



Manual of Procedures

Refractive Error
Among Children (REACH)



FOREWORD

The magnitude of the problem of uncorrected refractive error (URE) in children is well documented, and so is the solution – a simple pair of spectacles. If children in need of spectacles don't have it in time, their performance in school may suffer and may lead to school dropout. Socially, due to their impaired vision, they are bullied and excluded by their peers. The lack of education and social exclusion leads to limited employment opportunities, making them dependent on others for their daily needs. So, lack of spectacles for children with significant visual impairment due to URE is likely to affect their educational and career choices and may have a significant impact on their ability to support themselves and their family in future.



Dr. Rishi Raj Borah
Country Director, Orbis India

However, the story can be turned around with a pair of spectacles. With spectacles, they can have a chance to flourish at school, complete their education, go on to pursue a career and earn a living - ending that vicious cycle of poverty. Better vision allows them more opportunities for social engagement and sports too, allowing them to enjoy their childhood, remain independent and confident, and go on to lead a full life.

Recognizing this potential, Orbis launched REACH (Refractive Error Among Children) Program to address and cater to the issue of refractive error, the largest single cause of visual impairment. We recognized that schools can provide opportunities to promote eye health education through children to their peers, friends and family. In addition, support from teachers can improve children's and parents' understanding of issues such as early identification of refractive error, the importance of error correction and compliance with spectacle wear.

Initiated In 2016, REACH program aimed at screening school going children, referring children with surgical eye conditions to base hospital and most importantly, conducting regular compliance checks for children who are given spectacles. REACH also engaged school teachers for both screening of children and compliance checks. Students, identified as Vision Ambassadors were also involved in identifying children with refractive error, advocate for the use of spectacles among peers, and help overcome taboo on use of spectacles. On completion of REACH Phase 1, we share this Manual of Procedures to capture the knowledge that has been gained by all implementing partners and Orbis. The manual makes this knowledge available to users for the benefit of our children and the future of our country.

Dr. Rishi Raj Borah
On behalf of Orbis India Team

TABLE OF CONTENTS

Foreword

01. Genesis of REACH Program.....	1
02. Background.....	3
2.1 What is Refractive Error (RE).....	3
2.2 Types of Refractive error.....	4
2.3 Prevalence estimates - India.....	5
2.4 Prevalence estimates - Global.....	5
2.5 Importance of early identification.....	6
2.6 Uncorrected RE and its effect on child development.....	7
03. Program Aim and Objectives.....	8
04. The REACH Process - An Overview.....	9
05. Program Planning.....	10
5.1 Project area.....	10
5.2 Target setting.....	11
5.3 Resource planning.....	11
5.4 Information Education and Communication (IEC) planning.....	15
5.5 Approvals.....	19
06. Initiation.....	20
6.1 Stakeholder engagement.....	20
6.2 HR recruitment.....	21
6.3 Role mapping and Team Training.....	22
6.4 REACHSoft deployment and training.....	24
6.5 Equipment maintenance and care - medical & IT	25
6.6 Vehicle log.....	25
6.7 IEC consolidation.....	25
07. Project Implementation.....	29
7.1 Prepare.....	29
7.2 Deliver.....	31
08. Consolidate.....	59
8.1 Compliance.....	59
8.2 Annual follow-up.....	63

09. Child Protection Policy.....	65
9.1 Purpose and Overview.....	65
9.2 Definitions.....	66
9.3 Working with children.....	67
9.4 Communication and Child Protection Guidelines.....	68
9.5 Media Consent Form & Photography Release Form.....	70
10. Monitoring and Evaluation.....	71
11. Project Sustainability.....	76
11.1 Financial sustainability.....	76
11.2 Building a strong referral linkage through multi stakeholder engagement.....	77
11.3 Schemes and Programs to be leveraged.....	77
12. Annexure.....	79

01

GENESIS OF REACH PROGRAM

School eye screening is not new to India and has been undertaken for decades by various organizations across the country. However, the problem of uncorrected refractive error (URE) in the school-going age group remains a significant problem. Some of the challenges in existing school eye health programs include:

- No provision for annual vision screening to detect new cases
- No system in place for follow-up of children already identified with URE
- Lack of a mechanism to measure and promote compliance with spectacle wear; and
- Absence of integration with other school health programs or activities.

Like any public health issue, it is extremely helpful to have reliable data to facilitate planning of the intervention. It would be expected that considering the vast amount of school screening that has been conducted over time in India, there would be rich information available about the problem of URE in children in the country. However, this is not the case as organizations involved in school screening have conducted their work in a manner which best suits their requirements and capacity. The end result is that much work has been undertaken but due to the unique processes adopted by each implementing agency/organization, the scope for application of the data elsewhere may be limited.

The evident need for a standardized, comprehensive approach to school eye health was the trigger for development of REACH program, funded generously by the Qatar Fund for Development. REACH is a collaborative initiative in which Orbis and partners have worked together to arrive at common processes and standards which would drive the implementation of a large school eye health initiative. REACH was developed with a few key concepts in mind:

1. Many children need comprehensive eye examination, including cycloplegic refraction
2. Service delivery activities should be undertaken by trained teams in liaison with teachers to promote good school eye health practices
3. School eye screening should link with a system of follow up which aims to maximise compliance with spectacle wear
4. School eye health should occur annually to ensure that children who need care have ongoing access to it
5. Digital data capture facilitates improved planning, implementation, quality control and further analysis. REACH is addressing this requirement with dedicated software, REACHSoft, which is described in more detail later (refer section 6.1.4) in this manual
6. The school eye health program should be standardized across key areas such as clinical guidelines, processes, hardware, and software

In addition to the above-mentioned points, it is imperative that all activities are conducted keeping children at the forefront. The behavior of team members, the environment around service delivery activities, educational material and counselling should all be 'child-friendly'. Simple things such as allowing children to choose the style and color of their spectacles empowers them and encourages them to take ownership and care of their spectacles. It is also mandatory to have a comprehensive child protection policy to provide clear guidelines to team members ensuring a safe environment for children.

¹ Bruce A et al. Impact of visual acuity on developing literacy at age 4-5 years: a cohort-nested cross-sectional study. *BMJ Open*. 2016;6(2):e010434.

TIMELINE

SEPTEMBER

Her Royal Highness The Countess of Wessex visited Orbis Flying Eye Hospital in Kolkata and witnessed Orbis's work first hand.

In support of Orbis's initiatives, HRH travelled to Doha.

JULY

QCV REACH Partner Consultation

July 02, 2016, Gurgaon
To review progress till date, discuss launch activities, schedules and other timelines.

QCV REACH Project Launches

HV Desai Eye Hospital

July 06-07, 2016, Pune

VMA Netra Niramay Niketan

July 17, 2016, Kolkata

Sadguru Netra Chikitsalaya

July 28, 2016, Chitrakoot

APRIL

QCV REACH Partner Consultation

April 04-19, 2016 Gurgaon and Chennai
To finalize detailed project plans and budgets with REACH partners.

REACH Research Workshop

April 10, 2016, Gurgaon
To identify topics and modalities for conducting research related to refractive errors in children.

JUNE
REACH Phase i

IMPLEMENTATION



OCTOBER

Signing of agreement between QFFD & Orbis marking the formal launch of Qatar creating Vision Initiative. reception at Buckingham Palace.

Orbis India Internal Workshops in Gurgaon

To review initial proposal, develop program options

JANUARY

QCV REACH Partner Consultation

January 11-13, 2016, Gurgaon
All REACH partners met together at the Orbis India Office to develop the common guidelines and initiate the development of individual project plans and budgets.

AUGUST

Partner Agreements

Formal agreement signed with all REACH Partners.

AUGUST

QCV REACH Project Launches

Sankara Nethralaya
August 15, 2016

SEPTEMBER

QCV REACH Project Launches

Little Flower Hospital
September 23, 2016

Project Orientation

Project teams at all REACH partners oriented on project plan and activities by Orbis India team.

02 BACKGROUND

2.1 What is Refractive Error (RE)

RE is an optical defect of the eye in which the curvature of the cornea and lens brings light to a focus in front of or behind but not on the retina. As a result, the retinal image is blurred. The extent of the focusing error is known as the refractive error and the optical correction required to bring the focus onto the retina is known as refractive correction.

Normal



Myopia



Hyperopia



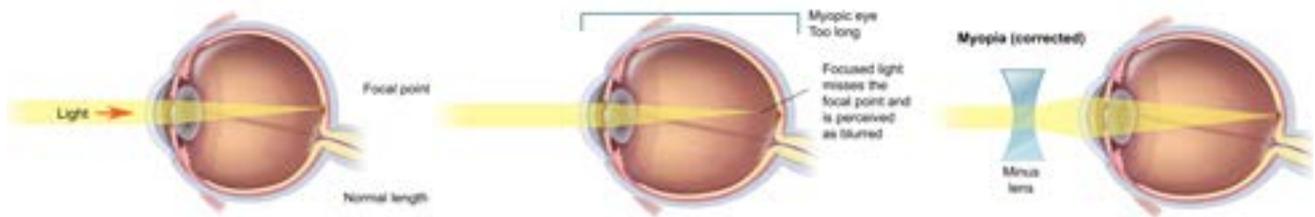
Astigmatism



2.2 Types of Refractive error

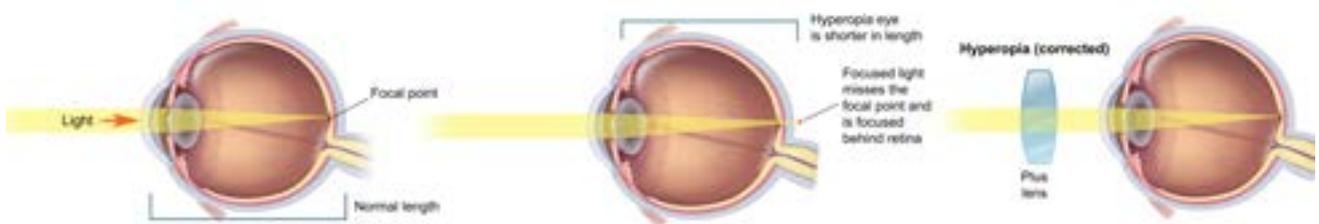
Myopia or short sightedness:

In this condition, the light rays are focussed in front of the retina and can be focussed on the retina using a concave lens (a minus or negative refractive correction). In myopia, uncorrected near vision is generally quite clear but uncorrected distance vision is blurred.



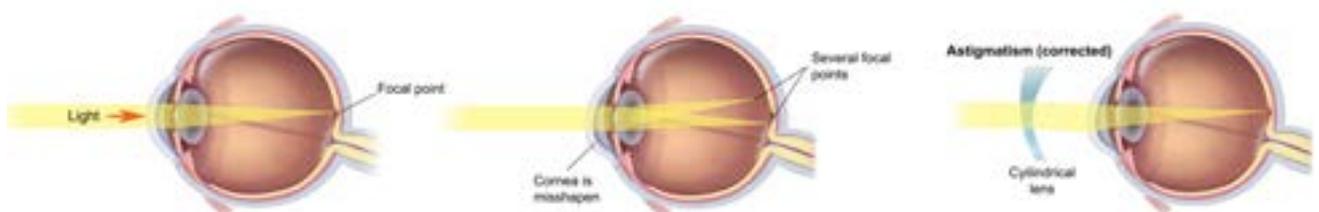
Hyperopia or long (far) sightedness:

In this condition, the light rays aim for a focal point behind the retina and can be focused on the retina using a convex lens (plus or positive refractive correction). In hyperopia, uncorrected distance vision is generally less blurred than near vision.



Astigmatism:

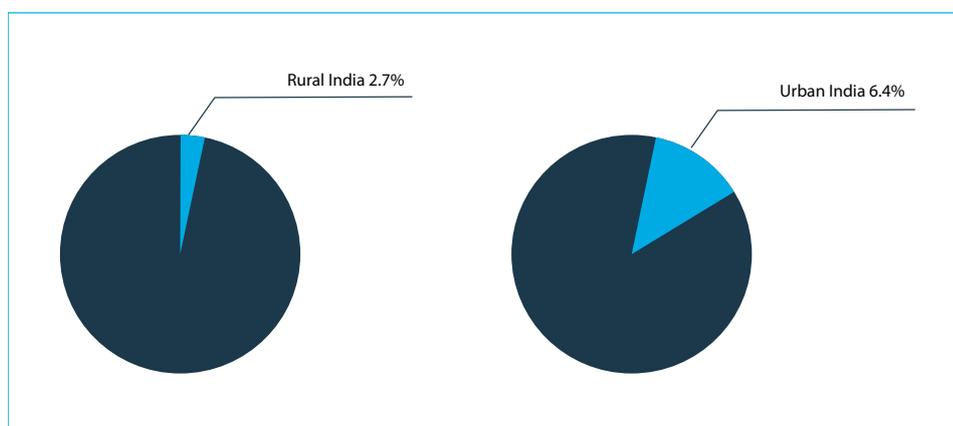
An irregularly shaped cornea or lens results in Astigmatism. In this case, light may be imaged in front of or behind the retina (myopic or hyperopic astigmatism respectively) but forms two focal points instead of one. For the image to be focused on the retina, two refractive corrections are required within the one lens. A detailed examination by a qualified eye health professional or an autorefractor can reveal the presence of astigmatism and the power of lens required to correct this.



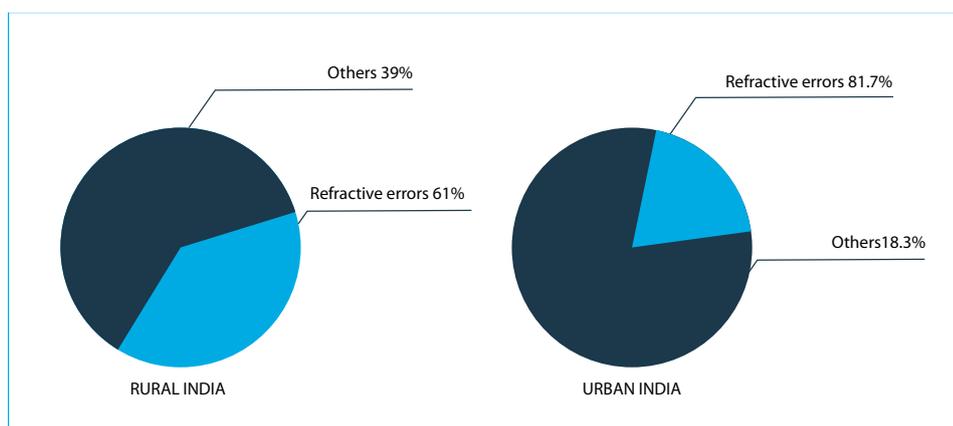
2.3 Prevalence estimates - India

Elimination of avoidable blindness and visual impairment in children due to uncorrected refractive error (URE) is a major objective of VISION 2020: The Right to Sight – A joint global initiative of the World Health Organisation (WHO) and International Agency for Prevention of Blindness (IAPB). Uncorrected refractive error remains the largest cause of visual impairment among children. Population-based studies from India report a prevalence of 2.7% in a rural population and 6.4% in an urban population for uncorrected visual acuity worse than 20/40 in the better eye among children aged 7-15 years^{2,3}. Refractive errors were the leading cause in 61% of eyes with visual impairment in a rural population and 81.7% of eyes with visual impairment in an urban population. The national program for prevention and control of blindness (NPCB) recognizes uncorrected refractive error as the second largest contributor to severe visual impairment and preventable blindness across age groups with a prevalence of 19.7%.

Percentage of population with uncorrected visual acuity worse than 20/40 in the better eye among children aged 7-15 years.



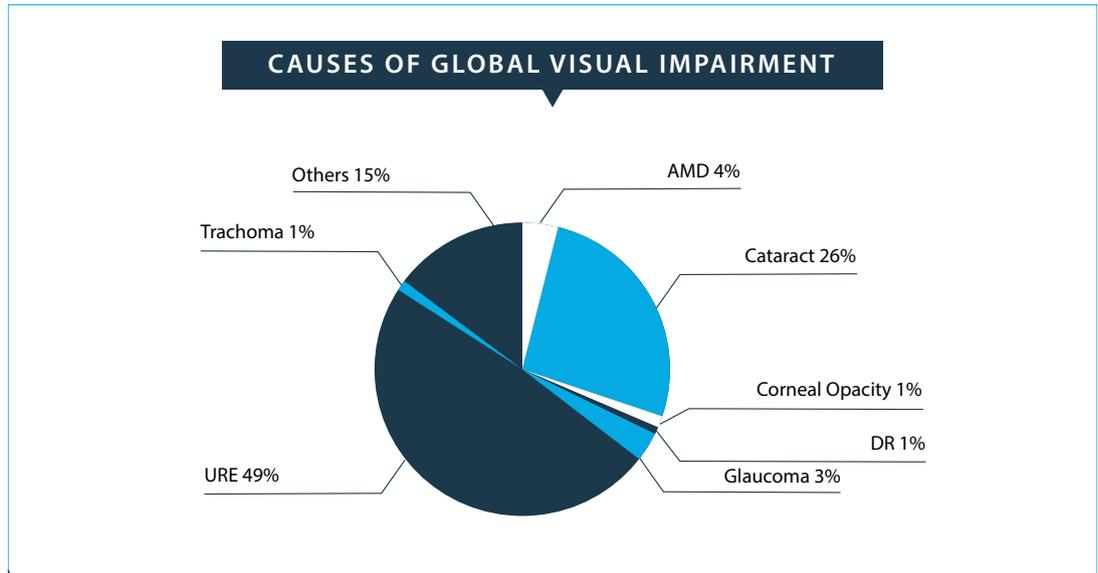
Visual Impairment Case



2.4 Prevalence estimates - Global

The Vision Loss Expert Group (VLEG) estimates that globally, in 2015, the total number of people visually impaired i.e. affected by blindness or by moderate/severe visual impairment (MSVI), was 253 million. Figure displayed in this section shows that the main causes of visual impairment globally,

as determined by the World Health Organisation (2012). Note that URE accounts for almost half of the world's visual impairment cases. Eighty-nine percent of visually impaired people live in low and middle-income countries⁵. Globally, almost 13 million children aged 5-15 years are visually impaired due to URE⁴, and in the same age group over 90% of visual impairment is due to myopia⁶.



Source:WHO 2012.

