect, analyse and use information. Monitoring and evaluation workshops, technical support, mentoring and data-quality processes are helping eye-health teams strengthen skills in data management, interpretation and reporting. This capability is enabling governments and eye-health teams to use locally generated evidence for planning, advocacy and system analysis.

Clinicians and academic stakeholders highlighted the importance of increasing the publication of Pacific-led research in peer-reviewed journals. The growing number of doctors completing the Master's programme presents an opportunity to expand the regional evidence base and elevate Pacific perspectives in eye health research. In-country partners have expressed interest in greater support from FHFNZ to translate Master's theses into published research.

Information-system maturity varies across the Region.

Information-system maturity remains one of the less developed areas of health-system strengthening. Across most countries, information systems are stronger at programme and service-delivery levels than at the national-system level.

Data quality and reporting consistency have improved. However, many countries continue to rely on fragmented, paper-based or partially digitised systems. Connectivity challenges, infrastructure limitations and workforce constraints also continue to affect system performance in some settings.

Countries are also at an early stage of strengthening equity-focused monitoring. Although collection of gender-disaggregated data has become more common, disability data and broader equity indicators remain inconsistently collected and reported. Evidence gaps also remain in relation to patient outcomes, lived experience, quality-of-life impacts and eye-health needs among populations younger than 50 years.

As eye-health systems mature, the primary information challenges are increasingly shifting from evidence generation towards strengthening routine systems, integrating information across services and improving the availability of data for ongoing management and decision-making.

> Everyone's at a slightly different stage of that journey. The pace of change is very dependent on countries' tools. (FHFNZ)

Evaluation judgement: Strong foundations have been established for a more evidence-informed eye-health system.

The Programme has made a substantial contribution to strengthening evidence generation, information use and health-information systems across the Pacific. Investments in surveys, situational analyses, research and capability building have improved understanding of population need, strengthened advocacy and supported more informed decision-making. Countries are increasingly using evidence to guide planning, prioritisation, and investment decisions, while also demonstrating stronger ownership of data and information systems.

Despite this progress, information-system maturity remains uneven. Many countries continue to rely on fragmented or partially digitised systems, while routine monitoring, outcome measurement and equity-focused reporting remain underdeveloped. The next phase of strengthening should focus on improving routine information systems, integrating eye-health indicators within national systems, strengthening workforce intelligence and patient tracking, and supporting country-owned data governance and analytical capability.

Essential medicines, equipment and technologies: Programme has expanded

This section assesses the Pacific Programme's contribution to strengthening access to the medicines, equipment, consumables, infrastructure and technologies required to deliver quality eye care across participating Pacific countries.

Access to equipment and technologies has expanded eye-care services and strengthened workforce capability.

Across the Region, the Programme has strengthened access to specialist equipment, diagnostic technologies, consumables, and infrastructure that underpins eye-care services. Investments in surgical equipment, outreach equipment, refraction services and specialist diagnostic tools have enabled countries to establish or expand services that would otherwise not have been possible. The Programme's workforce model recognises that health workers can only use and maintain skills when appropriate equipment, consumables and technologies are available in practice.

In Fiji, access to advanced technologies has supported the development of subspecialty services and reduced overseas referrals. In Tonga, portable retinal cameras and a mobile eye-health van have expanded access to screening and diagnostic services in outer-island communities. Investments in PEI, Centre for Eye Health and national eye clinics have also provided the infrastructure for workforce development and service delivery.

Improved access to equipment and technologies has strengthened both service quality and reach. Across countries, specialist technologies have enabled more services to be delivered closer to home, supported outreach into underserved communities and improved clinical capability. Diagnostic equipment, refraction technologies and surgical equipment are also enabling a broader range of eye-health services.

> We have all the equipment, all the updated equipment for eye surgery and eye checks. (Clinician)

Equipment, infrastructure, and procurement systems constrain progress.

As workforce capacity has expanded, the need for consumables, equipment and infrastructure has become increasingly visible. Across several countries, stakeholders described situations where trained personnel were unable to fully use their skills because equipment, consumables, clinical space or supporting infrastructure were inadequate.

In PNG, shortages of equipment and consumables were reported to limit the ability of trained personnel to provide services in provincial settings. Samoa identified shortages of clinical space and equipment as growing constraints on decentralised service delivery. Stakeholders also highlighted access to surgical cases, supervisors, clinical infrastructure, and theatre space as ongoing limitations to specialist training and workforce development.

As countries expand specialist services and decentralise care, the benefits of workforce investment will only be fully realised if trained personnel have the equipment, clinical facilities and support systems needed to use their skills effectively.

The emergence of satellite training models in countries such as Solomon Islands and Samoa highlights the importance of local infrastructure. Expanding training closer to where people live requires sufficient equipment, supervision capacity and clinical facilities to support training and service delivery.

Long-term sustainability depends on stronger government ownership of supply and maintenance systems.

Despite progress, access to essential medicines, equipment and technologies remains one of the less institutionalised components of eye-health system strengthening. Across several countries, stakeholders described ongoing reliance on Programme-supported consumables, equipment provision, maintenance and technical assistance to sustain services. Some stakeholders also described emerging discussions about introducing modest fee-for-service arrangements for consumables to help support longer-term financial sustainability. However, they also recognised the need to balance cost recovery with affordability and equitable access for patients.

> We don't get consumables from the hospital or the National Department of Health. (Clinician)

In many settings, specialist eye-health commodities are not yet routinely incorporated into government procurement systems, supply chains or asset-management processes. Financing for replacement equipment, ongoing maintenance and major infrastructure upgrades therefore remains limited. As a result, services can remain vulnerable when equipment fails, consumables are delayed, or external support is reduced. These challenges are becoming increasingly important as countries seek to sustain expanded services, retain trained personnel and transition towards greater system ownership.

> If we wait for them to provide it, there will definitely be no services at all. There's no training at all. (Clinician)

FHFNZ is addressing some of these challenges through training both doctors and nurses to be able to maintain their equipment.

> We don't get consumables from the hospital or the National Department of Health. (Clinician)

The next phase of system strengthening will require greater emphasis on integrating eye-health commodities and infrastructure into routine government systems. Without stronger national procurement, maintenance and financing arrangements, gains in workforce development and service delivery will remain vulnerable. Sustainable eye-health systems will depend not only on having access to modern technologies, but also on ensuring countries have the systems and resources needed to maintain and replace them over time.