2.5 Importance of early identification

Children usually do not complain of any vision problems especially if only one eye is involved. They may not even be aware of their problem. They adjust to poor eye sight by sitting near the blackboard, holding the book closer to their eyes, squeezing their eyes and even avoiding work requiring visual concentration. This evades early detection of refractive error. Timely detection of these problems and their correction by spectacles can improve the child's potential during his or her formative years and can prevent abnormal visual development and can treat visual impairment, an avoidable burden in the life of the child, family and society. The detection and treatment of URE among school children is highly cost effective as demonstrated by studies conducted in India and elsewhere in the world. For example, in one report⁶ the cost to examine a child as part of an eye and vision screening program was US \$0.64 and the cost to examine and dispense spectacles was US \$12.13 at that stage, while in the primary eye care system (at a later stage) these costs were US \$3.10 and US \$25.58 respectively. Untreated childhood blindness and visual impairment have critical individual, familial and social consequences given its long-term impact on quality of life including education, independence and productivity.



2.6 Uncorrected RE and its effect on child development

Eyes contribute greatly to one's learning capacities right from childhood. The school going years are the formative years for determining one's physical, intellectual and behavioural development. Any problem in the vision during the formative years can hamper the intellectual development and performance of a person in future life. It has been commonly accepted that good vision is critical to the child's ability to participate in and benefit from educational experience. The impact of UREs is manifold and may include loss of educational, employment and economic opportunities. Thirty-three percent of the world's working population has uncorrected vision problems that impact productivity with serious financial implications for the performance of economies worldwide⁷. \$269 billion of productivity is lost worldwide due to uncorrected vision⁸.

² Dandona R et al. Refractive error in children in a rural population in India. *Invest Ophthalmol Vis Sci* 2002;43:615-22

³ Murthy GVS et al. Refractive error in children in an urban population in New Delhi. *Invest Ophthalmol Vis Sci* 2002;43:623-31

⁴ Murthy GVS et.al. Refractive error in children in urban population in New Delhi. *Invest Ophthalmol Vis Sci* 2002;43:623-31

⁵ IAPB Vision Atlas, <http://atlas.iapb.org/>

⁶ A. Dominique Negrel et al, 'Refractive Error Study in Children: Sampling and Measurement Methods for a Multi-Country Survey, *Am J of Ophthal*, 129 (2000), 421-26

⁷ Social and Economic impact of Poor vision by Boston Consulting group and Essilor, May 2012

⁸ Smith et al, "Potential lost productivity resulting from the global burden of uncorrected refractive error", *Bull World Health Organ* 2009; 87

03 PROGRAM AIM AND OBJECTIVES

Aim

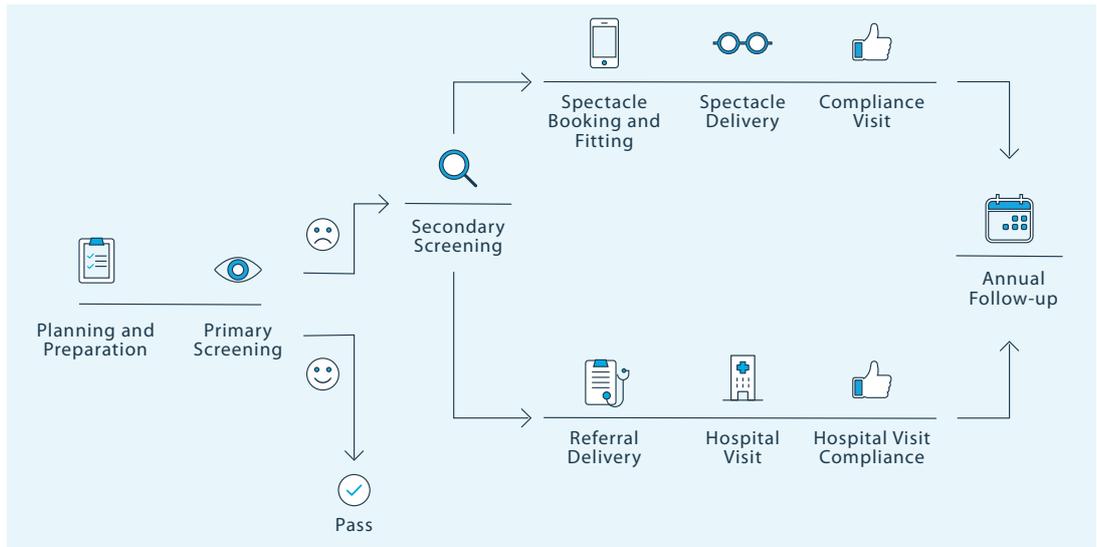
To eliminate avoidable visual impairment, especially due to uncorrected refractive errors, among school-going children.

Objectives

- To increase access to child eye health by providing quality refractive error services to school-going children.
- To promote child eye health by developing an enabling environment to ensure the delivery and sustainability of quality refractive error services for school-going children.
- To generate evidence for favorable policy and institutional environment that ensures effective school eye health delivery.



04 THE REACH PROCESS – AN OVERVIEW



REACH Framework

PHASE	PREPARE	DELIVER		CONSOLIDATE		
	Initial Contact	Screening	Refraction / Dispensing / Referral	Compliance	Annual follow-up	
ACTIVITIES	<ul style="list-style-type: none"> Establish rapport and obtain all required permissions Plan activities with at least a two-month lead time Generate databases on: <ul style="list-style-type: none"> schools in project area students in each of the participating schools Institutional resource database 	<ul style="list-style-type: none"> Confirm identity of children present Perform visual acuity Identify all children who: <ul style="list-style-type: none"> cannot read the 0.2 LogMAR optotype can read the 0.2 LogMAR optotype with +1.50 D sph. have any ocular complaints/symptoms already wearing spectacles 	<ul style="list-style-type: none"> Confirm identity of children present Complete visual acuity assessment, autorefractor exam, retinoscopy, refraction, acceptance Clinical eye examination Cycloplegia as require (if possible on-site or referral) Prescribe glasses Dispense glasses Refer for further evaluation / intervention Counsel all children advised glasses and/or referred 	<p>At 3 months ± 15 days from date of dispensing spectacles</p> <ul style="list-style-type: none"> Confirm identity of all children prescribed spectacles Check compliance for spectacle use Check visual acuity with spectacles (0.2 LogMAR) Complete compliance questionnaire Counsel as required 	<p>At 1 year from Refraction Visit</p> <p>To include:</p> <ul style="list-style-type: none"> All children who were identified to have a visual defect during initial visit All new students (including 1st Grade) + all students in 8th and 11th Grade Check compliance for spectacle use and complete compliance questionnaire Perform all activities listed under Deliver phase / Refraction / dispensing referral 	
TASKS						
AWARENESS & DEMAND GENERATION						
DATA MANAGEMENT						

05 PROGRAM PLANNING

5.1 Project area

This section describes the geographical limits within which the proposed project is implemented. The project area is defined based on a number of factors, as follows:

- The revenue district/block(s) as demarcated by the government of India/ state governments.
- Since URE prevalence differs to a large extent between rural and urban locations⁹ so both should be represented within each project area.
- To understand the demand and current service delivery of school eye screening services, it is important to be aware of the existing school eye health programs in the identified project area. This can be identified by engaging with multiple stakeholders including schools, district administration and other government authorities. It is recommended to identify a project area where currently there is no school screening activities or with limited coverage of schools.
- Availability of eye health services: It is essential that the identified catchment should have access to a fixed eye care facility where children who require further evaluation can be referred from the screening location. Therefore, a facility mapping exercise should be conducted to identify all the existing eye health services and infrastructure in the catchment area. The relevant information will be collected from the district blindness control society in the respective areas.
- Magnitude of the problem: To understand the need and to estimate the target for the project planning, it is essential to estimate the prevalence of refractive error in the identified catchment. This is possible with the support of available secondary data from published sources including journals and government reports.
- In addition, since REACH is a school-centred program, the number of schools and children in the area must be known. The most recent census data for the area and the School Geographic Information System (GIS) databases <http://schoolreportcards.in/SRC-New/> ; <https://schoolgis.nic.in/> may be accessed for these purposes.
- Stakeholder engagement: This is an important activity during the identification of the project area. Identify and explore all potential stakeholders including local Non-government organisations (NGOs), Corporates, Community based organisations (CBOs), Member of parliament (MP), Member of legislative assembly (MLAs), Local Senators, local influential persons etc. in the area who can be collaborated during the implementation stage of the project for effective service delivery.
- Identification of potential sources of local funding: For the sustainability of the project and its activities in the longer term, local sources of funding should be identified and explored.

Apart from the above points, it is essential to engage relevant government authorities during identification of catchment area from the project planning phase to help in garnering support in the long run for ease and sustainability of service delivery.

⁹ <https://ind.orbis.org/en/what-we-do/resources>

5.2 Target setting

Target setting is a critical part of project planning, since it determines the goals the project will strive to achieve within a defined period. Any over- or under-estimation of the targets during the initial phase can lead to operational challenges.

It is recommended to estimate the service delivery target based on the following factors:

- Consider the existing reported prevalence of URE in the region for a realistic estimation of service delivery targets. If current data of the region are not available, national prevalence can be used for estimation.
- Consider the school enrolment and absenteeism rate in the respective region to estimate the number of school-going children in the identified target locations. This information could be obtained from sources such as the education department, UNICEF, Save the children and SSA (Sarva Shiksha Abhiyan) in the respective region.
- Collect information on estimated prevalence of eye and vision health anomalies (other than URE) among school going children from secondary sources including published literature and from previous school eye screening referrals. For example, relevant data would include the proportion of children referred to tertiary eye care facilities for eye surgery.
- It is essential that the target identified should be in accordance with the funds allocated for the project. The available funding helps to determine the staff volume and other costs including equipment.

The following resources are useful when setting targets:

- Use the latest census data to calculate the children population in the targeted age group. Use DISE (District Information System for Education)/SSA (Sarva Shiksha Abhiyan) data to estimate the number of school going children in the identified area. (Web link for access to DISE data: <http://udise.in/udise.html>)
- Identify number of schools, block-wise, their GPS locations and distance <https://schoolgis.nic.in/> from the base hospital and distance between schools. The information related on distance will help in estimating the travel time from base facility and scheduling the school eye health activities in the same route for optimal utilisation of all resources. This will ultimately help in planning realistic service delivery targets and the required HR for achieving the targets.
- Calculate number of school open days using state school academic calendar from the District Education Office. This will help the team to plan the actual number of available working days for implementing the planned activities to achieve the service delivery targets within the available time. It is also recommended that the targets should be planned by keeping some days in buffer (10% recommended) considering unforeseen circumstances (civil disturbances, weather conditions, etc.)
- Based on the criteria mentioned above calculate the actual target separately for Primary Screening, Secondary Evaluation and other related service delivery for the project using the target setting tech tool (Refer- Annexure 12.1 – Target setting tool)

5.3 Resource planning

5.3.1 Human Resources

The project lead will decide the number of staff required for the project based on the target decided (number of schools and the children to be covered in the catchment area).

The recommended team composition for REACH project implementation to cover an annual screening target of 40,000 school going children is listed below. Any change in the target should proportionately reflect on the size of the team required.

Team	Staff Category	No.	Desired Qualification
Management	Project lead / Ophthalmologist	1 - Partially involved	Any qualified ophthalmologist (Preferably Pediatric / oriented ophthalmologist)
	Project Manager	1	Any post-graduate with 3 to 5 years of work experience in any community / hospital setting
Core service delivery	Project Coordinator / Outreach coordinator	1	Any Bachelor's degree with 2 to 3 years work experience in any community setting
	Vision screener	2	Higher secondary with good communication skills in local language
	Optometrist / Vision technician / Ophthalmic assistant	1	Certified optometrist / vision technician / Ophthalmic assistant with minimum 1 year work experience
	Counsellor	1	Graduation in any discipline with minimum 1 year of work experience in patient counselling.
	Optician	1	Certified / trained optician with 2 years of work experience
	Spectacle delivery and compliance (SDC) - Coordinator	1	Graduation in any discipline with minimum 1 year experience in any hospital setting, with good communication skills in local language
	Information Education and communication (IEC) – Coordinator	1	Graduation in any discipline with minimum 1-year experience in any hospital / community setting focused on awareness generation project, with good communication skills in local language
	Driver	1	Minimum higher secondary education with 3 years of experience in driving.
Support	Data entry operator	1	Minimum higher secondary education with good typing skills
	IT support	1 - part time	Graduation in any discipline / Diploma in Hardware and Networking with minimum 1-year experience
	Finance manager	1 - part time	As per organisational policy
	Purchase manager	1 - part time	As per organisational policy
	Equipment maintenance	1 - part time	As per organisational policy

This core service delivery composition is counted as one team and depending on the target a larger number of core service delivery team may be required. The requirement should be assessed based on the targets aimed to achieve from this project. All the team members in the project should have a clear job description (JD) and consider the following points while developing the JD's.

- Prepare detailed Job Descriptions (JD) for each position as a reference point while recruiting the persons with desirable skill sets to perform the tasks and is helpful for development of a training plan for the individual position. The detailed job descriptions of different project positions are attached as Annexure 12.2 – Sample Job descriptions.
 - The JDs will provide a basis for role mapping the various project tasks to different individuals. The details of role mapping are discussed later under section Initiation (6.1.3).

- Due to school academic breaks, examinations, local holidays and unforeseen circumstances, the school screening will only be possible for certain periods of time which will vary from state to state. The project plan should include a strategy for ensuring staff are engaged during these relatively 'lean' months. Suggested examples could be to screen the schools for the blind/ special schools, play/balwadi schools, engage in outreach work, review the past performance, refresher training, case study documentation (including development of audios and videos), data cleaning and analysis, seeking permissions from authorities for next academic year screening and engage the staff in any community based research (e.g. prevalence, barriers to access services) data collection. This should reflect on the JD's of respective project team.
- The project plan should include a strategy to seek volunteers/interns/ trainees from local optometry schools during busy or 'peak' months, if possible. This provides assistance to the project and valuable experience for the students. To this end, the project lead, should consult at an early stage with optometry school heads so that the positions may be approved within the school and included in the curriculum if necessary, well ahead of time.
- Always have a plan for a reserve team to cover staff absenteeism and to handle attritions to avoid any interruptions during project implementation.

5.3.2 Equipment

- As a part of planning, the project lead must develop a plan for procuring equipment and instruments which are necessary for implementation. This procurement process should start well in advance, at least two months prior to service delivery for facilitating necessary training for the project team. The projects leads plan should consider the following points:
- A final list of necessary and desirable equipment is required for the project. The standard list of equipment necessary for implementation is attached as Annexure 12.3 – Recommended Equipment list. The amount of equipment required will be determined based on the clinical guidelines, team size and the funds available for the project.
- It is suggested that the project implementing organization should conduct an internal audit to identify any spare equipment (fully working condition) which can be used for the project.
- When purchasing equipment to be used within an organization such as a hospital, the internal purchase policy for procurement should be followed. Considering items with long lead time a plan should be made to avoid any delay in completing the process.
- All project equipment should be labelled with an inventory number according to the organizational policy. This can help in tracking and maintenance of the equipment by the organization on a regular basis.

5.3.3 Transport services

- It is necessary to have a plan for transport requirements for the implementation. The mode of transport can be decided based on the availability of resources. The choices are either to buy a new vehicle or hire (taxi aggregator services can be used wherever available) whichever is cost effective. This can be decided internally by the organizational management. The following points are important considerations when purchasing equipment for the project:
- Based on the implementation plan, the project lead should plan the transportation requirement including the type of vehicle (two/four-wheeler) required. This decision should be based on the team size, equipment amount and the size, terrain of travel and the distance while finalizing the purchase of the vehicle.
- As outlined above, the organization's purchase policy for procurement should be followed and if significant lead times are anticipated the order should be placed sufficiently early.
- If the project procures a dedicated vehicle, it is suggested to use the vehicle as a tool for

communicating eye health messages. Example: display the organization name, address and eye health promotional slogans to reinforce the content within the communities.

- Ensure both legal and safety compliance for the vehicle and the project staff. For example, driving licence, helmet, accidental insurance, first aid kit, emergency contact list and indemnity to avoid any unforeseen circumstances.

5.3.4 IT equipment

- REACH being a technology enabled project the IT equipment plays a pivotal role in successful implementation of the project. It is recommended to procure new IT equipment from the beginning of the project with the latest configuration. It is recommended to follow the organization’s purchase policy for procurement. Necessary plan should be made to avoid any delay in completing the process.
- The recommended IT list for REACH project and the specifications are given below:
- The hospital must check with the technology support team to ensure compatibility with the software while deciding on the hardware purchase.
- Management should have a replacement policy for IT equipment as depreciation of value can be high.

Recommended IT Equipment and its specification for REACH implementation

Equipment	Suggested configuration
Laptop	Core i3, 4GB RAM, 500GB HDD, 14” Matte screens, 3-5 Hr Battery backup, Windows 8 or above License 2 years extended warranty Extra
Tablet 8/10-inch Screen size (preferable)	2GB RAM, 16GB ROM, > 3000mAH and above, Wifi, Camera 5MP, Robust Body (Sturdy Cover Optional)
Power Bank	10000 MAH or more
WiFi Router	Wireless Dual Band 2.5 GHz and 5GHz, with triple antenna
Uninterrupted power supply (UPS) for Wifi Router	600VA, Double Battery (at least provide 8 hrs backup to Wifi device)
Data Card (Internet) optional	Hotspot & Self Powered (Speed Test response as below: Ping - less than 100ms Download/Upload - more than 2mbps)
Printer (Laser) Optional	Monochrome laserjet, Mobile printing and WIFI enabled

5.3.5 Lenses & Frames for spectacles

- As REACH focuses on addressing the problem of URE, spectacles are the prime service delivery in the project. The children in the project are given the freedom to choose their own frames to achieve maximum spectacle compliance. The library of frames and lenses should be planned considering children’s preferences and the latest trends in the market.
- It is recommended to follow hospital’s/ organization’s purchase policy for procurement.
- The stock of pediatric lens and frames should be maintained by updating whenever new orders are placed. This responsibility can be outsourced to the hospital if necessary.
- The hospital should also have a spectacle replacement policy in case of breakages or other returns, and the details of this are discussed in Spectacle management section 8.9.

5.3.6 Financial planning

- This is a crucial step during the planning phase and it is vital to ensure availability of adequate funds for implementation of the project. A detailed plan is essential to work out how much funding is needed to implement the project. Ideally, this should happen while planning the targets for this project since the funding required for the project will be based on the agreed target and the necessary resources required to meet it. However, in some situations, the availability of funds determines the target to be finalised, so either the finances are planned for the agreed target or the targets are decided based on the funding availability. The following steps should be considered for effective financial planning.
- The two major divisions in the project budget are Capital and Revenue expenditure. Refer to the budget planning sheet attached as part of target setting tool (Annexure12.1).
- Capital Expenditure includes all equipment and instruments that need to be purchased for the implementation. The essential and desirable list of equipment needed for REACH implementation is described above in the equipment planning section (section 5.3.2 & 5.3.4). The amount of equipment required in each category should be determined based on the target and fund availability.
- Revenue expenditure includes all expenses incurred for the implementation of the project. Major categories include salaries, training, transport, printing and communication, stationeries and other supplies etc. For more details on the list of revenue expenditure refer to the budget planning sheet (Annexure12.1).
- While planning for salaries and other local expenses, consider all necessary local norms including the organization policy for budgeting. Also, give due consideration to the inflation charges for every year in the budget.
- While planning for the revenue expenditure, consider adding 'non-cash' expenditure to include the depreciation charges for all major capital expenditure (approximately 20% of the total cost of equipment per annum for 5 years). This will support the organization at the time of replacement of this equipment. It is suggested to save the depreciation charges planned per year separately and show them against the expenditure on annual basis.
- It is suggested to use an excel based tool for monitoring the finances of the project on a monthly basis to ensure optimal utilisation of all budgeted resources. Indicators for monitoring the finances are described in the Monitoring and Evaluation section - 10.

5.4 Information Education and Communication (IEC) planning

An enabling environment for the delivery of care as well as the health seeking behavior of the community are critical for acceptance of any health service provided. Therefore, service delivery should always be coupled with a mechanism to effectively communicate with stakeholders to nurture favourable health seeking behavior.

This section presents guidance for planning and implementing social and behavior change communication (SBCC) activities for improving eye health in the targeted community. SBCC is defined as the use of communication strategies—mass media, community-level activities, and interpersonal communication—to influence individual and collective behaviors that affect health. Research shows that theory-driven, interactive communication that follows a proven design and implementation process can increase knowledge, shift attitudes and norms, and produce changes in a wide range of behaviors⁹.

SBCC for eye health among school-going children aims to:

1. improve knowledge and develop a favorable attitude towards eye health, with special emphasis on refractive error;

2. adopt favorable practices regarding refractive error and spectacle usage;
3. increase the practice of recommended eye health seeking behaviors including acceptance of services among school going children;
4. promote preventive eye health;
5. improve teachers' knowledge, perceptions, practices and act as a key informant;
6. increase parental and community support in cultivating an "enabling environment" for eye health;
7. inculcate favorable eye health seeking behaviour among the community;

Opportunities for education across the continuum of care



Steps for Planning and Implementing SBCC for eye health

Most health communication programs employ a planning model or framework that guides design, implementation, and evaluation, such as the following:

STEP 1: UNDERSTANDING THE SITUATION

The process of planning SBCC activities for eye health requires understanding the current eye health seeking behaviors within a specific population, the factors influencing the practice of these behaviors, and the channels through which members of the population communicate and receive information. Gathering this information requires reviewing existing literature or (if no such literature exists) conducting a Knowledge Attitude Practice (KAP) study if resources allow. In case of lack of relevant literature and resources, it is suggested to adopt the IEC materials developed and used by other organizations in the country after piloting the resources in their context to confirm its relevance to the intended audience.

Reviewing existing literature

Review existing studies and reports on child eye health in general and refractive error in particular. Also, review existing educational materials.

Key areas to explore in the review of existing literature include the following:

- Knowledge and attitude towards eye health among different stakeholders.
- Current eye health seeking behaviors within the population.
- Factors influencing the practice of these behaviors.
- Coverage or reach of eye health and refractive error services.
- Barriers to utilise the existing eye health and refractive error services.
- Communication channels or platforms through which members of the population communicate and receive information.
- Previous activities conducted within the target sites on eye health.

This information provides guidance in developing communication materials specific to the target population.

Knowledge Attitude Practice (KAP) study

If there is no existing literature relevant to the project area and if there are resources and expertise available, it is suggested to design a KAP study in the target communities before the project implementation to set a baseline of KAP. Evidence of any change in the eye health seeking behavior within the community can be documented through a repeat KAP study in the same area at the end of the intervention.

A KAP study is a representative study of a specific population to collect information on the population’s knowledge, beliefs and behaviour in relation to a particular topic — in this case, refractive error and eye health.

A KAP study on this topic gathers information about what respondents know about eye health and refractive error, what they think about people wearing spectacles or about the health system response to eye health issues, and what they actually do with regard to seeking care or taking other action related to eye health issues. A KAP study can identify knowledge gaps, cultural beliefs, or behavioral patterns that may facilitate understanding and action, as well as pose problems or create barriers for eye health efforts. The study can identify information that is commonly known and attitudes that are commonly held. To some extent, it can identify factors influencing behavior that are not known to most people, reasons for their attitudes, and how and why people practice certain health behaviors. A KAP study can also assess communication processes and sources that are key to defining effective activities and messages in eye health prevention and treatment. KAP surveys may also be used to identify needs, problems and barriers in program delivery, as well as solutions for improving quality and accessibility of services.

These studies are resource intensive and require expertise. Therefore, effectively reviewing existing literature in a population with a similar demography as the project population can be impactful too.

STEP 2: DESIGNING THE FRAMEWORK FOR COMMUNICATION

When designing SBCC for eye health, it is important to ensure that the activities implemented are targeted to the needs of the population, and that they actually address the factors which most motivate or make it challenging for individuals to practice the recommended eye health seeking behaviors. The designing phase involves using findings from the ‘Understanding the Situation’ phase to inform the development of a SBCC matrix to guide communication. The matrix, an example of which is shown below, includes seven key questions to aid the development of communication strategies:

Objective of the communication Why	Material What	Information / message being conveyed	Target Audience Who	Medium (Primary)* How	Medium (Secondary)** How	Frequency When

* Targeted at the school to create awareness among children and teachers.

** Targeted at the extended community in which the school is located, mainly to spread awareness in the larger community.

Refer Annexure 12.4 - for a sample copy of completed communications plan.

Sample Communication Channels and Activities to Consider

The list given below covers a wide range of communication channels (relating to the ‘how’ columns in the matrix) and the examples of activities under each communication channel. Identify a list of communication activities which are feasible within the project and finalize these prior to

implementation. At the end of this process, finalize the necessary resources required to develop the communication strategy further. These include the cost of development, persons required to disseminate describing their individual roles and the training requirement and the plan for implementation.

Communication channel	Examples of activities
Mass Media Channels	
Broadcast (television or radio at national or regional level)	Public Service Announcements (PSAs), Talk shows/Call-in shows (for example, “ask the expert”) Documentaries /testimonials/ case stories Magazine Animated cartoons Songs and jingles Celebrity endorsements
Print media	News coverage in newspapers and magazines Direct mail Comic books Pamphlets Flyers Posters Billboards
Digital media	Online publications Social media Mobile phone programs Emailers
Interpersonal Channels	
Between service provider and children/teachers Child-Parent Peer-Peer	Orientation programs Counselling Certificates or prizes Vision Club*
Community - level	
Live performances	Street theatre Puppet shows
Community media	Community newspapers Community radio Local announcements

*Vision Club is a children’s peer education program designed by Orbis for promoting eye health. It is a school-based model that will act as a platform to deploy the peer education approach to improve eye health and eye health behavior among school children. Peer education is a strategy whereby individuals from a target group provide information, training, or resources to their peers. It is one of the lower-cost interventions widely used in many areas of public health 10. Refer to Annexure 12.5 for more details about the Vision Club.

Revisit the budget proposed for the project implementation and ensure all necessary communication related cost has been included in the project budget. The final steps of material (e.g. comic books) creation and the plan for implementation and monitoring is described later in the IEC consolidation section 6.1.7.

5.5 Approvals

In order to implement the REACH program in schools it is essential to obtain approvals from relevant authorities. It is recommended to use the standard project information sheet while approaching various stakeholders (refer Annexure: 12.6 – Project information sheet). The following are the mandatory approvals required for the project

- Establishing contact with District Administration Authorities, Health and Education: Since this project involves school going children and eye health activities mostly in the school premises it is necessary to establish contact with and obtain permission from all the relevant departments during the planning period. The District Collector (DC) and higher officers can also be approached if necessary.
- Collaboration with Sarva Shiksha Abhiyan (SSA): Since SSA is a Centrally Sponsored Scheme implemented by Government of India in partnership with State Governments, a main programme for universalising education in India, a formal collaboration or coordination with SSA during the time of program planning is helpful for communications regarding the necessary permissions for project implementation.

06 INITIATION

6.1 Stakeholder engagement

Stakeholder engagement is a continuous process for successful implementation of any community-based programs. It involves interactions between identified individuals and groups within the catchment area who are able to support the project activities and can potentially influence the communities for better eye health seeking practices.

The aim of engaging the various stakeholders in this project is to:

- Achieve effective service delivery
- Advocate and generate awareness on eye health and
- Increase the uptake of eye care services
- Achieve sustainability of service delivery activities within the school

The project should develop a plan to engage stakeholders on a regular basis throughout the project and provide them with opportunities to participate in various project events such as service delivery activities, World Sight Day, Children's Day and any other special events organised as part of this project.

Following are the suggested stakeholders and ways in which to engage them in the project. This framework is developed based on the past experiences of implementing REACH projects, however, these are guidelines only and should be modified as appropriate to suit each individual project.

Stakeholders	Ways to engage them
Children	<ul style="list-style-type: none"> • Vision club activities – peer to peer education • Engagement during the service delivery and eye health education • Child to parent's education • Child friendly approach
Parents	<ul style="list-style-type: none"> • Keep them informed regularly about the various service delivery activities through phone, letter and or by one to one communication. (invite them for spectacle delivery and to inform the details of referral if any) • Presentation during parents and teachers meeting about children's eye health • Invitations to attend eye health awareness meetings in school and in the community
Teachers	<ul style="list-style-type: none"> • Involve them during the service delivery within the school campus • Orient them about children's eye health and its importance • Involve them during one to one counselling to the parents about spectacle or referral compliance • Keep recognising their contribution to the project

NGO / CBOs/ Other health facilities	<ul style="list-style-type: none"> • Keep them informed regularly about the various service delivery activities through phone, letter and or by one to one communication • Establish partnership for cross referrals for further service delivery • Invitations as guests for health awareness events or spectacle distribution events
Local elected representatives	<ul style="list-style-type: none"> • Keep them informed regularly about the various service delivery activities through phone, letter and or by one to one communication • Invitations as guests for health awareness events or spectacle distribution events • Seek support for local awareness events / seek support for local fund allocation under various government schemes
PMOA's / Anganwadi teachers / Local committees	<ul style="list-style-type: none"> • Keep them informed regularly about the various service delivery activities through phone, letter and or by one to one communication • To disseminate IEC on children eye health
School and other Associations / Corporates	<ul style="list-style-type: none"> • Keep them informed regularly about the various service delivery activities through phone, letter and or by one to one communication • Invitations as guests for health awareness events or spectacle distribution events • Keep them updated about the beneficiaries from the project, highlight success stories • Disseminate press release on special events such as world sight day and Children's day
Media	<ul style="list-style-type: none"> • Keep them informed about the project using project information sheet and keep them updated about the beneficiaries from the project. • Invitations to attend and support eye health awareness meetings in school and in the community • To garner financial support for the sustenance of school's service delivery activities

6.2 HR recruitment

The Project lead should take responsibility for recruiting the project staff in coordination with HR department. Following points may be considered before recruiting the project team.

- Reallocation of existing staff in the hospital is desirable to have experienced staff to run the project more efficiently.
- Recruitment external to the organization occurs where necessary.
- Recruitment/reallocation should be completed at least two months prior to the commencement of service delivery to allow sufficient time for the team to become oriented to the project activities. If necessary, they may be allocated to pediatric eye care service delivery within the hospital to gain hands-on experience in dealing with the children.
- It is recommended to give preference to locally available skilled personnel from the project area to avoid unnecessary attrition and to promote local ownership.
- Once the recruitment is complete, each individual's training requirements must be assessed including identification of any specific skill gaps for each position. The training should accommodate all the gaps identified at this stage.

6.3 Role mapping and Team Training

This section outlines the basics of the team training:

- Project orientation needs to be organised for the entire project team and concerned departments in the hospital so that all involved personnel understand the project's aims and methods.
 - Points to be covered during orientation
- Project aims and objectives
- Process and framework
- Target and duration
- Role of each supporting department at the hospital
- Organise a detailed training for the project team to understand the REACH processes and the REACH common guidelines (Refer Annexure 12.7: REACH Common guidelines) thoroughly before the REACHSoft training, this refer to custom software to support the REACH processes and procedures including screening, secondary evaluation, quality monitoring and referrals.
- Plan and organise ongoing refresher training based on the staff performance. The key indicators for monitoring the performance of the team are discussed in detail in the Monitoring and Evaluation section -10.
- REACHSoft training to be organised for all the staff at the beginning of the project and the details of this specific orientation are discussed in the next section.
- It is recommended that secondary evaluation team should be placed in the pediatric department at the tertiary hospital for at least a month to gain necessary expertise to deal with children and their eye care needs.
- It is recommended to develop a team of trainers for service delivery within the hospital for continuous assessment and training.

A detailed training schedule should be developed for all core service delivery team and the suggested list of areas of training is given below:

Staff Category	Specific Areas of training
Vision screeners	<ul style="list-style-type: none"> • Setting up screening site • Vision assessment • External eye examination • Common eye diseases in children • Identification for secondary evaluation • Child friendly communication • Crowd management • REACHSoft module – Primary screening, calendar, data synchronisation
Optometrist/Ophthalmic Technician/Vision Technician	<ul style="list-style-type: none"> • Pediatric eye examination and refraction • Pediatric eye diseases, diagnosis and advise • Pediatric counselling • Pediatric optical dispensing • Training the primary vision screeners • Medical equipment maintenance • Compliance assessment • REACHSoft module – Primary, secondary evaluation, compliance • Case selection and documentation for developing case stories

Counsellor	<ul style="list-style-type: none"> • Common eye diseases in children • Stakeholders Communication – children, parents, teachers, hospital departments and other community members • Orienting school teachers • Referral compliance follow-up • Updating clinical data for referred children at the base hospital in REACHSoft including usage of counselling module • Case selection and documentation for developing case stories • IEC dissemination • REACHSoft module – Primary, secondary evaluation, compliance • SBCC planning and implementation
Project Manager/Project Coordinator	<ul style="list-style-type: none"> • Project implementation training • School mapping • Project financial management • Team building • Rapport building and networking – internal within the organisation and with externals • Training of trainers for project co-ordinators and other nonclinical staff • Data analysis and reporting • Case stories development • Problem solving • Usage of REACHSoft • SBCC planning and implementation
Outreach coordinator / Social worker	<ul style="list-style-type: none"> • Obtaining school permission • Allocating teams and equipment • Planning activity calendar • Orientation of school teachers • Team building • Rapport building and networking • Stakeholders Communication – children, parents, teachers, hospital departments and other community members • Problem solving • Usage of REACHSoft • SBCC planning and implementation
IT support- person	<ul style="list-style-type: none"> • IT equipment maintenance • Updates • Preparation for the service delivery programs • Data synchronisation and backups • Coordination with external IT vendors for trouble shooting
Optician	<ul style="list-style-type: none"> • Pediatric optical dispensing • Child friendly approach • Stakeholder communication – information and education fo children and parents. • Optical library stock management • Quality standards in optical dispensing • REACHSoft module

Co-ordinator – spectacle delivery and compliance (SDC)	<ul style="list-style-type: none"> • Primary screening • Spectacle delivery • Monitoring spectacle compliance (including compliance questionnaire administration) • Monitoring referral compliance • Lensometer measurement • Managing minor spectacle repairs • Counselling children • REACHSoft modules – compliance, counselling and primary screening
Co-ordinator – Information Education and Communication (IEC)	<ul style="list-style-type: none"> • SBCC planning and dissemination • Case stories development • Stakeholder engagement • Vision club planning, implementation and evaluation • Vision ambassador training

All staff categories require continuous refresher training and it is recommended to organise refresher sessions on a 6-monthly basis. It can also be arranged as and when required based on their performance for continuous improvement.

Role mapping

This exercise needs to be conducted as a group involving the entire project team. The first step is to list all the different tasks that need to be completed for the project and assigning each task to various roles identified for the project. The task varies between organizations and it depends mainly on the process adopted by the respective organization. In some locations, there will be a separate designated person for performing each role. However, in most places more than one person will be sharing an individual role. It is also recommended to train people to perform cross functions to support coverage during absenteeism. Refer to Annexure 12.8 for a sample framework for conducting role mapping exercise.

6.4 REACHSoft deployment and training

This is a critical step in the planning process, however, the REACHSoft training should begin only after everyone in the project has completed the project processes training (framework, guidelines etc.). This step covers the two important phases of software deployment and training. The following activities are to be completed in order to ensure the team is confident in handling the IT components of the project.

Deployment

- Identify the hardware requirements (such as the number of tablets, laptops and routers) based on team compositions, linked in turn to the estimated target.
- Complete all procurements well before the team undergoes training, allowing time for possible delays.
- Sign an agreement with the technology partner for REACHSoft deployment and support.
- Prepare the schedule in consultation with the REACHSoft deployment team, to organise deployment and team trainings.
- Organise deployment team visits to the hospital and configure (system and masters) both the hardware and software.

- The deployment of REACHSoft ends with the necessary orientation to the IT team at the implementing organisation / hospital for usage and for trouble shooting. They also need to be oriented to guide the service delivery team to handle the IT components in their absence.

REACHSoft end user training

- Organise a REACHSoft orientation program to all the team members including the Project director / lead.
- Train the end users in respective modules to ensure the individuals are competent in using the respective modules in the REACHSoft.
- Organise role based training on respective REACHSoft modules for the project team including hands on using dummy data sets.
- The IT support person will create user logins to all users based on the role mapping exercise conducted as described in the previous section and provide access to the relevant modules.
- Identify a few persons who can be trained as trainers for continuous IT support. They should be identified from both IT as well as clinical team to support all processes.
- Organise pilot testing for the entire team in the field to test all the processes using REACHSoft.
- Review and feedback after completion of pilot testing with the entire team to ensure every process and person involved is confident in proceeding with the main project implementation.