Evaluative judgement: Expansion of equipment, consumables and infrastructure; future focus is sustainability.

The Programme has strengthened eye-health service delivery across the Pacific through investments in specialist equipment, diagnostic technologies, consumables and infrastructure. These investments have expanded clinical capability, improved service quality, supported outreach, reduced reliance on overseas referral, and enabled trained personnel to apply and maintain their skills in practice. The strongest gains are evident in expanded service capacity and the introduction of specialist technologies, often linked to workforce development.

However, many countries remain dependent on Programme support for the provision, maintenance and replacement of equipment, as well as broader procurement and infrastructure needs. As eye-health systems mature, the challenge is shifting from establishing access to essential technologies to ensuring their long-term sustainability. Future system strengthening will require greater integration of eye-health equipment, consumables and infrastructure into routine government planning, financing, procurement and maintenance systems. Without stronger national arrangements, gains in workforce development and service delivery will remain vulnerable.

Leadership and governance: Progressing towards country-led eye health systems.

This section assesses the extent to which the Programme has strengthened leadership and governance for eye health across participating Pacific countries. Within the WHO Health System Building Blocks framework, leadership and governance refers to the structures, relationships and processes that provide strategic direction, coordination, oversight, and accountability. For the Pacific Programme, this focuses on whether eye health is becoming more visible, better coordinated, and increasingly embedded within national health systems.

This section also examines progress towards the long-term outcome of more sustainable eye health systems, with eye care integrated into national policy, plans and budgets.

National coordination and planning are strengthening.

Over the last four years, eye health leadership and governance have strengthened through the development of National Eye Coordinators (NECs), national eye health plans and stronger Ministry engagement. Together, these mechanisms have increased the visibility of eye health within government systems, strengthened coordination and advocacy, and supported more structured planning and decision-making.

National Eye Coordinators are strengthening eye health leadership, coordination, and advocacy.

NECs act as a bridge between eye health priorities and wider health system planning. They coordinate implementation, support national eye health planning processes, monitor progress and advocate for eye health within budgeting, workforce, outreach, service delivery and procurement discussions. NECs also broker relationships between Ministries of Health, eye health professionals, training institutions and development partners, helping ensure that eye health priorities are reflected in broader health system decisions.

FHFNZ has supported NECs through technical advice and capability building, evidence use, including training in monitoring, advocacy, partnership approaches and GEDSI. These investments have helped strengthen local leadership capability and support the progressive integration of eye health within government systems.

> For the National Eye Coordinators, we've done some knowledge transfer and training on partnership approaches and uses of monitoring data. (FHFNZ)

An NEC or equivalent coordination function is now evident across six Pacific countries. The role has evolved differently across settings, reflecting local context and capability. Solomon Islands and Vanuatu now have government-funded NEC roles. However, these positions often encompass broader responsibilities than eye health alone. For example, in Vanuatu the role is combined with responsibility for ear, nose and throat (ENT) services and is located within the NCD Unit.

Tonga and Samoa have Ministry staff undertaking coordination functions supported by FHFNZ. In PNG, the NEC role is embedded within the National Department of Health and in Fiji the position operates

through Ministry-supported arrangements. A dedicated NEC role may not be feasible in smaller Pacific countries. However, a coordination function remains important for maintaining visibility of eye health and connecting planning with implementation.

National eye health planning has strengthened significantly over the partnership period.

The development and updating of national eye health plans through Ministry-led and collaborative planning processes has helped move eye health from a programme activity to a recognised health system priority.

These plans provide a framework for country-led priority setting, coordination and accountability, while supporting the integration of eye health within national policies, planning processes and budgets. Increasingly, national planning processes are helping shift decision-making from partner-supported activities towards greater country ownership and leadership.

The growing influence of NECs and the establishment of national eye health plans are closely linked. NECs have played an important role in developing, coordinating, and advancing national plans, helping translate strategic priorities into implementation and strengthening government ownership of eye health. The status of national eye health planning, coordination and governance maturity varies across countries (Table 5).

Table 5: National eye health planning, coordination, and governance maturity by country

Country	National Eye Health Plan	NEC funding	Governance maturity
Fiji	Eye Health Action Plan (2024–2026)	Ministry contract, FHFNZ-funded salary	Government-endorsed plan with emerging government investment and strengthening ownership
PNG	National Eye Health Strategic Plan (2025–2029)	WHO-linked role with FHFNZ-supported funding	National plan established, though integration into coordination and implementation mechanisms remains developing
Samoa	National Eye Care Plan (2024–2028)	Ministry staff with FHFNZ top-up allowance	Strong Ministry ownership with active implementation coordination
Solomon Islands	National Eye Health Strategic Plan (2026–2030)	Government funded	Integrated with government funding, HIS indicators, and eye health embedded in planning and reporting systems.
Vanuatu	National Eye Health Strategic Plan	Government funded	Eye health integrated into national planning and reporting systems
Tonga	National Eye Care Plan under review	Ministry staff with FHFNZ top-up allowance	Governance foundations developing with implementation arrangements still maturing

Governance maturity differs across countries, reflecting variations in leadership, institutional capacity, workforce depth, financing arrangements, and government ownership of eye health priorities. FHFNZ has influenced this trajectory through long-term investments in national eye health planning, workforce development, research, technical assistance, and NEC roles. These investments appear to have been directed towards countries and system areas requiring the greatest support and have strengthened governance capacity across the region. However, feedback from FHFNZ suggest that stronger early attention to government financing, institutional ownership, and integration into routine Ministry planning, budgeting, and accountability processes may have accelerated progress and reduced some of the variation observed between countries today.

Increasingly, evidence from RAABs, ECSAT assessments and programme monitoring is helping strengthen the visibility of eye health within government planning and decision-making processes. In Vanuatu, findings from the RAAB directly informed national planning and resulted in three eye health indicators being incorporated into the National Health Strategic Plan.

Country ownership is strengthening although progress remains uneven.

Pacific partners now have greater capability, leadership and influence than at the beginning of the partnership period. Investments in ophthalmologists, eye nurses, coordinators, educators and managers have strengthened local leadership across clinical practice, teaching, supervision, planning and regional engagement. Increasingly, decisions are being led by Pacific institutions and professionals rather than external partners.