6.5 Equipment maintenance and care - medical & IT

- Routine preventive maintenance of the equipment including calibration must be planned and executed by the implementing organization. However, the project team should ensure that the maintenance/calibration is completed on time to avoid any challenges during the outreach activities.
- It is suggested to have Annual Maintenance Contracts /extended warranty for any expensive equipment such as autorefractor or lensometer.
- To have continuity of service delivery the project must hold reserve kits of batteries and bulbs.
- Always ensure the items of equipment are packed and transported with utmost care and safety.

6.6 Vehicle log

If the organization uses its own vehicle or hired vehicle for project implementation, it is mandatory to have a vehicle log to track the movement of the vehicle. The vehicle log maintenance serves as a tool for the project manager:

- To plan and allocate resources as per the requirements of the team.
- To ensure efficient utilisation of transport services.

For hired vehicles, ensure all necessary safety guidelines are followed.

6.7 IEC consolidation

This section covers the process of creating the IEC materials and finalising the implementation plan including training the staff for dissemination.

Creation of Materials

After preparing the communication strategy, this step in the process involves: developing content

outlined in the matrix (refer to IEC planning section 5.4); pre-testing concepts, messages and materials; and revising the content to incorporate findings.

First, the activity concepts developed during the planning phase must be refined, after which messages and materials to be incorporated within the activities will be developed. The content must be:

- Accurate
- Comprehensible
- Attractive to the intended audience
- Tailored to address barriers and motivators faced by specific groups
- Appropriate in tone (e.g. simple, supportive, positive)
- Geared toward local literacy levels, using local terminology
- Consistent with other program communications
- Sensitive to local customs and values

Pre-Testing

All concepts and materials developed should be pretested prior to finalization. Pretesting is a process for determining a target group’s reaction to and understanding of health messages or behavior change information before materials are produced in final form. Pre-testing may be conducted through individual interviews or Focus Group Discussions (FGD).

Pretesting Element	Recommendation	Sample Questions
Attractiveness	Allow participants to compare alternative versions of materials.	<ul style="list-style-type: none"> • What do you think about the pictures? • What was the first thing that caught your attention?
Comprehension	Try to focus participants on the main idea of the message.	<ul style="list-style-type: none"> • What do you think this material is telling you to do? • What words / sentences are difficult to read / understand?
Acceptance	Explore issues that could potentially be overlooked.	<ul style="list-style-type: none"> • Is there anything about the material that you find offensive? • Is there anything about the material that you find annoying?
Relevance	Have participant confirm whether the material is appropriate for them.	<ul style="list-style-type: none"> • What type of people should read / watch this? • In what ways are people in the material like / different from you?
Motivation / Persuasion	Explore the effect on behaviour and desires.	<ul style="list-style-type: none"> • What does this material make you want to do? • How likely are you to do that?
Improvement	Find out other ways to enhance the material.	<ul style="list-style-type: none"> • What new information did you learn? • What do you think is missing?

The two most common pretesting methods are individual interviews and focus group discussions:

1. Individual Interviews are one-on-one interviews in which discussion between one interviewer and one participant takes place in a private, confidential and in local setting.
2. Focus Group Discussions (FGDs) are small group gatherings (8- 10 people per session) in which the materials and messages are discussed in a group setting.

The responses should be recorded and categorised to arrive at definitive changes to be made to the draft materials. It is suggested to conduct a literature review on these topics for more information on how to use these methodologies and interpret the findings.

Implementation & Monitoring

Once the planning and pre-testing have been completed, implementation of SBCC activities can begin.

Firstly, print the materials finalized after pre-test keeping in mind the number of schools, estimated number of beneficiaries one will reach to decide the print materials. For other formats such as videos, jingles etc. keep them in appropriate formats easy for dissemination within the target group of stakeholders.

A suggested sample of IEC materials are available in this link.

<https://ind.orbis.org/en/what-we-do/resources>

Some tips for printing:

- Find out your printer's turnaround times before beginning print and plan your project milestones accordingly so that you can submit your work to the printer on schedule.
- Embed your fonts for accurate reproduction
- Proof your document thoroughly
- Check your image proportions, dimensions and resolution
- Print out a proof before going for the final run in bulk
- Make sure you create bleed (area that needs to be trimmed off after printing) for your designs. Different printers prefer different sizes, but it is generally recommended to leave an eighth of an inch to a quarter of an inch on all sides.
- Printers can accept many document formats, including Illustrator, InDesign, Photoshop, PDF, and Microsoft Word. However, communicate with the printer in advance to ensure that your documents are in an acceptable format.

Following the production of the materials, the team which will be deploying different SBCC activities or materials discussed in the matrix will be trained in use of the materials. This training should be organised to all the project staff after everyone is trained about the REACH project implementation.

The suggested session plan for the training is given below.

Topic	Particulars
Introduction	Purpose and objective of the training
SBCC	<ul style="list-style-type: none"> • What is SBCC • Importance of communication for the delivery of comprehensive eye care
Rewind	Process followed to arrive at this point
Understanding the IEC materials	Show and discuss the different communications materials developed and how to use them
Communications Matrix	Different activities at different stages of the project intervention
Planning for 3 months	Roles and responsibilities for <ol style="list-style-type: none"> 1. Deployment or dissemination 2. Maintaining the log of materials distributed Communications activity plan for 3 months and integrate it into the Annual Implementation plan for the overall project

Further, monitor the implementation of the planned activities and consider the following important questions:

- Is the implementation of the IEC materials and activities occurring as intended?
- Are communication tools and materials being used as designed?
- What is the level of community member participation in the activities?
- Do community members remember key information disseminated during counselling and community activities?
- What implementation challenges is the team facing?
- Have there been any changes in the uptake among children prescribed spectacles or referred for treatment in the project sites?
- What barriers continue to prevent the group from practicing the recommended behaviors?
- How satisfied are implementing team with the activities?

07 PROJECT IMPLEMENTATION

7.1 Prepare

7.1.1 List Schools in the project area

Once the project area is decided the Project Manager/Co-ordinator will be responsible for compiling the list of schools and actual number of children to be enrolled. This can be done in coordination with SSA and Department of Education at district and at the block level. This will help in validation and supplementing of data if necessary. (At present the data available on DISE website is not updated regularly). Once the school details are obtained, the project team clusters the schools according to the geographic location available at the DISE website. Based on the school cluster prepare a tentative schedule for organising service delivery.

7.1.2 School permissions

In order to implement program in schools seeking permission from relevant authorities are essential. It is recommended to use the standard permission letters and project information sheet (refer Annexures: School permission letter -12.9; Project information sheet – 12.6) for explaining the school authorities while seeking permission.

During the initial visit to the school the outreach co-ordinator should aim at accomplishing the following tasks:

- Project introduction and signing permission letter
- Finalise dates for service delivery with the school headmaster / principal
- Finalising the teacher co-ordinator for further contact
- Collect the student database for service delivery preparation
- Introduce the concept of vision clubs
- Update the latitude and longitude of school location in REACHSoft.

It is mandatory to upload the school permission letter on REACHSoft prior to further planning and implementation. Without uploading the permission letter, the project team will not be able to use the REACHSoft functions further.

7.1.3 Activity calendar

REACHSoft has an interactive calendar to plan various activities of the project. The calendar is used for two major functions:

1. Visit Planner

This section is mainly for scheduling visits to various departments / stakeholders for initial discussion/ permission for the project implementation. In some cases, more than one visit is required to complete the desired task. This function of the calendar supports the project manager to assess and allocate the resources accordingly. For example, this function can be used for:

- Planning and recording the visits to health and education departments for obtaining permissions.

- Planning and recording the visits to each school for seeking permission.

Although it is recommended to actively use the planning calendar on a prospective basis, it can also be updated retrospectively if needed.

2. Service Delivery Scheduler

It is mandatory to use the calendar to schedule the service delivery activities, otherwise the REACHSoft will not permit to access any service delivery modules. Also, this helps in avoiding any miscommunications in scheduling the activities.

- The date of primary screening, secondary evaluation, compliance visits, spectacle delivery and annual follow-up activities are to be scheduled into the activity calendar.
- It is recommended to plan the service delivery activities on a quarterly basis and update it on the activity calendar.
- Organise role based training on respective REACHSoft modules for the project team including hands on using dummy data sets.

A template for project planning and implementation calendar is given below:

Activities / Time period	Year I				Year II				Year III			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Program Planning												
Project area												
Target setting												
Resource planning												
IEC planning												
Approvals												
Initiation												
Stakeholder engagement												
HR Recruitment and training												
REACHSoft deployment												
IEC consolidation												
Implementation												
Prepare												
School permission												
School data collection												
Activity calendar												

Deliver												
Primary and secondary screening												
Spectacle deliver												
Referral management												
Consolidate												
Compliance assessment												
Annual follow-up												
Monitoring												
Evaluation												

7.2 Deliver

The program delivery has four major components, including primary screening, secondary evaluation, spectacle and referral management. For logistical reasons, it is recommended to organize both primary screening and secondary evaluation on the same day. However, the implementing organization can decide to have independently or combined activity as per their convenience.

7.2.1 Primary screening

Primary screening involves basic vision and eye screening by the trained project staff for all children present in the school on a chosen day. The planning for this activity must be initiated at least two months in advance to establish necessary contact with the school authorities. During the initial visit the project staff should describe the whole process of REACH activities and handover a copy of the permission letter from district government officials to the school headmaster. After obtaining necessary approval to conduct the school eye health activities, the project staff should confirm a mutually agreed date for organizing primary and secondary evaluation at the school campus. If the primary screening is organized independent of secondary evaluation, the processes discussed in the section given below are recommended.

7.2.1.1 Planning for the screening day

Prior to the screening day, the project co-ordinator must complete the following activities in order:

- Send a reminder to the school about the school activity schedule on the previous day.
- Ensure all children’s names and necessary details are uploaded in REACHSoft.
- Prepare each tablet with 250 – 300 student details prior to screening to facilitate data input.
- Complete the checklist given below to ensure all instruments / equipment and the team are available to perform the service delivery.

Checklist for the screening day

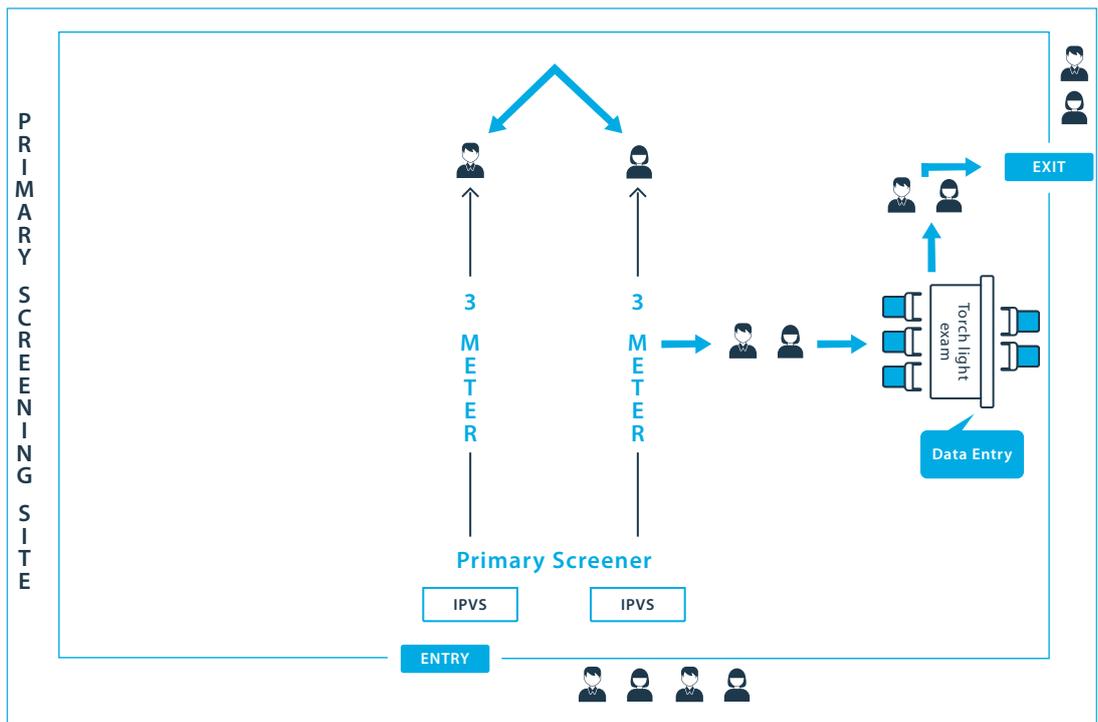
Check list for preparation of screening day			DATE:	
SLNo	ITEM	TOTAL	CHECK IN	CHECK OUT
	Instruments			
1.	3 metre tape			
2.	1.50 D spectacle			
3.	Illuminated Pocket Vision Screener/ pocket screener with charger or PVS card			
4.	Torch (yellow light)			
5.	Vision Screener Charger			
6.	Occluders			
	IT Equipment			
7.	Tablet with charger			
8.	Power bank with cable			
	Others			
9.	Consent form for cycloplegic refraction			
10.	Hand rub			
11.	Tissue paper			
	HR			
12.	Primary screeners / vision technicians			
	Communication			
13.	IEC materials			
14.	Case story format			
15.	Media consent forms			
16.	Camera			
Signature:		Optometrist	Counsellor	Project Manager

7.2.1.2 On the day of screening Site preparation

The first task involved in the site preparation is to meet with the school head master by the outreach co-ordinator or the designated project staff and complete the following tasks before organizing the screening activities at the school campus.

- Orient the screening and examination process.
- Discuss and agree on the space requirements and other infrastructure (Table, chairs etc).
- Identification of internal school co-ordinator / class teachers and vision ambassadors. Vision ambassadors are few older children selected by the school teachers, who will be able to support the school screening activities within the school. All selected Vision ambassadors will undergo a brief orientation to make them understand their specific roles before the screening program.
- Handover the education materials to be displayed during the screening program.
- Orient about the consent forms and the procedure for contacting parents when necessary.
- Update all missing information and details for any student whose details were not available during the initial contact.

Arrange the screening site as per the sample layout given below.



Preparation of the screening room

- The screening can be organised inside a class room which has at least 4 meters dimension to enable VA screening. If the school has corridor and open area outside the class room with sufficient day light, the screening can also be conducted in the open area. When it is organised in open area necessary precautions to be taken to avoid glare from direct sunlight.
- Check for lighting inside the room to ensure moderate ambient room illumination for conducting visual acuity using primary vision screening cards.

Define student flow

- Start screening from younger to older children class wise, coordinated by the respective class teachers. The secondary evaluation team will be available to support the primary screening in the

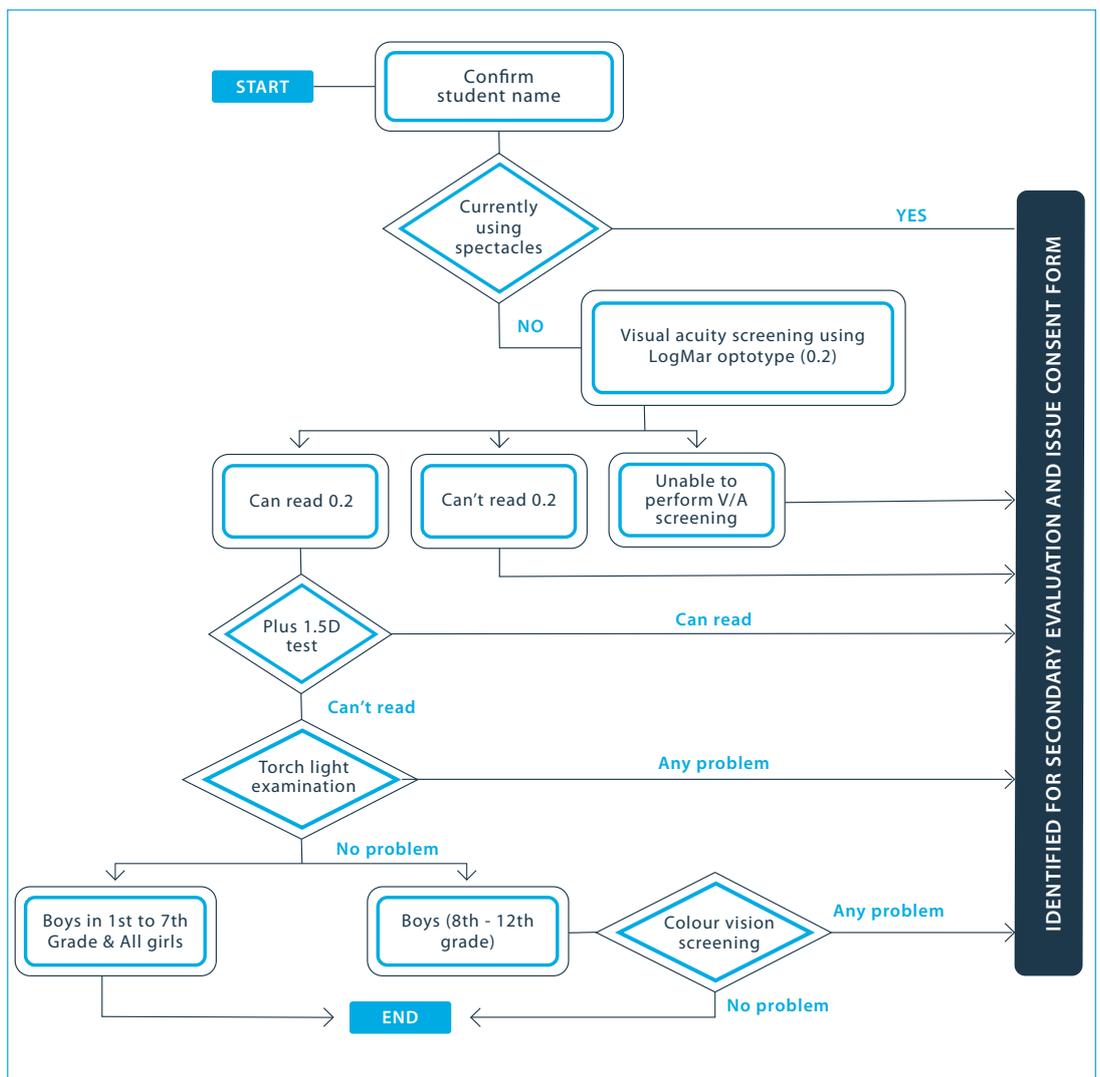
beginning till sufficient number of children are identified for secondary evaluation. Moreover, young children take more time to complete the screening and need more support to manage them at the screening site.

- Engage vision ambassadors and other volunteers to manage the queue of children.