Progress towards country ownership is evident across all countries, although the pace and depth of change vary considerably. Key enablers include long-term partnerships, strong NEC leadership, growing clinical leadership, the use of evidence to support decision-making and sustained efforts to integrate eye health within Ministry structures and planning processes.

However, progress remains constrained by broader system factors that sit largely beyond the Programme's direct influence. Ministries of Health continue to balance multiple competing priorities, health budgets remain constrained, and workforce, infrastructure and climate-related challenges affect the pace of change. As a result, ownership and sustainability are developing unevenly across countries.

Solomon Islands appears relatively advanced, with strong Ministry ownership, government-funded coordination and increasing budget visibility. Samoa is also advanced, with strong Ministry leadership and eye health integrated into planning and coordination processes. Fiji has strong technical capability and is working through questions of governance and institutional ownership. Tonga and Vanuatu are strengthening national leadership and ownership, although financing and workforce constraints continue to affect progress. PNG has made significant investments in planning, infrastructure and governance, although sustainability remains challenged by workforce shortages, financing pressures and continued reliance on partner support.

Accountability mechanisms are strengthening yet remain unevenly embedded.

As national eye health planning matures, the critical challenge becomes ensuring that plans are supported by clear decision-making authority, implementation responsibilities, monitoring, and accountability mechanisms. Progress is evident across the Region, although accountability systems remain at different stages of development.

Governance arrangements are strongest where eye health plans are linked to formal Ministry structures, named leadership roles, budget processes, steering committee decisions and national indicators. Examples include governance committees and Provincial Health Authority engagement in

PNG, Ministry-led planning in Solomon Islands and Vanuatu, and increasingly formalised governance arrangements in Fiji.

Regional platforms strengthen Pacific leadership and governance.

Leadership and governance are not solely national responsibilities. Many Pacific countries face common challenges associated with small populations, workforce shortages and geographic dispersion. Regional leadership and coordination therefore remain important components of sustainable eye health systems.

PacEYES has emerged as an important regional platform for professional leadership, peer learning and shared governance. PacEYES provides a space for Pacific eye health professionals to share experience, strengthen clinical practice, discuss common challenges and build a stronger Pacific eye health identity. The 2023 PacEYES conference brought together more than 120 stakeholders from nine Pacific countries, creating a forum for professional development, collaboration and discussion of regional priorities.

Stakeholders described PacEYES as an important platform for continuing professional development, leadership and coordination. FHFNZ continues to provide the backbone support that enables regional collaboration through coordination, convening, mentoring, technical advice and support for knowledge exchange. As PacEYES matures, it is increasingly contributing to professional standards, regional coordination, and shared approaches to quality and clinical practice across the Pacific. These functions are strengthening Pacific leadership while supporting greater consistency in clinical practice and governance across small and dispersed health systems.

Several stakeholders raised questions about the long-term sustainability of PacEYES. While the platform is highly valued, it requires ongoing support for coordination, convening and administrative support. Stakeholders identified a need to strengthen organisational capacity, broaden regional ownership, and establish more sustainable funding arrangements to ensure PacEYES can continue to evolve and operate effectively over time.

The shared vision for PacEYES to develop beyond a professional network into a stronger regional institution supporting workforce development, professional accreditation, research collaboration and knowledge sharing across the eye health sector. Stakeholders viewed these functions as important mechanisms for strengthening regional ownership, resilience and the long-term sustainability of Pacific eye health systems.

> [PacEYES] an important regional platform for continuing professional development, leadership, and coordination.

Evaluative judgement: Leadership and governance are strengthening; full country ownership is not yet embedded.

The MFAT–FHFNZ Outcomes Arrangement has made a credible contribution to strengthening leadership, coordination and governance across Pacific eye health systems. Progress is most evident through the establishment of NEC functions, national eye health plans, stronger Ministry engagement, growing clinical leadership and increasing use of evidence to inform planning and decision-making.

These developments have increased the visibility of eye health and strengthened its integration within national systems.

Progress towards country ownership is evident across all countries, although governance maturity varies. Solomon Islands and Samoa demonstrate the strongest levels of Ministry ownership and integration. Vanuatu has embedded eye health within national planning and reporting systems. Fiji and PNG have strengthened governance structures and planning arrangements, although questions of institutional ownership, implementation and accountability remain. Tonga has established important foundations, though governance arrangements continue to mature.

Regional leadership has also strengthened through PacEYES, which is supporting professional development, coordination and shared standards across the Pacific. Long-term sustainability will depend on stronger organisational capacity, broader regional ownership and sustainable funding arrangements.

Overall, leadership and governance foundations are substantially stronger than at the start of the partnership. The next challenge is embedding these gains through stronger accountability, implementation and country-led governance arrangements, particularly in PNG, Tonga and Fiji.

Financing: A sustainability constraint for Pacific eye health systems.

This section assesses whether the Pacific Programme is contributing to more sustainable financing of eye health across participating Pacific countries. In the WHO building blocks framework, health financing concerns how funds are raised, pooled and used to purchase health services, to improve service coverage and financial protection. For this evaluation, the key question is whether eye health costs are increasingly recognised, budgeted, shared and absorbed within national health systems.

The available finance evidence is relatively high-level and is drawn mainly from interviews, programme reporting and finance summaries, rather than detailed country-level financial data. The assessment therefore focuses on financing patterns, sustainability risks and emerging signs of country ownership, and not a detailed assessment of cost-effectiveness or value for money.

Eye health financing is transitioning, although external support remains essential.

FHFNZ and MFAT funding remain central to the functioning and development of Pacific eye health systems. External financing supports a wide range of inputs, including workforce training, scholarships, outreach, consumables, equipment, infrastructure, national planning, coordination roles and technical support. Without this external support, several countries would struggle to maintain current levels of eye health activity.

Over the last four years, signs of increased domestic financing are emerging across the Pacific:. Examples include:

- **Solomon Islands** has integrated eye health into government planning and reporting systems, established a government-funded NEC role, and increased government financing for coordination and implementation.
- **Samoa** funds workforce salaries and contributes to outreach costs, reflecting growing government ownership and co-financing.
- **PNG** is increasing Provincial Health Authority contributions to outreach, logistics and workforce positions, and has invested in the Pacific Centre for Eye Health. Long-term sustainability will depend on securing recurrent funding for operations, staffing and consumables.
- **Fiji** has strengthened government ownership of eye health. However, external support remains important for consumables, outreach and specialist services. Stakeholders highlighted the need for a dedicated eye health unit and budget line within the Ministry of Health.
- **Vanuatu and Tonga** are strengthening planning and coordination arrangements, although dedicated financing mechanisms remain underdeveloped.