Display education material

- Display the flow chart of screening process in the local language at the screening site.
- Display eye health education material and highlight the importance of referral and compliance.
- Wall paintings can be planned and executed at the school premises depending on the resources and other logistic convenience.

Independent Primary Screening



Ensure concurrent data entry while performing the primary screening

7.2.1.3 Screening procedures

Visual Acuity Testing

- Set up the visual acuity testing in the allocated room.
- 3-meter distance is measured between examiner and children and marked with double sided tape.
- Right eye of the child is checked first by occluding the left eye with an occluder and he / she is asked to read the letters in middle line using a 3 -metre logmar chart. If more than 3 letters in the middle line is read by the child then it is considered as “Can read” otherwise the child is considered for secondary evaluation (Cannot read).
- Repeat the test for the other eye. Remember visual acuity testing should be done for each eye separately.
- Children who do not currently wear spectacles and “can read” with the Pocket vision screener (PVS) and are checked with +1.50D test and if the child “can see” the child is considered for secondary evaluation.
- All children who are currently using spectacles will be screened with the PVS card and will be checked with +1.50 D test with the spectacles and are referred for secondary evaluation.

Colour Vision Screening

- Colour vision test should be performed only for all male students from 8th to 12th standard with the Dalton’s pseudo Isochromatic Plates (PIP).
- The testing should be done in a well illuminated room.
- The child is asked to read out the number plates shown in the booklet at a distance of 40 cm at an angle of 45 degrees with spectacles binocularly.
- Each number in the booklet is shown for 3 seconds. The first plate is a demo plate containing numbers which children with and without a colour vision defect can see; this plate is useful to check that the child understands the task. The plates 2, 3 and 4 are vanishing plates where children with a colour vision defect will not be able to see the numbers. The screener also has a set of classification plates to identify children with Protan or Deutan defects.
- There are 6 sets in the screener; if the child is not able to comprehend any of the numbers in the first set, second set can be used for rechecking.

External Eye Examination Using Torch Light

Children’s eye health is assessed for any external ocular abnormalities, media opacities, pupillary defects and strabismus.

- Hold a torch light at 30 - 40 cm from the child’s eye.
- Look for ocular deviation using corneal reflex test.
- Examine the external ocular structures - eyelids, eye lashes with the eyes closed.
- Ask the child to open the eyes and look for abnormalities in the conjunctiva, cornea, pupil and lens.
- If there are any abnormalities in the external eye examination, ocular alignment, or in the anterior segment of the eye, the child is identified for secondary evaluation.

Autorefraction

Auto refraction has to be performed in younger children aged less than 6 years and as well as in some older children who was unable to cooperate for visual acuity screening due to other health conditions. All those identified with vision problems has to be sent for secondary evaluation.

7.2.1.4 Selection criteria for secondary evaluation

After completing the primary screening, all children who met with any one of the following criteria should be selected for secondary evaluation. Consent forms should be issued to all children selected for secondary evaluation with clear instructions to get it signed by their parent / guardian and be presented on the day of secondary evaluation.

7.2.1.5 Post screening

- Complete screening details of the children including the total number screened, number identified for secondary evaluation and submit the summary details to the headmaster.
- Discuss with the headmaster and agree on a date for secondary evaluation.
- Request the headmaster to remind all the children identified to attend the school without fail on the day of secondary evaluation organised at the school. Also, inform them to share this information with their parents and get the consent form signed by their parents.
- Thank all the teachers and the vision ambassadors supported the screening activities and reorient them their role on the day of secondary evaluation.
- Once the primary screening is completed, the data need to be synced to the server after reaching the base facility.
- After screening completion, the designated person checks the asset list, makes the entry, and gets the equipment register signed from the in charge.
- Any repairs/ calibration requirement for any equipment need to be documented before the next service delivery activity.

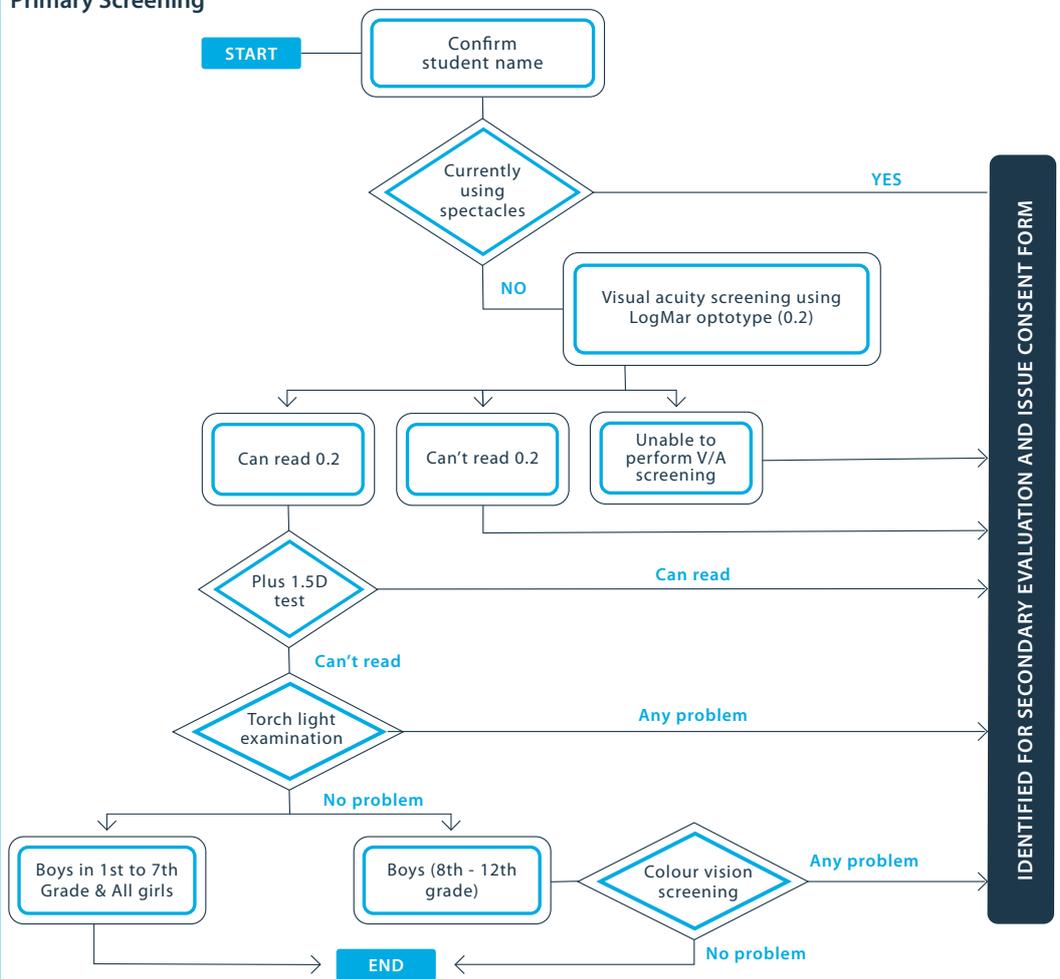
PRIMARY SCREENING

Primary screening involves basic vision and eye screening by the trained project staff for all children present in the school on a chosen day.

Planning for Primary Screening



Independent Primary Screening



Section criteria for Secondary Evaluation



7.2.2 Secondary evaluation

Secondary evaluation should be conducted only by a qualified optometrist/ trained refractionist / trained vision technician at the school campus. It is not mandatory for the ophthalmologist to be present during the secondary evaluation. All children needing cycloplegic examination must be referred to an appropriate fixed facility where the ophthalmologist is present.

It is recommended to comply with National Programme for Control of blindness (NPCB) guidelines to obtain consent either from parents / guardian for cycloplegic examination and for secondary evaluation (Refer Annexure on Parent Consent form – 12.10).

7.2.2.1 Planning for the day

Prior to the secondary evaluation, the project co-ordinator must complete the following activities in order:

- Send a reminder to the school about the activity scheduled.
- Ensure laptop with the relevant database from the primary evaluation for the school is carried on the secondary evaluation day.
- Generate the list of absentees on the day of primary screening and plan to complete the primary screening for absentees on the day of secondary evaluation.
- Complete the checklist given below to ensure all instruments / equipment and team members available to perform the service delivery.

Checklist for the secondary evaluation day

Check list for preparation of screening day					DATE:				
S.No	Item	Total	Check in	Check out	S.No	Item	Total	Check in	Check out
	Instruments								
1.	Portable Trial Set				36.	Router + Adapter			
2.	Measuring tape				37.	Camera			
3.	Pediatric Trial frame				38.	Junction box/ Power extension cord			
4.	Streak retinoscope with charger				39.	Tab + Charger			
5.	Direct Ophthalmoscope with Charger				40.	Generator (Optional)			
6.	Auto Refractometer (hand held) with charger				41.	LCD Projector & Screen			
7.	High contrast LogMAR self/ non illuminated VA chart with adapter				42.	Printer			
8.	Ishihara pseudoisochromatic plate				43.	Power Bank			

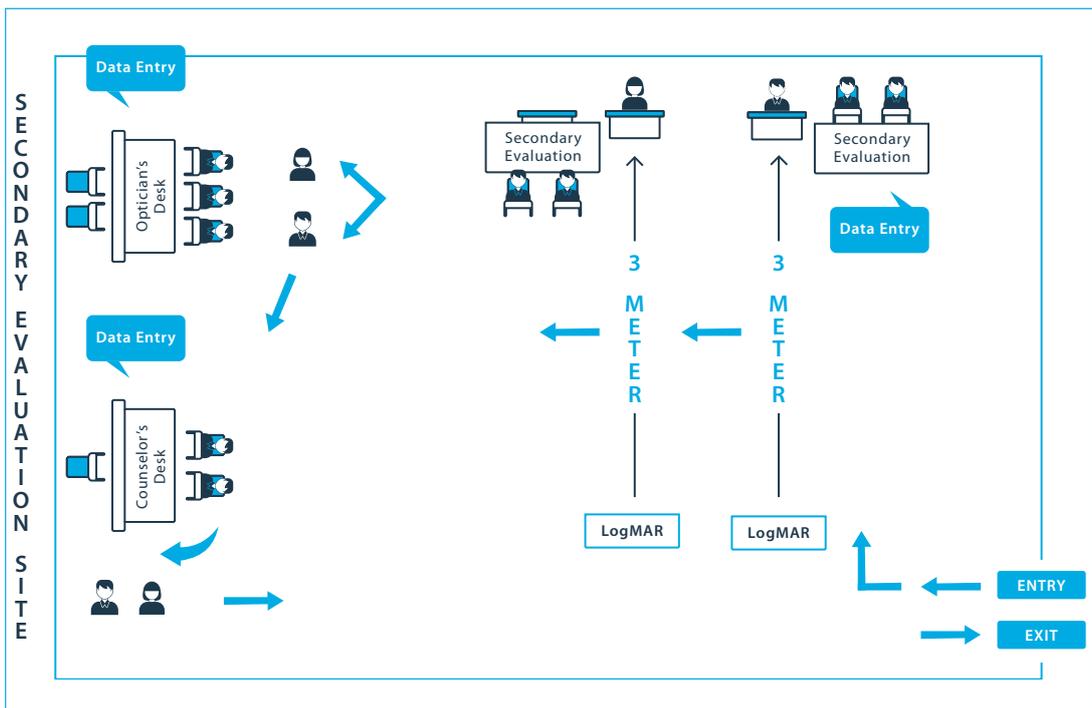
9.	Pinhole / Occluder				44.	Spare battery and bulbs			
10.	Maddox rod				Stationery				
11.	JCC(Jackson Cross Cylinder)				45.	Stapler			
12.	Lensometer				46.	Seal			
13.	Torch				47.	Stamp pad			
14.	TNO				48.	A -4 Paper			
15.	PVS				49.	Spectacle prescription pad			
16.	Duo Chrome				50.	Medicine prescription pad			
17.	LogMAR chart with adapter				51.	Referral card			
18.	Flippers				52.	Register for vision Ambassador			
19.	Howell Phoria card				53.	Registration form			
20.	MIM (Muscle Imbalance Measurement) Card Distance and Near				54.	Pen			
21.	Pupillometer / PD meter				55.	Notebook			
22.	Mirror				HR				
23.	Slit lamp (Hand held)				56.	Ophthalmologist			
24.	Frames/ Near vision spectacles for teachers				57.	Optometrist			
25.	Spectacles library				58.	Optician			
26.	Medicines (only when ophthalmologist present during the evaluation)				59.	Counsellor			
	IEC Materials				60.	Data Entry Operator			
27.	Handbook				61.	Driver			
28.	IEC materials for distribution				62.	Outreach Co-ordinator			
29.	IEC materials for display				63.	SDC - Co-ordinator			

30.	Case story format				64.	IEC - Co-ordinator			
31.	Consent form								
IT Equipment					Others				
32.	Laptop				65.	Sterllium Hand Rub			
33.	Hand rub Laptop charger				66.	Tissue Box			
34.	Mouse with Dongle				67.	Vehicle			
35.	UPS				68.	First Aid Box			

7.2.2.2 On the day of secondary evaluation

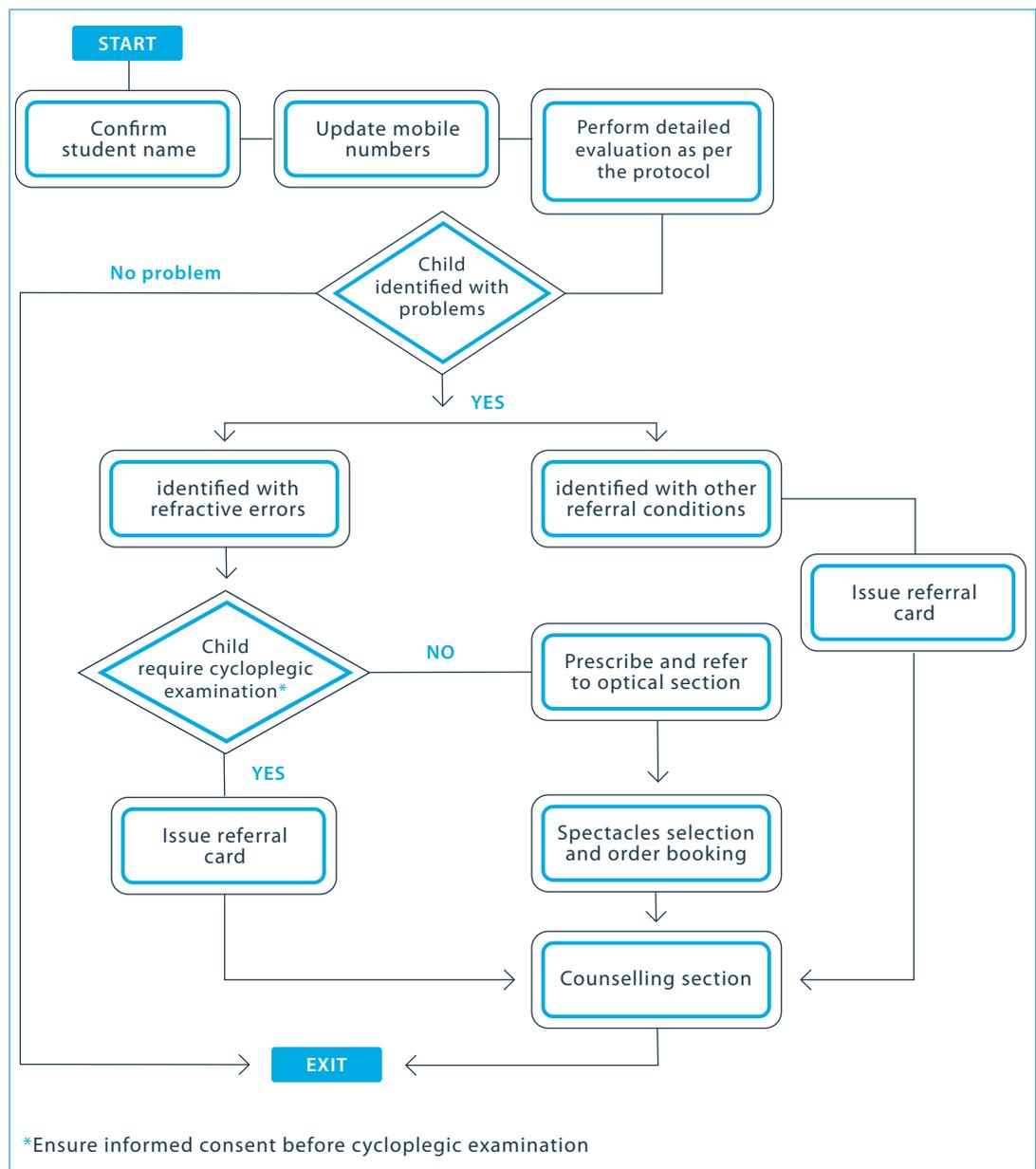
- Meet with the school headmaster / school co-ordinator and vision ambassadors and brief them about the day’s activities.
- Organise Teachers’ orientation & deploy teachers for class-wise screening.
- The project staff will orient the teachers collectively at the school campus using multimedia presentation and videos. [Click this link](#) for accessing various resource materials for teachers’ orientation.
- Orientation will include REACH project process, eye health and awareness, roles and responsibilities of teachers during screening, referral and compliance.
- Handover educational materials including school eye health [handbook](#) to all the participants.
- Maintain the teachers’ training record with their signature for documenting the participation. The details should include name of the school, date, trainer name, teacher’s name and their individual signature.

Arrange the examination room as per the layout suggested below:



- Ensure ambient room illumination, Electricity connections/ alternative power sources (power bank/ UPS support) for the day.
- Introduce the clinical team, vision technician from local area (only if there is any facility available within the coverage area of the respective school) and other community-based organization's representatives who have collaborated for this school eye health activities to the school authorities.
- Set up the optical display at the examination site
 1. Always carry adequate stock of frames of all shapes and colours to every school.
 2. Display the variety of frames in a table for the children to choose from the available choices.
 3. It is suggested to carry a foldable display rack in a suitcase for convenient display.

Secondary evaluation



7.2.2.3 Evaluation procedures

Refractive error estimation

- If the child is using spectacles currently, measure the power of the previous spectacle with the help of a Lensometer.
- Use REACHSoft to record the duration of current spectacle wear and the prescription.
- Perform refractive error assessment for all children referred after primary screening.
- Use internally illuminated log MAR charts for the identification of uncorrected and best-corrected visual acuity for each eye separately and binocular.
- Measure habitual vision, unaided or with spectacles if worn.
- Perform objective refraction using Spot vision screener/ streak retinoscope / autorefractor, and check for subjective acceptance. Find the best corrected visual acuity.
- Record the autorefractor values/retinoscopy and final subjective refraction using REACHsoft.
- Perform cycloplegic refraction in the school premises only in the presence of an Ophthalmologist (ensure necessary permission or adhere the local state government rules related to cycloplegic examination), after getting written informed consent from the parents. In the absence of an Ophthalmologist in the school refer all children to the base hospital for cycloplegic examination.
- Prescribe spectacles as per the spectacle prescription common guidelines (Annexure 12.7) to all those children whose vision improves on subjective refraction.

Ocular Examination

- Perform torch light examination for all the children to assess any ocular abnormalities at the anterior segment.

Direct Ophthalmoscopy Examination

- If possible, perform direct ophthalmoscopy on all children undergoing secondary evaluation.
- If logistical constraints prevent the above, perform direct ophthalmoscopy on those children whose vision in either eye did not improve beyond 0.2 logMAR with refraction.
- If any pathology is identified or if the cause of visual impairment is unknown the child must be referred to the base hospital for further examination, and the ophthalmoscopy findings should be described in the referral.

Binocular Vision Assessment

- When children have asthenopic symptoms (eye strain) with normal visual acuity, perform detailed evaluation including near point of convergence, phoria measurement and accommodation measurements.
- For any child identified with a non-strabismic binocular vision anomaly, arrange for vision therapy at the school premises.

Cycloplegic refraction

- Cycloplegic retinoscopy/refraction should be conducted in the following cases:
 - Age under 10 years
 - Children with any ocular deviation and with either eye
 1. cannot read 0.2 LogMAR, or
 2. can read 0.2 LogMAR with +1.50 D or
 3. is currently wearing prescription spectacles
 - Hyperopia with asthenopic symptoms

- Sudden shift or difference in refractive error beyond 2 D from the existing prescription
- Fluctuating visual acuity with fluctuating retinoscopy not correlating with uncorrected visual acuity
- In myopic cases, discrepancy between retinoscopy and subjective refractive error by >-0.75 D
- Dynamic Retinoscopy lag of > 1.00 D
- Cycloplegic agents: 2% Homatropine & 1% Tropicamide (< 10 years) 1% Tropicamide (=/> 10 years)

Spectacle prescription guidelines

Age group	Myopia	Hyperopia	Astigmatism
Less than 11 years	> -0.75 DS	> +3.00 DS	> -1.00 DC (With the rule, against the rule or oblique)
11 years and above	> -0.75 DS	> +2.50 DS	> -1.00 DC (With the rule, against the rule and oblique)

- The guideline mentioned here is applicable only on site for the following:
 1. All children who cannot read 0.2 LogMar.
 2. All children who can read both 0.2 LogMar and +1.5D test .
- Any prescription given outside this guideline at the school must have an explanation in the remarks.

Measuring Spectacle parameters

Frame size and interpupillary distance are important spectacle measurements.

Frame selection

- Those children who need spectacles should be allowed to choose their own frames.
- Display frames that are trendy and stylish with wide choice of colors, shapes and sizes.
- Provide mirrors for the children to see for themselves to select suitable frames.
- Ensure that the frame fits for the child well before the final decision.
- Document the frame dimension including size, box size, frame code, and color of the frame.
- Tag both the lens prescription and the frame together and submit it to optician.

Interpupillary distance

- Interpupillary distance (IPD) should be measured with a pupillometer/ PD meter. Hold the pupillometer at the eye level and request the child to hold the pupillometer and look at the target inside.
- Measure the distance IPD monocularly and record the readings.

Colour vision assessment

- All those children identified with colour vision deficiency during the primary screening will undergo a confirmatory test with the Ishihara pseudoisochromatic plates.
- This test must be performed only by a qualified optometrist / trained vision technician.
- The child with only a suspected colour vision defect and no other anomaly need not complete the other processes during the secondary evaluation and will be directed only for confirmatory test followed by counselling along with the parents.

- If there is no possibility for appropriate counselling at the secondary evaluation site, all children with a confirmed diagnosis of defective colour vision must be referred to the base facility for career counselling.

7.2.2.4 Optional tests

Near Phoria Test

Near phoria and Near point of convergence are measured as a part of minimum battery of tests needed to identify binocular vision anomalies in school vision screening. The presence of heterophoria and the magnitude of deviation is measured using the Modified Thorington test. This procedure is conducted for children in class 8th to 12th standard.

- The test is conducted in a moderately illuminated room ensuring the visibility of the red line produced by the Maddox rod.
- The child wears his/her optical correction.
- The Maddox rod is placed in front of the right eye with the streaks oriented horizontally to measure the horizontal deviation and vertically to measure the vertical deviation.
- The child is then instructed to report the number through which the red streak passes along with the direction of the streak's deviation (center, right, left, up or down).
- Heterophoria greater than +/- 4 would be considered for vision therapy
- Cover test is performed when the child has a difficulty in comprehending the modified Thorington test.

Near Point of Convergence (NPC)

- The testing is done in a dimly illuminated room with the child's optical correction worn.
- With the red filter in front of the right eye the child is asked to fixate the pen light from 40 cm.
- The pen light is taken closer to the eye 1 – 2 cm/ second; the child is asked to report when he/she sees a red light and an orange light separately (double) and the value on a ruler held adjacent to the light is noted as the subjective NPC break.
- If the examiner observes a loss of fusion, without a subjective report of double, the point at which the examiner observed a loss of fusion is considered the objective NPC break.
- Once the break is noted, recovery of fusion should be noted by slowly moving the pen light away from the eyes, the point where the child reports single vision or the examiner notes a recovery of fusion.
- The break and recovery would be repeated for three times within interval of 10 seconds between each paired break and recovery measurements.
- A value of 10cm and above with penlight and red filter is considered abnormal and those students are further managed with vision therapy procedures.

7.2.2.5 Criteria for further referrals

Following are the indications for the referral to the base facility:

- All children who requires cycloplegia which cannot be performed on-site.
- All children with any ocular diseases requiring further evaluation and /or management.
- Other ocular conditions such as low vision, high myopia, strabismus, nystagmus, congenital ptosis, vernal catarrh, corneal opacity and degenerations, congenital cataract, retinal dystrophies and degenerations or any other condition that warrants further evaluation by an ophthalmologist.
- All children with complex refractive errors needing re-confirmation.
- Confirmed colour vision deficient children for career counselling.
- All children with special needs (who have not had a detailed examination in the last 2 years).

Counsel children who need spectacles/or referral

All those children who were prescribed spectacles or referred for further examination at the base hospital are counselled about the need for spectacles and the importance of referral services. The following procedure is recommended:

- Issue a referral card to those children and clearly instruct them to hand it over to their parents.
- The referral card should contain the hospital phone numbers and details of the social worker and counsellor who will be the contact point when they visit to the hospital.
- Explain to them the possibility of getting free treatment and free spectacles when they present with this referral card within the stated time period at the referred facility.
- Explain to them clearly that parents must accompany them on the day of spectacle distribution to receive the spectacles.
- Children and parents should be instructed to contact the social worker / counsellor at the base hospital for any further queries while accessing the services.
- Handover all the communication/ eye health materials (comic books, etc) to the children and request them to read and share with other family and friends in their vicinity.

Referral Card Sample:



Spectacle ordering and checking

- Once the screening is complete, send the selected frames to the optical services for dispensing of lenses.
- Using REACHSoft Optician Module, the optician has to update all the spectacle booking.
- Once the spectacles are ready the power, frame dimensions and the frame model chosen by the child have to be rechecked and the spectacles are made ready for the distribution.

Teachers' screening and refraction

As teachers are one of the important stakeholders in educating the children and the parents, it is important to screen all the teachers for refractive errors on the day of secondary evaluation. This will be an added opportunity for the implementing organization to provide screening and refractive errors service delivery to these key stakeholders whose participation and support is essential for achieving effective school eye health.

- Conduct a basic eye and vision screening for all school teachers present on the chosen day.
- Prescribe spectacles where necessary and issue referral card for those who require further detailed evaluation at the hospital.
- The teachers' screening is limited to refractive error correction and this does not constitute a comprehensive eye examination. This information must be emphasised and all participants including teachers must be encouraged to undergo a detailed eye examination at the fixed facility.

7.2.2.6 Post Evaluation

- Complete screening details of the children including the total number screened, number of spectacle prescriptions, number of other referrals and submit the summary details to the Headmaster (Refer Annexure: Thank you letter and eye screening report - 12.11). The detailed list will be handed over to the headmaster (HM) once the data is synced.
- Generate the list of referrals / spectacle prescription by individual class wise on the day of evaluation and hand over to the respective class teacher (Refer Annexure: Spectacle prescription summary list – 12.12).
- Discuss with the headmaster and agree on a date for spectacle distribution. The headmaster will need to send a formal request to the parents for all those children prescribed with spectacles and identified for referral services and invite them to be present on the spectacle distribution day. This will enable all the children to collect their spectacles along with their parents and for those who need to access referral services, the purpose will be explained to the parents based on the referral issued earlier.
- Handover the certificates for the student volunteer vision ambassadors to the HM in recognition of services they provided (Refer Annexure: Sample certificate of appreciation – 12.13).
- If the school has decided to implement REACH clubs, the IEC co-ordinator must finalise the implementation plan for the respective school. See Annexure 12.4 for more details on the REACH club's implementation.

Syncing of the data into live server

- Once the secondary evaluations are completed, the data need to be synced to the server after reaching the base facility. The data goes live into the secured cloud server and the data will be available online for the registered users.

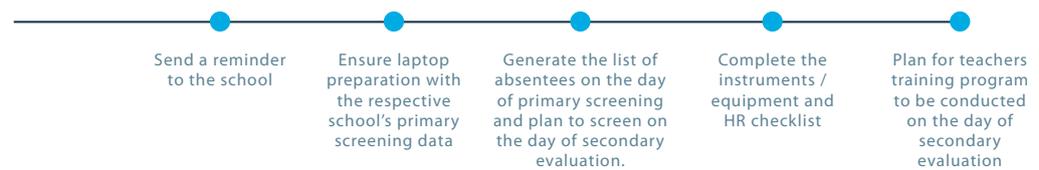
Assets handover and clearance

- After completion, a designated person checks the asset list, modifies this to show any changes such as loss or breakage of equipment and asks the personnel in charge to sign the asset register.
- Any repairs/ calibration requirement for any equipment need to be documented at the end of secondary evaluation and must be completed before the next service delivery activity.

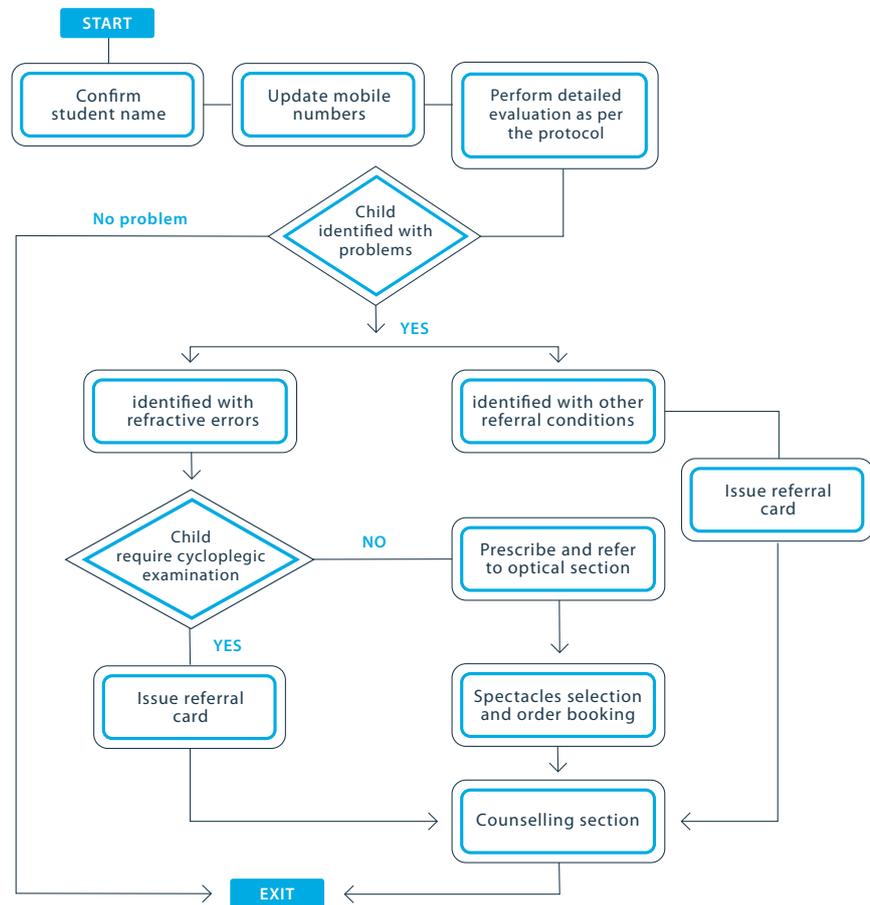
SECONDARY EVALUATION

Secondary evaluation should be conducted only by a qualified optometrist/ trained refractionist / trained vision technician at the school campus.