Overall, the financing story is one of transition rather than transfer. Governments are increasingly recognising eye health as a planning and budget issue. However, most Pacific countries are not yet in a position to fully finance the recurrent costs of eye health services without continued partner support.

Sustainability depends absorbing recurrent costs.

The key financing challenge is whether the recurrent costs required to keep eye care functioning are visible, budgeted for and increasingly absorbed by national systems. The evidence indicates that training clinicians is only part of the issue for sustainable eye health in the Region. Below are the four key recurrent cost areas.

Workforce sustainability depends on funded positions and workforce retention.

FHFNZ and MFAT funding supports scholarships, tuition, equipment, travel, supervision and student support. This investment is highly valued and has helped build a stronger Pacific eye health workforce. However, training only translates into sustainable service delivery when graduates return to funded positions with access to equipment, consumables, supervision and career pathways. In several countries, government absorption of trained staff into funded roles remains uncertain. As a result, the sustainability challenge extends beyond producing qualified clinicians to ensuring health systems can recruit, retain and support them throughout their careers.

Outreach remains essential although costly to sustain.

Outreach is critical for reaching rural, remote and outer-island communities, and for reducing patient travel, accommodation and indirect costs. However, outreach requires transport, fuel, accommodation, logistics, equipment movement and staff time. Rising fuel, transport and operational costs place pressure on delivery. In PNG, outreach was described as increasingly expensive, with efforts underway to encourage PHAs to share costs. Across geographically dispersed countries, long-term sustainability will depend on whether outreach becomes a routine part of government, hospital or provincial budgets, rather than remaining dependent on flexible partner funding.

Consumables remain outside routine financing systems.

In PNG and other Pacific countries, ophthalmic medicines, surgical supplies, lenses, eye drops and diagnostic consumables are not included in national procurement systems. Pacific countries therefore continue to rely on FHFNZ and external suppliers for consumables. This creates a direct sustainability risk. Investments in workforce development and infrastructure cannot be fully realised if clinicians do not have the consumables needed to practice. The recently endorsed PNG National Eye Health Strategic Plan provides an opportunity to integrate ophthalmic consumables into national procurement and budgeting processes.

Infrastructure investments create ongoing financing obligations.

New and upgraded facilities require funding for staffing, utilities, maintenance, equipment replacement, infection prevention systems and biomedical support. In PNG, the Centre for Eye Health is an example of investment designed around eventual government ownership. However, the long-term sustainability of this investment will depend on whether capital expenditure is matched by adequate recurrent funding, operational planning and long-term stewardship from government and local institutions.

Flexible funding supports integrated system strengthening.

External funding appears to generate the greatest value when it supports interconnected investments across workforce, outreach, service delivery, equipment, planning and evidence generation. Workforce development supports service delivery and outreach. Service delivery generates data and evidence. Evidence informs planning, advocacy and future investment decisions.

The flexibility of the MFAT–FHFNZ funding model allows resources to be directed towards changing country needs and priorities. This is particularly important in small and geographically dispersed Pacific settings where service requirements can change rapidly.

Financing arrangements influence both equity and access.

Financing arrangements directly affect who can access eye care. Free or subsidised services, outreach, transport support and local workforce development help reduce barriers for rural, remote and low-income populations.

Outreach is particularly important because it reduces patient travel, accommodation and other indirect costs. Despite this, financial barriers remain. Many people still face significant costs associated with travel, accommodation and lost income. Stakeholders therefore emphasised caution with future cost-sharing or cost-recovery arrangements to ensure that affordability and equitable access are not undermined.

A recurring tension exists between equity and sustainability. Fee-free services improve access and often require ongoing subsidy. Cost-recovery approaches may support service continuity and can create barriers for the populations most in need. Examples from PNG and Fiji illustrate this trade-off.

The transition to sustainable financing remains a key risk.

Financing is the clearest test of whether eye health system strengthening is becoming institutionalised. The Programme has helped build workforce capacity, service platforms, planning systems and evidence for decision-making. However, these gains remain vulnerable where recurrent costs are not routinely funded through government systems.

The main financing risks relate to workforce absorption, outreach financing, consumables, equipment maintenance and infrastructure operations. These costs are increasingly recognised within national planning processes. They are not yet consistently reflected in routine government budgets. Strengthening long-term sustainability will require more explicit transition planning, clearer financing responsibilities between governments and partners, and ongoing monitoring of domestic financing contributions.

Evaluative judgement: Financing remains the weakest WHO building block and the main sustainability risk.

The Pacific Programme has strengthened the foundations for more sustainable eye health financing through investments in workforce development, outreach, infrastructure, planning and coordination. It has also increased the visibility of eye health within government systems and supported early signs of greater country ownership and co-financing. However, external funding remains essential across most countries and continues to underpin critical elements of service delivery and system strengthening.

Financing remains the Programme's greatest sustainability challenge. Progress is strongest in planning, coordination and government recognition of eye health priorities. Progress is weaker in the absorption of recurrent costs, including workforce positions, outreach, consumables, equipment maintenance and infrastructure operations. Sustaining gains will require greater government financing, clearer transition arrangements and, in some countries, deliberate shared financing models that balance sustainability with equitable access to care.

DAC judgements & future directions

Overarching DAC evaluative judgements

This section synthesises the evaluation findings and assesses the Pacific Programme against the OECD DAC criteria. The assessment draws on evidence across the WHO Health System Building Blocks and considers the Programme's contribution towards the MFAT–FHFNZ partnership outcomes. Appendix 5 contains the performance standard ratings used to assess the Programme against the DAC criteria.

The Programme has strengthened Pacific eye health systems.

Overall, the Programme has made a substantial contribution to strengthening Pacific eye health systems. As shown in Table 6, the Pacific Programme is assessed as highly relevant, coherent and effective, with clear evidence of substantial contributions to strengthening Pacific eye health systems. Sustainability is progressing but remains uneven as countries continue the transition towards greater ownership, financing and integration of eye health within national systems. Future success will depend on strengthening country financing, workforce deployment, governance, and system capacity.

Strong evidence exists of system-level change, including strengthened workforce capacity, service delivery and governance. Evidence that these changes have translated into population-level improvements in eye health, such as reductions in avoidable blindness and vision impairment, is still emerging and cannot yet be reliably assessed.

Table 6: The assessment of the Programme against the DAC criteria

DAC criterion	Rating	Rationale
Relevance	High	Strong partnership quality with MFAT, country and regional partners Strong alignment with Regional Pacific eye health needs and national priorities Addressing workforce shortages and building country and regional eye health workforce with high representation of women Contributing to service delivery and improving access to eye health care for people living remotely.
Coherence	High	Demonstrates a coherent systems-strengthening approach. Investments in workforce development, service delivery, governance, information systems, infrastructure, outreach and partnerships are mutually reinforcing and contribute to shared regional and national objectives.
Effectiveness	High	Achieved substantial results across workforce development, service delivery, leadership, governance, and evidence use. Strong evidence demonstrates increased workforce capacity, expanded service access, improved quality and safety, and strengthened country ownership of eye health services.

DAC criterion	Rating	Rationale
Efficiency	Moderate	Flexible funding and integrated delivery add value to maximise results across geographically dispersed contexts. Efficiency is constrained by high outreach costs, small populations, workforce shortages, infrastructure limitations, and the logistical challenges of delivering services across Pacific Island nations.
Impact	Cannot be assessed	Strong evidence exists of system-level change, including strengthened workforce capacity, service delivery and governance. However, the current evidence base does not yet demonstrate whether these changes have translated into population-level improvements in eye health, such as reductions in avoidable blindness and vision impairment. Impact therefore cannot yet be reliably assessed. A stronger focus on measuring population-level outcomes in future arrangements will help determine the longer-term effects of these investments.
Sustainability	Moderate	Significant progress has been made in workforce development, institutional strengthening, leadership and country ownership. Long-term sustainability remains dependent on continued investment, workforce absorption, procurement systems, infrastructure, equipment maintenance and the integration of eye health into national planning and financing systems.

GEDSI: Moderate contribution to equitable access and participation

The Programme demonstrates a strong commitment to equity through outreach delivery, workforce development and efforts to reach underserved populations. GEDSI considerations are increasingly recognised across Programme design, planning and implementation. However, evidence of outcomes for different population groups remains limited, making it difficult to assess the extent to which benefits are being experienced equitably across gender, disability, and other population groups.

Future efforts should strengthen equity monitoring and continue targeting remote, low-income, disability-affected and other underserved populations to ensure gains in access are shared equitably.

Future directions for the next Outcomes Arrangement

The evaluation demonstrates the Programme has successfully established many foundations of a stronger Pacific eye health system. The next Outcome Arrangement phase should focus on consolidating these gains by strengthening country ownership, sustainability and system resilience.

Priority recommendations for the next Outcomes Arrangement

Recommendation 1: Strengthen the pathway to sustainable Pacific ownership.

Greater emphasis is needed on strengthening national eye health governance, accountability, financing and implementation. Priority areas include workforce absorption, recurrent financing, national eye health coordination functions, and embedding eye health within Ministry planning, budgeting and reporting processes.

Future investment should reflect the different stages of system maturity across Pacific countries. Fiji and Papua New Guinea should be strengthened as regional centres of excellence for training, clinical mentorship and specialised services. Smaller Pacific countries should be supported through satellite training models, outreach networks and targeted system-strengthening initiatives.

Country needs differ. Solomon Islands and Samoa are focused on consolidating government ownership, financing and sustainability. Fiji and PNG need greater attention on institutional ownership, workforce absorption and recurrent financing to sustain major training and service-delivery investments. Tonga and Vanuatu need continued support to strengthen governance, workforce capacity and financing foundations. Tailoring support to these differing needs will help accelerate progress towards sustainable country ownership across the region.

Recommendation 2: Sustain and strengthen the Pacific eye health workforce.

Continue supporting workforce development with an increasing focus on workforce retention, deployment, supervision, succession planning and advanced clinical capability. This includes strengthening pathways for specialist and sub-specialist development, satellite training models, and the systems required for trained personnel to practise effectively and contribute to sustainable service delivery.

Recommendation 3: Strengthen the systems that underpin sustainable eye care.

Strengthen the enabling systems required to sustain quality eye care, including procurement and supply chains, equipment maintenance, infrastructure planning, clinical governance, information systems, and financing arrangements for outreach and recurrent service costs.

Recommendation 4: Demonstrate long-term outcomes

Greater emphasis is also needed on quality assurance, routine outcome monitoring, research, and evaluation to support continuous improvement, inform decision-making, and assess progress towards improved eye health outcomes and reductions in avoidable blindness and vision impairment.

Considerations for the next Outcomes Arrangement

Future investment may also consider opportunities to sustain successful approaches, grow system capability and support long-term Pacific ownership of eye health. These considerations are intended to inform future programme design rather than represent priority recommendations. They also recognise that future investment decisions will involve trade-offs, requiring resources to be targeted towards the areas most likely to strengthen long-term sustainability, country ownership and equitable access to eye care.

Sustain what works.

The evaluation identified several components of the Programme that contribute to strengthening Pacific eye health systems and are important foundations for long-term development. These investments are mutually reinforcing, supporting workforce capability, service delivery, leadership, planning and regional collaboration. Maintaining the following foundations will be important for sustaining progress towards resilient, locally led, and sustainable eye health systems:

- Workforce development pathways for ophthalmologists, eye care nurses and other eye health professionals.
- The integrated model linking training, supervision, equipment, outreach, and service delivery and health information.
- Outreach and decentralised service delivery models.
- National Eye Coordinators and national eye health planning processes.
- Evidence-informed planning, including RAABs, ECSATs, research and country-led planning processes.
- Regional learning, professional development and Pacific leadership.

Grow system capability and resilience.

As Pacific eye health systems mature, the focus also needs to be about strengthening quality, capability, and long-term resilience. The following opportunities exist to build on current investments by strengthening the systems, leadership and evidence needed to support sustainable and locally led eye care.