Planning for Secondary Evaluation

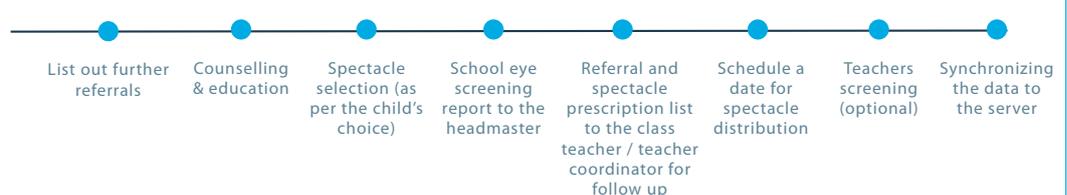


Secondary evaluation process flow



*Ensure informed consent before cycloplegic examination

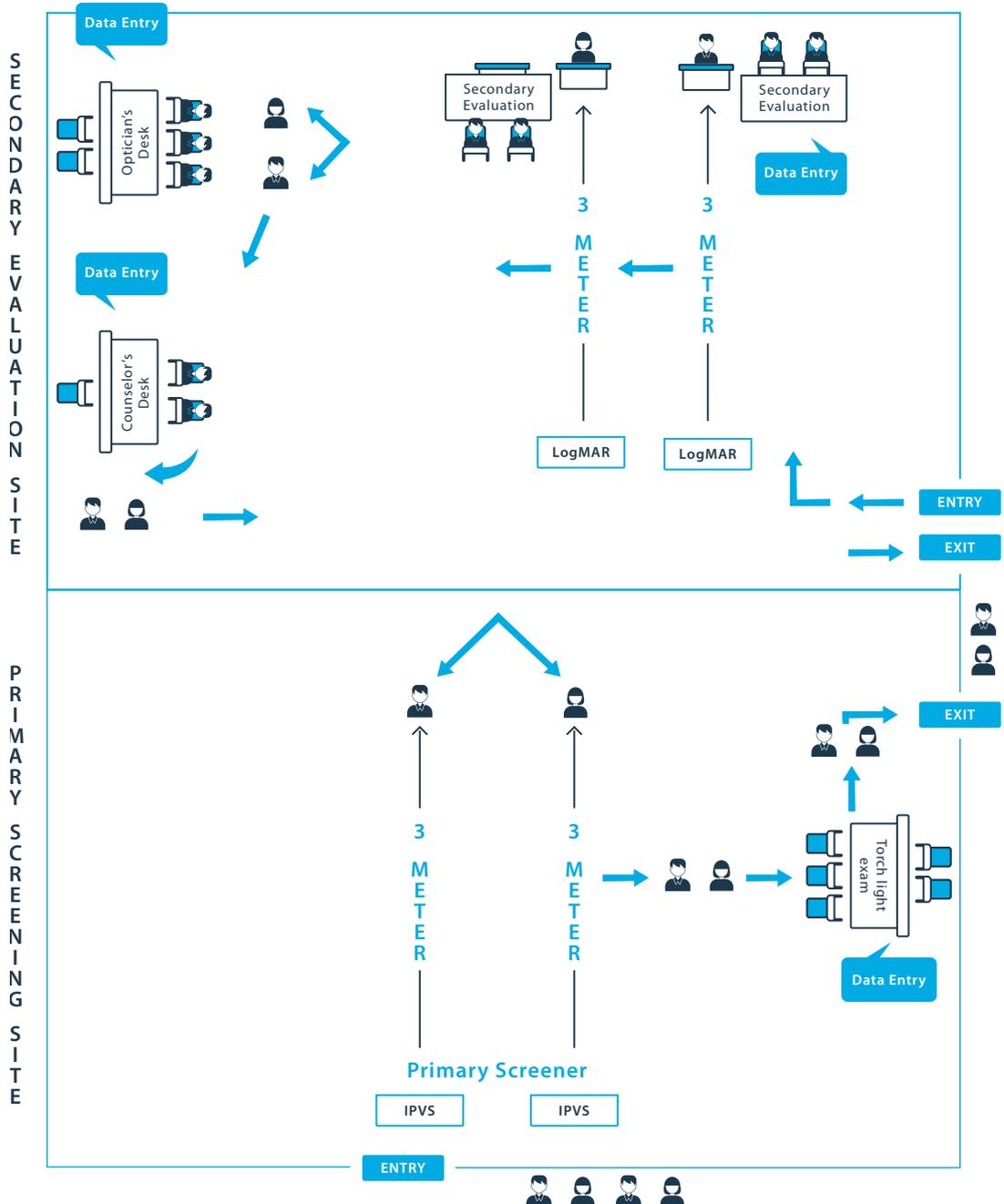
Post Evaluation



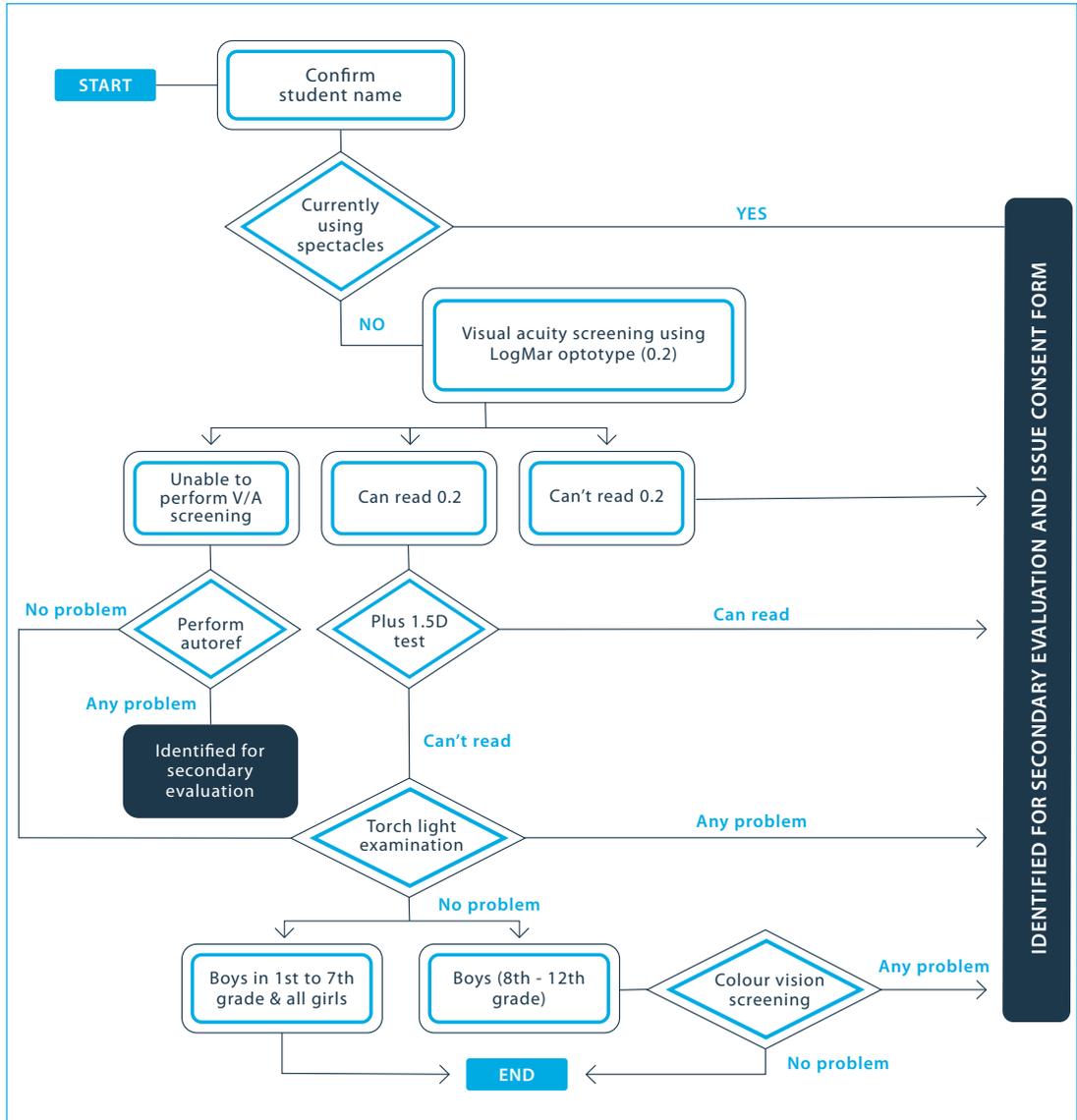
7.2.3 Combined activity (primary screening and secondary evaluation)

If the implementing organization planned to organise both primary screening and secondary evaluation on the same day, follow the preparations described above under primary and secondary evaluation. Please consider the following variations in the process when there is a combined activity.

- This combined activity provides an opportunity to screen all children in grade 1 – 5 using an auto refractor and assess the visual acuity objectively. If visual acuity test using LogMar 0.2 was feasible then they will undergo all the processes similar to older children. However, if the visual acuity test was not feasible then it is important to estimate refractive error using an auto refractor in these age groups as described the flow chart shown below: This process helps to ensure that all refractive errors are identified.



Combined Primary Screening & Secondary Evaluation



7.2.3.1 Quality assurance

Plan and implement quality assurance programs targeted at the team functions, data quality and overall processes involved in the project. Assign the quality assurance responsibilities to both the Project Manager Lead Optometrist/ Vision Technician.

Team

- Ensure every individual receives a user id after rigorous training. It is mandatory not to share the login details with others and use their individual login at all times when they are involved in service delivery. This helps in tracking the quality of service rendered by the team and for planning the team training if required.
- Ensure the vision screening team are certified and the refractions are conducted by appropriately qualified personnel.
- Train the trainers for continuous monitoring and support to ensure quality in service delivery.

Data

- School coverage in the target population.
 - Over 80% coverage in all government schools.
 - Maximum coverage in private schools (Depends on the approval to conduct school eye health activities).
- Ensure 10% of the primary screening data to be scrutinized by the lead optometrist to ensure all required fields are completed- onsite.
- Correlate the visual acuity and refraction values recorded on 10% of the refractions performed.
- Check for all typographical errors at regular intervals.
- Randomly check the results of +1.50D lens test - onsite by the lead optometrist.
- Cross check the total number of spectacle bookings against the actual delivery to teachers, parents and to the children.
- Check timely delivery of spectacles (difference between the date of booking and the actual delivery date).
- Produce an overall report to look for trends in refractive errors, compliance and referrals by age, gender and region wise.
- Check regularly the team's understanding of the data entry fields to ensure correct data being captured - onsite.

Entire process on site

- Fix one day of the month to check quality assurance at the schools. A trained optometrist / refractionist / senior vision technician repeats evaluation of 10% of the children or at least 25 (whichever is higher) on that screening day.
- Auto-refractometer reading to be documented for every 5th child screened who pass the PVS for classes 1 – 3, and for every 20th child from class 4-12.
- Detailed examination
 - Recheck of refraction by the lead optometrist for 5% cases.
 - Recheck retinoscopy with autorefractor for minimum 20% of cases.
 - Correlate clinical findings with subjective acceptance.
 - Recheck data entry and glass prescription for 5% of the spectacle prescriptions.
 - Recheck whether the Spectacle prescription is as per guidelines.
- 10% of the spectacle prescriptions should be checked for errors by the Lead Optometrist.
- The project manager should make an unannounced visit to the screening site (3 schools for every quarter). During the visits, the manager should assess the following parameters and take necessary action.
 - Check for the correctness of flow of the process.
 - Recheck refractions and other referrals.
 - Check the procedure for handover over of the data to the school authorities.
 - Monitor the communication within the team and with externals.
 - Decide on retraining.

7.2.4 Spectacle management

Once the spectacles have been prescribed and the child has selected the frame post-secondary evaluation, the next step is to ensure spectacles reach the children within two weeks of secondary evaluation. Five steps for spectacle management are as follows-

1. Submit prescription with selected frames to optical shop
2. Preparation of spectacles
3. Collection of spectacles from optical shop and verification
4. Delivery of spectacles
5. Disseminate communication material

7.2.4.1 Submit prescription with selected frames to optical shop

- Screening team will extract spectacles prescription summary list (SPSL) of every school from REACHSoft. (Refer Annexure 12.12)
- Spectacles prescription summary list duly signed with date will be sent to the optician at the optical shop by the screening team.
- Each frame should be labelled clearly with the required prescription, the frame details and the student ID at the time of spectacle booking and double check at the time of submission to the optical shop.

7.2.4.2 Preparation of spectacles

- The Optician will collect and sign with date upon receiving the SPSL and prepare the spectacles.
- The optician would ensure the availability of all the required lens blanks, and order any that are not immediately available.
- The preparation of spectacles may be carried out at the optician's location which may be an eye camp site, vision centre, base hospital or mobile dispensing unit.

7.2.4.3 Delivery of spectacles from optical shop and verification

- The SPSL and spectacles are sent by the optician to the outreach co-ordinator. The spectacles should be in hard case with a lens cleaning cloth included.
- The co-ordinator checks the lens power using a lensometer and verifies the frame specification. Any discrepancy must be rectified by the optician.
- The co-ordinator keeps records of received and pending spectacles and the status is updated in REACHSoft.

7.2.4.4 Planning for delivery of spectacles to students

- Prior to the delivery of spectacles, the outreach co-ordinator should plan delivery based on the number of students, schools, and proximity of location.
- The outreach co-ordinator should agree with school authorities a date on which to inform parents at least two days prior to spectacle delivery either through text message, phone call or e-mail.
- The co-ordinator will also request help from school authorities in the form of teacher co-ordinators, vision ambassadors and where possible parents to assist the team with spectacle delivery at the school.
- Tablets should be prepared by the IT support person at least one day before delivery of spectacles. The following items should be available at the time of delivery to each student:
 - PVS (primary vision screening card, to check acuity with the spectacles)

- Spectacles
- Spectacle hard case
- Lens cleaning cloth
- Tablet
- Fitting instruments for frame adjustments as needed
- IEC material
- Human resource (HR) required for spectacle delivery depends on the number of spectacles to be delivered to students. It is recommended to have 1:5 HR and children ratio.

7.2.4.5 Delivery of spectacles

- The spectacles are delivered to the student after checking the fit in front of teacher co-ordinator and where possible parents.
- As a part of quality check, test the visual acuity for each eye separately to match with the recorded best corrected visual acuity. This will be conducted by the co-ordinator and if acuity does not meet the expected level provision of spectacles should be deferred until they have been re-checked and any error rectified.
- Parents will be counselled by the co-ordinator on the importance of compliance with spectacle wear and on care and correct handling of spectacles.
- The REACHSoft is updated to show that the spectacles have been delivered to the student. Pending status of any non-delivered spectacles due to quality issues should be updated in the dashboard with a reason for non-delivery and a reminder from REACHSoft should be sent to the co-ordinator within a week.
- To ensure spectacle delivery to children who are absent on delivery day, the teacher co-ordinator/ headmaster (HM) would be requested to arrange delivery of spectacle to the child and parents are also informed by the outreach co-ordinator.
- The total number of students absent should be updated on the REACHSoft dashboard with reason and a reminder should be sent to the outreach co-ordinator within a week to follow up with teacher co-ordinator/HM/parents.
- However, if the number of children present is lower than specified in the REACH guidelines, then the outreach co-ordinator must plan a second visit to complete delivery of spectacles. In this case, a counsellor should be involved, to make phone calls to the parents and to ensure the spectacles are collected from school.
- Final report on spectacle delivery to be shared with the HM and his/her acknowledgement to be received.
- Data on spectacle delivery should be synced to the server on the same day.

7.2.4.6 IEC Dissemination on the day of spectacle delivery

- The teacher co-ordinator/Vision Ambassador should be the contact people for sharing communication material.
- On the day of spectacle delivery, students receiving spectacles should be assembled and engaged by the IEC Co-ordinator and Vision Ambassador or any of the student with support of IEC material. Eg. one can read aloud singing tree book with the group once the spectacle delivery is done.
- IEC Co-ordinator to maintain record of the number of materials distributed per school. Depending upon the local circumstances, the spectacle delivery day can be used to raise awareness on eye health beyond school by involving local influential persons, Village heads, local NGOs, ASHA workers or AWW, parents, teachers and media wherever possible.
- The following list of IEC material can be used and also refer to the IEC matrix described earlier in the planning section for more suggestions.

- Spectacle booklet/ leaflet with Instructions on how to take care of your spectacles.
- Timetable card with reminder to the children about the spectacles.
- Spectacle case printed with messages.

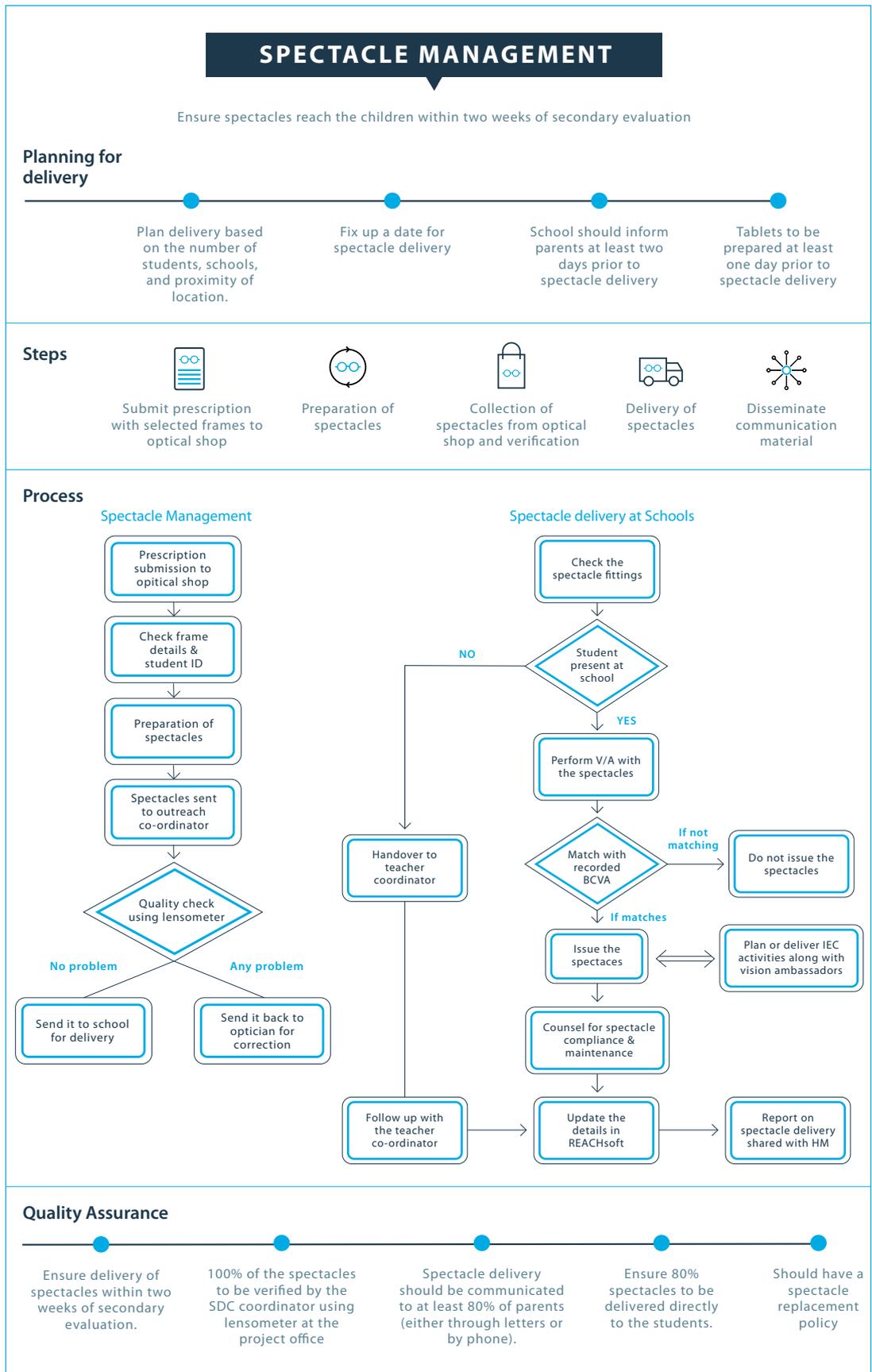
7.2.4.7 Quality Assurance

- Outreach co-ordinator should track the spectacles at all stages on REACHSoft i.e. prescribed, booked, prepared, and delivered.
- Outreach co-ordinator should ensure delivery of spectacles within two weeks of secondary evaluation.
- 100% of the spectacles to be verified by the SDC co-ordinator using lensometer at the project office.
- Spectacle delivery should be communicated to at least 80% of parents (either in person or by phone).
- Ensure 80% spectacles to be delivered directly to the students.
- Assessment of the counselling can be done by unannounced visits or video recording by the project manager to assess information provided on:
 - Importance of continuous wear
 - Maintenance of spectacles
 - Where to access for any problem

7.2.4.8 Replacement policy

The project should have a spectacle replacement policy for the following conditions:

- In case of incorrect prescription given by the project team.
- If the frames or lenses are defective at the time of delivery.
- In case of any breakage or loss within 3 months of delivery. The policy for charges of replacement can be decided internally by the project and hospital team.
- Co-ordinator – Spectacle delivery and compliance should be made responsible for receiving all communication related to spectacle replacement and he / she should follow up the matter and ensure the spectacles are replaced as per the organization policy.



7.2.5 Referral management

The primary objective of referral management is to ensure all those children identified for further management after secondary evaluation (refer to the secondary evaluation section for referral criteria) must be followed up until they reach the base hospital to undergo any necessary treatment. It is important to follow certain strategies based on location/context and make sure that the child's parent understand the need for treatment. This is possible only when the base hospital identifies a counsellor for effective communication with parents.

The following are the key steps in Referral Management-

7.2.5.1 Counselling in the school premises

At the school premises the counsellor will meet individually all those children who are prescribed with spectacles and children who are referred to the base hospital.

- The children are counselled about the need for spectacles and referral to the base hospital. The primary contact and alternate contact details in the REACHSoft database are updated for further communication.
- The need to bring parents on the day of spectacle distribution is explained to the children. Information about any cost of spectacles is also provided.
- For children who are referred to the base hospital, the referral card should be given in the local language with the details of the contact person (Counsellor) and address of the base facility with the date and time of the hospital visit indicated clearly. (Refer sample referral card displayed in section 7.2.2.5)
- Ensure parents are informed about the details of the referral including the condition for which the referral letter is given, the location and contact person at the base hospital and the time validity for receiving free services at the base hospital. It should be clearly mentioned that the validity of referral card is one month (or any other fixed period must be mentioned as per the policy of hospital) for availing free services at the referred facility.