- Clinical governance, quality assurance and continuous quality improvement systems.
- Satellite and in-country training models.
- Advanced clinical and sub-speciality training.
- Country capability in monitoring, evaluation, research, and the use of evidence.
- More systematic integration of GEDSI considerations into planning, implementation, monitoring, and reporting.
- Routine information systems, patient tracking, workforce intelligence and outcome monitoring.

Enable sustainable Pacific ownership.

The next challenge is ensuring these gains are increasingly embedded within national systems and led by Pacific institutions. This involves strengthening government ownership of planning, financing, implementation, and accountability. The Outcome Arrangements need to influence and support countries to progressively assume greater responsibility for the systems, workforce and resources needed to sustain quality eye care over the long term.

Demonstrating contribution to long-term outcomes and impact

Greater emphasis is needed on measuring whether the system-level gains achieved through the Programme are translating into improved eye health outcomes and reductions in avoidable blindness and vision impairment. This includes strengthening outcome measurement, monitoring and evidence generation across the impact pathway. The next Outcomes Arrangement should support the collection and use of data needed to assess progress towards reducing avoidable blindness and vision impairment across the Pacific.

Future evidence generation could include a combination of population-level, service-level and system-level indicators. Potential measures include avoidable blindness and vision impairment prevalence, cataract surgical coverage, effective cataract surgical coverage, workforce availability and distribution, service utilisation, outreach coverage, referral completion, waiting times, quality of care indicators and the integration of eye health into national planning and financing systems.

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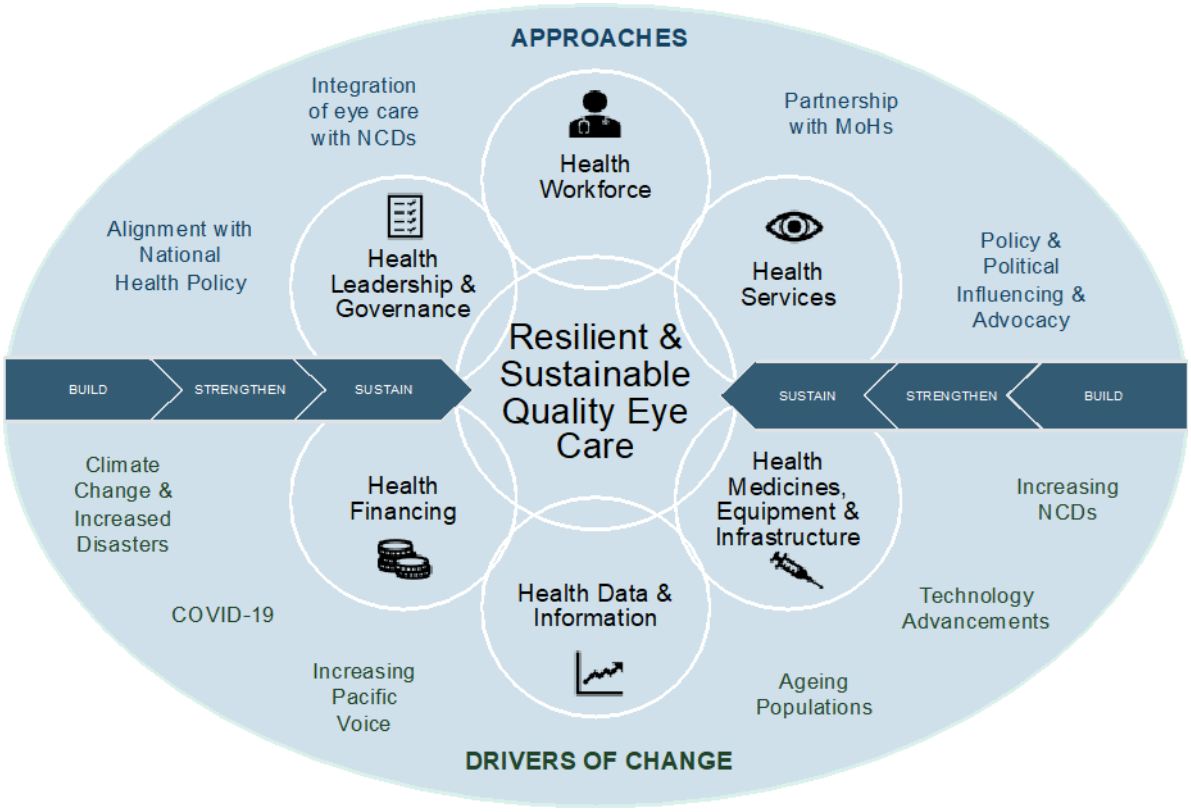
Appendix 1: High-level theory of change (from the MERL Framework)

The theory of change highlights the country's health system change process required to enable resilient, sustainable, high-quality eye care. The change is driven by Pacific Governments and multiple in-country stakeholders.

The theory of change shows the six WHO health system building blocks, the three phases, the key drivers of change, and the approaches to integration and influence.



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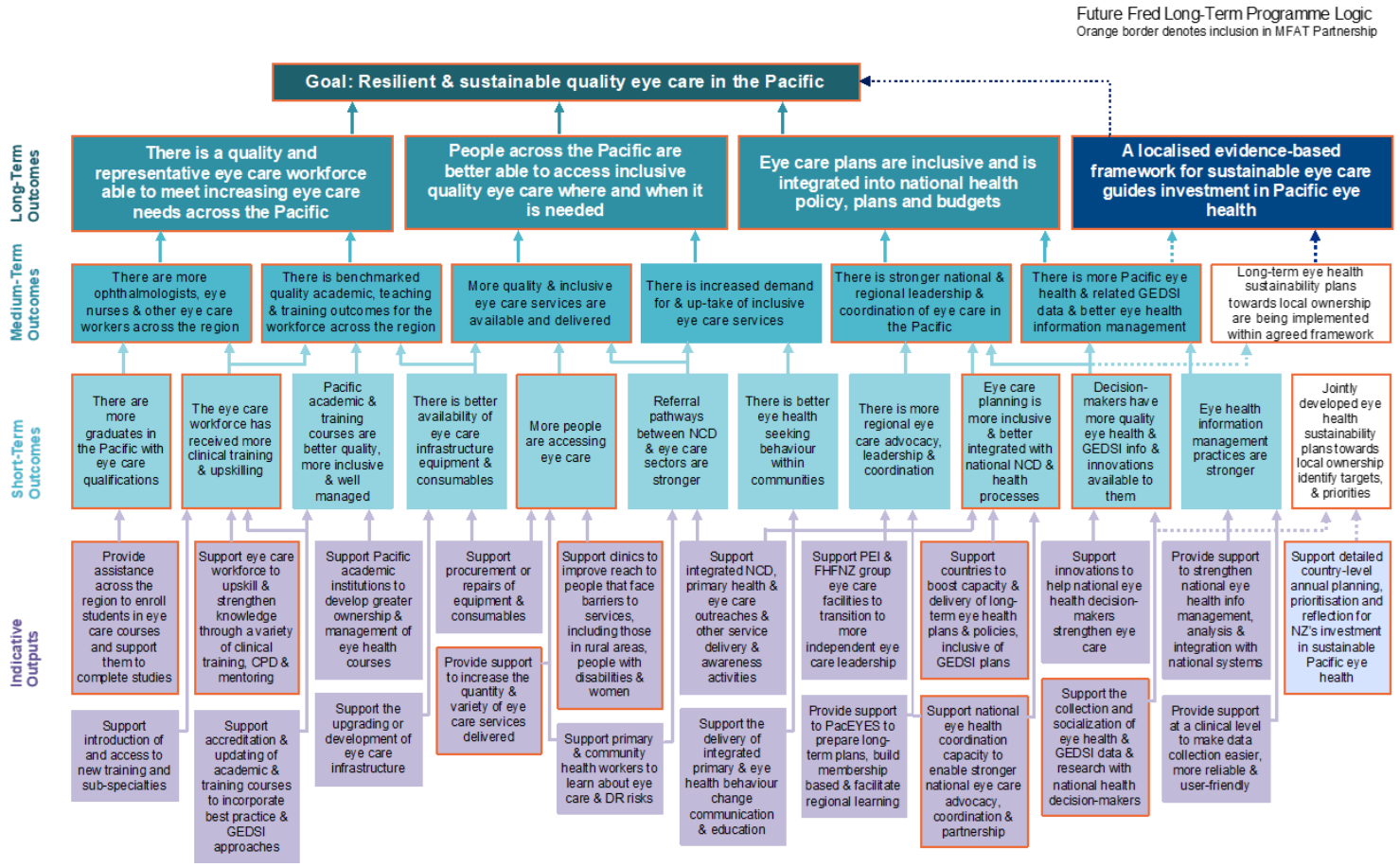
Appendix 2: Programme Logic (from the MERL Framework)



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Appendix 3: Indicator table (from the MERL Framework)

MFAT Partnership Impact Statements	
Indicative High-Level MFAT Partnership Impact Statements	**Relevant Indicators from the RMT**
The MFAT-FHFNZ partnership has enabled Pacific governments to recover and strengthen their eye care from COVID-19 impacts	# countries with good in-country clinical training and supervision capacity
	# / proportion of countries that reduce reported COVID-19 backlog levels
The MFAT-FHFNZ partnership has supported the strengthening of integrated people-centred eye care across the Pacific, reducing the burden of avoidable and treatable blindness and vision impairment	# ophthalmologists and eye nurses that are supported to succeed at their studies
	# countries with increased service delivery targeted at GEDSI populations & remote areas
	# eye care personnel that have accessed clinical training and support
The MFAT-FHFNZ partnership has enabled Pacific governments to better understand their eye health needs and monitor progress towards the SDGs, in particular universal health coverage (SDG 3)	# countries that are on track to meeting their eye care workforce targets
	# countries with dedicated eye health coordination and/or planning capacity
	# countries with more GEDSI-inclusive eye health related information available to decision-makers

Outcome Area 1: Workforce Training and Academic Support				
Long-Term Outcome 1: There is a quality eye care workforce able to meet increasing eye care needs across the Pacific				
Outcome Level	**Outcome Statement**	**Indicative MFAT Indicator[3]**	**Baseline**	**Indicative MFAT Targets[4]**
Medium-Term Outcome	There are more ophthalmologists, eye care nurses and other eye care workers across the region	# countries that are on track to meeting their eye care workforce targets	0	5 / 70% (5 of the following: Fiji, PNG, Vanuatu, Samoa, Tuvalu, Nauru, Kiribati
Short-Term Outcome	There are more graduates in the Pacific with eye care qualifications	# ophthalmologists and eye nurses that are supported to succeed at their studies (MFAT supported)	0	TBC at country level

[3] Indicators are for activities completed with MFAT funding only or where MFAT funding makes a significant contribution to it.
[4] Country level indicators will be further developed and refined during detailed year 1 planning with countries

Medium-Term Outcome	There is benchmarked quality academic, teaching and training opportunities for the workforce across the region	# countries with good in-country clinical training and supervision capacity	2 (Fiji & Solomon Islands)	6 (Tonga, Samoa, Kiribati, Vanuatu, Fiji & Solomon Islands)
Short-Term Outcome	The eye care workforce has received more clinical training and upskilling	# eye care personnel that have accessed clinical training and support	0	TBC at country level
Outcome Area 2: Service Delivery & Universal Access				
Long-Term Outcome 2: People across the Pacific are better able to access inclusive quality eye care where and when it is needed				
Medium-Term Outcome	**Short-Term Outcome**	**Indicative MFAT Indicator**	**Baseline**	**Indicative MFAT Targets**
Medium-Term Outcome	More quality and inclusive eye care services are available and delivered	# countries with increased service delivery targeted at GEDSI populations & remote areas	0	5 / 70% (5 of following: Fiji, Tonga, Samoa, Solomon Islands, PNG, Kiribati, Vanuatu)
		# / proportion of countries that reduce reported COVID-19 backlog levels	0	5 / 70% (5 of the following: Fiji, PNG, Vanuatu, Samoa, Tuvalu, Nauru, Kiribati)
Short-Term Outcome	More people are accessing eye care	# regional and national outreach visits to reduce COVID-19 backlogs completed	0	TBC at country level
		# countries/clinics that participate in training on clinical GEDSI approaches	0	5 / 70% (5 of following: Fiji, Tonga, Samoa, Solomon Islands, PNG, Kiribati, Vanuatu)
Outcome Area 3: Information, Policy & Planning				
Long-Term Outcome 3: Eye care is integrated into national health policy, plans and budgets				
Medium-Term Outcome	**Short-Term Outcome**	**Indicative MFAT Indicator**	**Baseline**	**Indicative MFAT Targets**
Medium-Term Outcome	There is stronger national and regional leadership and coordination of eye care in the Pacific	# countries with a national eye health plan	1 (Solomon Islands)	TBC at country level 7 / 75% (7 of following: Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu, PNG, Tuvalu, Nauru)
Short-Term Outcome	Eye care planning and coordination is more inclusive and better aligned with national health processes	# countries with dedicated eye health coordination and/or planning capacity	2 (PNG & Solomon Islands)	TBC at country level. 5 / 70% (5 of following: Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu, PNG)

Medium-Term Outcome	There is more Pacific eye health data and better eye health information management	# countries using GEDSI-inclusive eye health related information in decision-making	0 (PNG)	5 / 70% (5 of following: Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu, PNG)
Short-Term Outcome	Decision-makers have more quality health & GEDSI information and innovations available to them	# GEDSI eye health assessments completed	1 (PNG)	6 (Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu)
MFAT Partnership Outcome: Supporting Sustainable and Local Eye Health				
MFAT Partnership Long-Term Outcome: A localised evidence-based framework for sustainable eye health guides investment in Pacific eye health				
Medium-Term Outcome	**Short-Term Outcome**	**Indicative MFAT Indicator**	**Baseline**	**Indicative MFAT Targets**
Medium-Term Outcome	Long-term eye health sustainability plans towards local ownership are being implemented within agreed frameworks	# countries using eye health sustainability plans to guide national eye health planning and implementation	1 (Solomon Islands)	5 / 56% (5 of following: Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu, PNG, Tuvalu and Nauru)
Short-Term Outcome	Jointly developed eye health sustainability plans towards local ownership identify targets and priorities	# countries that have developed eye health sustainability plans	1 (Solomon Islands)	7 / 78% (7 of following: Fiji, Samoa, Tonga, Kiribati, Solomon Islands, Vanuatu, PNG, Tuvalu and Nauru)
Programming and Partnership Approaches				
Focus Area	**Indicative Activity**		**Indicative MFAT Indicator**	
Adaptive learning	Undertake annual reflection and planning meetings and work-planning internally and with partners		Annual MFAT work-plans identify key partnership and programming lessons and adaptations	
Supporting local leadership	Support annual planning with country partners providing opportunities for them to understand and identify their own priorities and targets		# countries taking the lead in determining annual work-plan targets and priorities	
Partnership approaches	Support development of contextualised country-level workplans and use these during partner check-ins, reflection and planning		# countries that use agreed country-level annual work-plans to monitor programming and partnership progress	
	Undertake annual partnership check-in meetings and/or surveys (complementing annual reflection & planning with partners)		# countries that report satisfaction with the FHFNZ partnership and partnership approach	

Appendix 4: Participant list

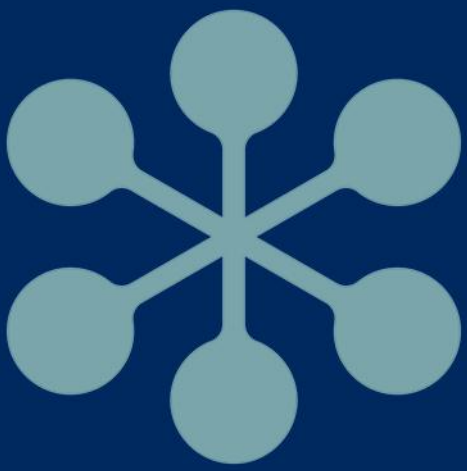
Country	Participant name
Aotearoa New Zealand	Dr Audrey Aumua, Peter Raynes, Elizabeth Wood, Iris Wainiqolo, Jenita Prakash, Karen Humphries -Waa, Komal Ram, Kyle Da Silva, Sharon Orr, Adele Harmer
Papua New Guinea	Alyanna Kolma, Ambrose Kwaramb, Ben Zuvani, Charisma Blain, Dr Brian Sasingian, Dr David Pahau, Dr Jambi Garap, Dr Lissing Hames, Dr Martin Daimen, Dr Mulusew Melesse, Dr Robert Ko, George Gani, Isabella Mou, Karen Watromu, Karika Lynne Anea, Lydia Seta, Meg Williams, Nasomai Pokam, Priscilla Sine Mal Peter, Professor Fr Philip Gibbs and two support people, Professor Temple, Sr Getruth Bare
Fiji	Ashreeta Lingam, Dr Luke Nasedra, Dr Mundi Qalo, Dr Nola Pikacha, Dr Varanisese R Naviri, Kirti Prasad, Professor Jayantha Weerasinghe, Raijieli Bulatale, Sereima Vatuvatu, Dr Pius, Dr Elizabeth
Samoa	Dr Lucilla Ah-Ching Sefo, Dr Glenn Fatupaito, Caroline Auva'a and 7 nurses
Solomon Islands	Dr John Szetu, Kaitu Aisake
Tonga	Dr Duke Mataka
Vanuatu	Danstan Tate, Dr Andronico Ly

Appendix 5: Performance standard ratings

Table 7 summarises the performance standard ratings used to assess the Programme against the DAC criteria. Ratings reflect both the extent of progress achieved and the degree to which outcomes appear likely to be sustained.

Table 7: The definitions of the performance standard ratings

Rating	Definition
High	Strong and consistent evidence that the Programme is achieving intended outcomes and making a substantial contribution to system strengthening. Achievements are evident across most countries and domains, with only minor limitations or risks.
Moderate	Evidence demonstrates meaningful progress and positive contribution towards intended outcomes, although achievements are uneven across countries or domains, and important constraints, gaps or risks remain. Further investment or action is needed to fully realise outcomes.
At Risk	Limited or fragile progress towards intended outcomes. Significant constraints, sustainability concerns, implementation challenges or external risks threaten the achievement or maintenance of results. Without corrective action, gains may not be sustained.
Cannot be Rated	Insufficient evidence is available to make a credible judgement, or outcomes are expected to occur over a longer timeframe and cannot yet be reliably assessed. Evidence may suggest positive contribution, but attribution, extent of change or long-term effects cannot yet be demonstrated.



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