7.2.5.2 At the base hospital

For the referred children, the counsellor should do the following things -

- Referral advice must be reiterated by the counsellor via a telephone call to the child's home and she/he must follow up via calls if the child fails to arrive within the allocated date.
- In non-priority referral cases: If the child fails to attend the hospital and the family does not respond after up to five telephone calls at one-week intervals (the final call being approximately one week beyond the hospital's period for subsidised treatment), the child is no longer contacted.
- While no further calls are made to the family, the counsellor may further enquire with the teacher co-ordinator / REACH advisor to determine whether further effort could be made to facilitate the child's attendance at hospital.
- In priority referral cases: The counsellor must persist with rescheduled calls and work with the teacher co-ordinator or REACH advisor to ensure that the child receives the treatment.
- It is recommended for the project lead to periodically reorient the base process to be followed when referred children reports at the facility.
- When the child arrives at the hospital, the child must meet the designated place/ person mentioned in the referral card, who will guide them through the hospital process. Once the child completes the first visit, they must return to the counsellor before leaving the base hospital. At the end of every visit, the counsellor tags hospital medical record (MR) number and update relevant clinical information into the REACHSoft database.
- When the child / parent needs help or support during the hospital visit, they can approach the counsellor at any point.
- Identify and document compelling case stories. **(Refer Annexure 12.15: Case story template)**

Priority referral conditions:

S No	Group	Description
1.	High myopia	>-6D
2.	High hyperopia	>+4D
3.	Cycloplegic refraction	Children under 8 years
		Hyperopic refractive error
		Varying reflex
4.	Cataract	total cataract
		congenital cataract
		central opacity
		media opacity
		cortical cataract
		developmental cataract
5.	Injury	penetrating
		perforating
		blunt
6.	Acute conjunctivitis	
7.	Strabismus	Tropia

Role of SDC Co-ordinator

The SDC Co-ordinator who is designated for compliance check will also have a key role in engaging community in strengthening referral system.

- During the compliance check in the schools, he /she must involve the teachers to discuss about importance of referral and treatment for the child.
- He/ She should seek the help from various stakeholders (ASHA, teachers, community head and other influencing persons) to counsel the parents for the importance of visiting the fixed facility and to complete all necessary treatment suggested for the child.

Other Strategies to increase the uptake of referral services-

- The role of existing vision centers (VCs) in the catchment area can be expanded to provide services to referred children, tracking and follow up of other children referred to any fixed facility.
- When no VC exists in the project area, a new VC may be established to provide an additional contact point for families of referred children.
- VCs provide sites for cycloplegic examination under the supervision of an Ophthalmologist.
- While the REACH IEC counsellor has particular responsibility for communication and education, any project staff should take opportunities to sensitize the PMOAs/ASHA/Anganwadi workers and teachers to improve their knowledge base pertaining to eye health.
- PMOAs/ASHA/Anganwadi workers can be engaged in follow up of referrals wherever possible. If their services add value to the referral and other services of the project, plan and recognise their service either through remunerative or non-remunerative ways. Examples of non-remunerative / remunerative recognition include the following:

- Free eye tests for ASHA workers and their family members.
- Discounts/subsidised rates in surgical fees and spectacle costs for the individual and their family members.
- Reimbursement of transport expenses for coordinating referral visits.
- An annual award function at the hospital or project area to recognise the contributors.

To enhance the involvement of teachers, the project team should acknowledge the teacher's contribution with a small award.

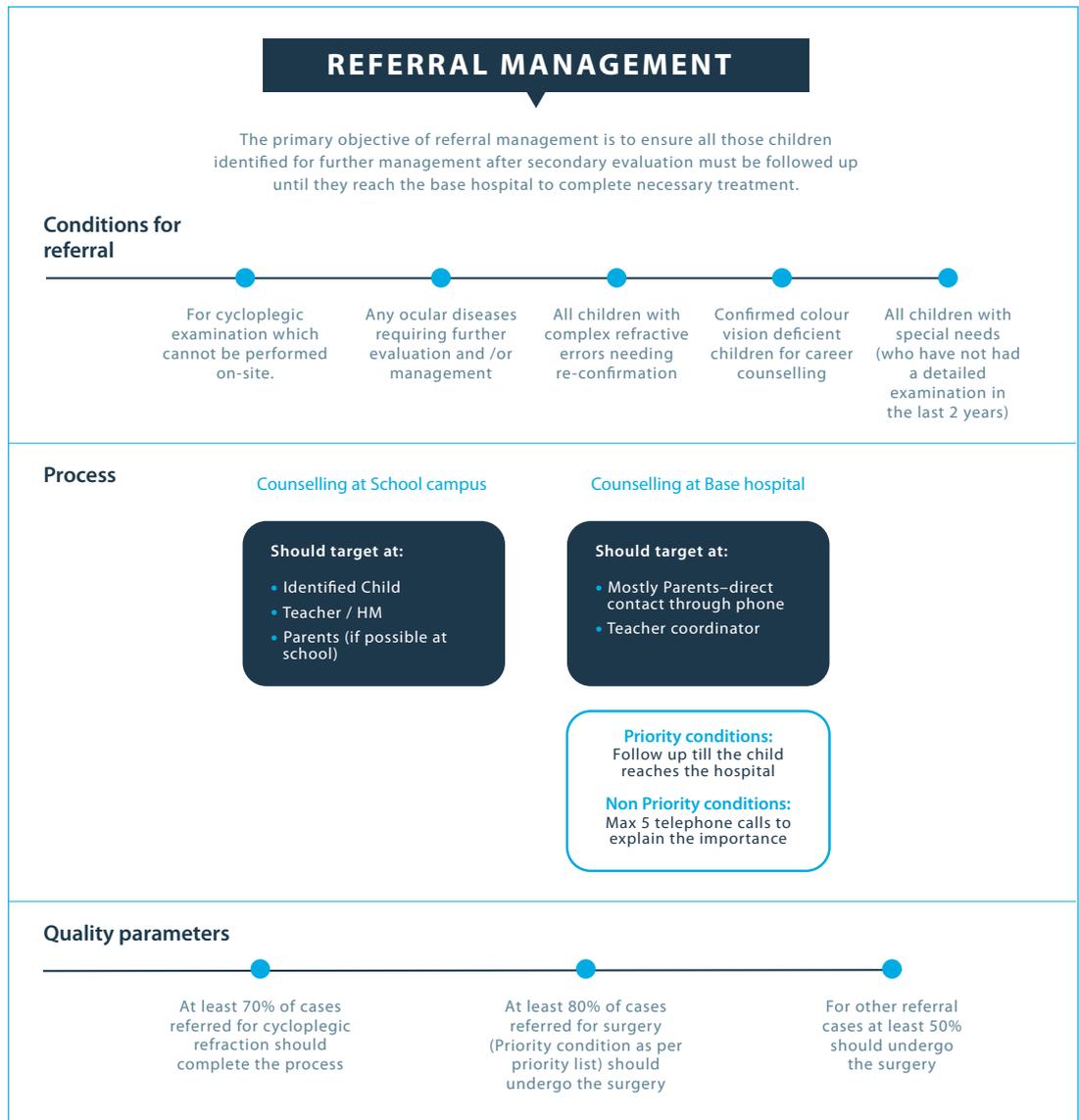
The project team can also send personalised letters to teachers to inform children about the importance of referral services.

The hospital must encourage the referrals by facilitating transportation and reimbursement for children whose treatment must be completed as a priority.

7.2.5.3 Quality check for referral management

- To provide quality markers, the project should fix targets for ensuring referral compliance on an annual basis. Some suggested markers are as follows:
 - At least 70% of cases referred for cycloplegic refraction should undergo this process.
 - At least 80% of cases referred for surgery (Priority condition as per priority list) should undergo the surgery.
 - For other referral cases at least 50% should undergo the process or treatment for which they are referred.

The above-mentioned percentages are minimum requirement, but the project should aim to achieve maximum compliance among the referred children.



08 CONSOLIDATE

8.1 Compliance

Once the child has been provided with spectacles, ensuring that s/he wears them is critical to improve vision. Along with this, it is critical that the children identified and referred for further examination at the base hospital/ vision center report to the facility and undertake appropriate treatment. Hence, compliance constitutes a key component of the REACH project. This section provides guidelines to monitor compliance (including spectacle and referral compliance) among school children.

The recommended time frame for compliance visit is three months post the date of spectacle delivery. A buffer period of seven days before or after the three months' timeline should be considered to allow the implementing team to plan their visits and other logistics.

8.1.1 Planning compliance assessment visit

The planning of compliance visits should start two months post the spectacle delivery, to enable the compliance officer to visit schools during the compliance time frame. The compliance officer should consider planning for the following three components during the compliance assessment visit:

- Monitor spectacle compliance for students prescribed spectacle during secondary evaluation as well as the ones advised to continue their existing spectacles.
- Conduct primary screening for students who have not yet undergone this process.
- Referral compliance: Follow up with students who were referred to the base hospital/ vision center on secondary evaluation but have not attended.

Prior to the compliance visit, the following should be planned:

1. SDC Coordinator should have the list of schools and students due for compliance, which can be generated from REACHSoft.
2. The compliance visit should be performed as an unannounced visit for the students, as it also monitors spectacle compliance, along with the referral compliance. However, it is mandated that the outreach coordinator/ SDC Coordinator informs the school authorities (only Principal, HM, teacher coordinator) in advance and request them to not inform the teachers and students beforehand as prior notice might lead to non-compliant students presenting with spectacles. If school authorities are not informed in advance, the implementing team could be denied entry to the school on that day.
3. Equipment: The equipment required for compliance visit include primary screening kit (refer to section 7.2.1.1) and referral card. The SDC Co-ordinator should ensure all equipment are available prior to the visit.
4. Tab preparation: Once the visit plan is confirmed, SDC coordinator should have the tab prepared. This should be done at least one day prior to the visit.
5. IEC materials: Refer Annexure 12.4 – sample communication plan for various IEC materials to be used during the compliance visit.

Quality Assurance: The quality assurance criterion is a compliance rate of 60% for all prescriptions (60% of the children who were prescribed spectacles are wearing when visited at the school). If compliance rate is less than 60%, the causes should be identified and the team should intervene as appropriate (e.g. with communication). For schools with fewer than 10 children with spectacles prescriptions, a compliance visit is not mandatory. However, if a visit is not planned or any child is

absent on the compliance day, a telephone call should be made for compliance assessment and the outcome recorded in REACHSoft.

8.1.2 Assessment Day

On the day of compliance assessment, the compliance officer conducts an unannounced visit to the school to see the students who were prescribed spectacles, those who had not undergone primary screening yet and those who were referred for further evaluation but have not yet reported at the hospital.

1. Student identification:

Students will be observed in their respective class rooms and the respective class teacher would be informed just before the class visit. Students prescribed with spectacles should be identified and assessed as to whether they are wearing (spectacles on the face) / not wearing spectacles, and this should be recorded in REACHSoft.

2. Complete spectacle compliance /non compliance questionnaire:

Compliance questionnaire should be administered for children wearing and not wearing spectacles. For students wearing spectacles, questionnaire section 1 will be administered and for those not wearing spectacles, questionnaire section 2 will be administered (Refer Annexure 12.16 – Compliance assessment questionnaire). The questionnaire is to be administered individually and not in a group (to avoid all students providing the same answer) and no question should be omitted.

3. Check presenting vision:

Check the vision of the students using the PVS card for the left eye and the right eye separately following the same procedure as for primary screening (refer section 7.2.1.3). Based on that procedure, any student who is found to require secondary evaluation should be referred to the base hospital/ VC. Teachers/ school authorities/ parents/ community workers/ counsellors must be informed about the referred children to follow up and to ensure they report to the base hospital/ VC 7.2.5.

4. Checking the condition of spectacles:

For students who are wearing their spectacles, the Coordinator – Spectacle delivery and compliance should check their condition and if required make any minor adjustments either onsite or by referral to the nearest Vision Center. If spectacles require replacement, SDC Coordinator should coordinate this with the outreach coordinator. The implementing partner organization's policy should be followed for spectacle replacement (refer to spectacle management section 7.2.4).

5. Referral Compliance assessment:

The Co-ordinator- SDC Coordinator identifies all children who were referred to base hospital/ vision center on secondary evaluation and have not yet reported to any fixed facility. The coordinator should seek to understand from the child individually the reasons for not compliance and record these in REACHSoft. If the child has reported misplacing the referral card, the compliance officer should provide a replacement.

6. Primary Screening:

For students who had not yet undergone primary screening, this should be carried out on the day of compliance assessment and if required, they should be referred to the nearest VC or to the base hospital. This should be recorded in REACHSoft.

7. IEC:

Check display of IEC materials, educate the children about the importance of both spectacle and referral compliance. Reorient the REACH ambassadors in the school to continue the REACH club activities with special focus on improving the compliance to spectacle wear and referral services.

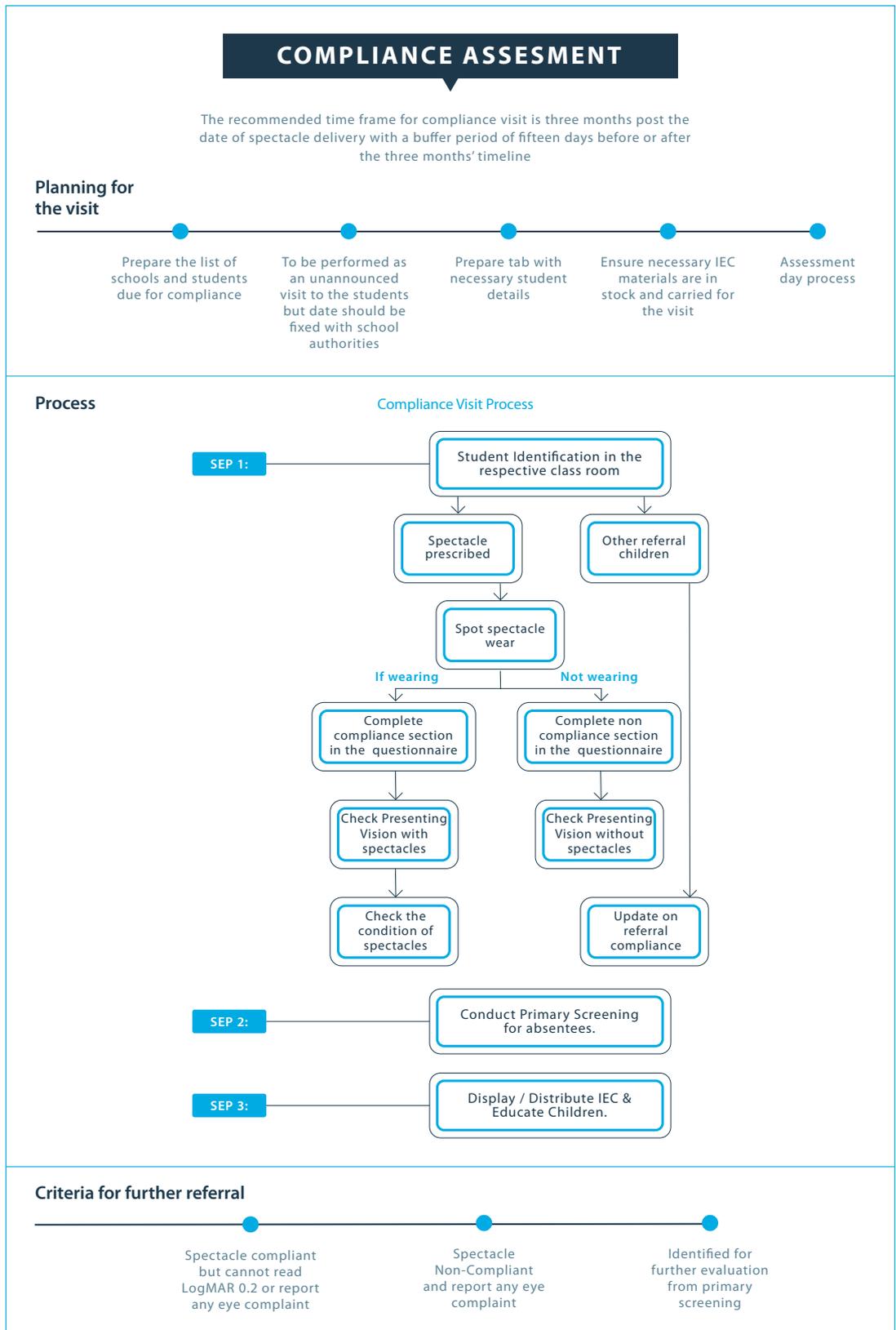
Referral Guidelines:

During the compliance assessment visit, students to be referred for further evaluation at base hospital/ vision center should be identified as per the following guidelines:

- Spectacle compliant but cannot read LogMAR 0.2 or report any eye complaint.
- Spectacle Non-Compliant and report any eye complaint.
- Identified for further evaluation from primary screening.

8.1.3 Post assessment

Synchronize data: Compliance officer to record the compliance status in REACHSoft. Internet connectivity is required for syncing of data into server. Syncing of data should be done on the same day on returning to the base facility. Asset handover and clearances should be completed post assessment.



8.2 Annual follow-up

Annual follow up is an important activity in the REACH project. This activity provides an opportunity to re-examine the children who have been identified with any eye problem in the previous year. This helps in ensuring whether the child has completed the recommended service delivery. Further it helps us in identifying any need for additional services required for the child. In addition, all new admissions in this year and other potential age groups of children who are likely to develop refractive errors can be examined during the annual follow up.

8.2.1 Planning for the day

The project team must organise an annual follow-up to each school included in the project. Prior to the annual follow-up, the project coordinator ensures that the following activities are completed in order:

- Using REACHSoft the team generates the schedule for annual follow-up, only for those schools which have completed both primary and secondary evaluation. The follow-up date should be set at one year plus or minus one month (window period) from the secondary evaluation date for the respective school.
- The annual follow-up date must be agreed with the respective school headmaster / principal before it is finalised.
- The finalised date and requirements for the annual follow-up should be communicated to parents (see Annexure: 12.17 Annual follow-up intimation letter.)
- Ensure the availability of the teacher coordinators who were involved in the previous evaluations; if not, new teacher coordinators who are available should be identified and given appropriate orientation prior to the follow-up date.
- Re-orient the school headmaster/ Principal the following category of children will be examined during that follow-up and the rationale for screening them:
 - All children who underwent secondary evaluation in the school
 - Children newly enrolled in the school in the given academic year
 - All children in 1st, 8th and 11th grade
 - Additionally, screen all children who have complaints as self-reported or identified by the teachers / vision ambassadors
 - All children who could not complete (absentees) eye screening during the last year
- Email or personally handover the list of previous year's secondary evaluation list to the school prior to the annual follow-up.
- Collect and update all the new admissions list and all the students in 1st, 8th, 11th grade section wise prior to primary screening. In certain cases, the list will be available on the day of follow-up. Hence, make necessary plans to enter the data on site on the day of follow up. This may require an additional person for data entry.
- Prepare all logistics as for the primary screening and secondary evaluation conducted previously in the school.

8.2.2 On the day of follow-up

- Arrange the site separately for primary and secondary evaluation as described earlier in the 'Deliver' section 7.2.
- Organise refresher training for all the school teachers, REACH advisors and REACH ambassadors in the school.

- Complete both primary screening, and secondary evaluations for all the children as listed above.
- During the annual follow-up, recognize the schools for their participation.
- Honour REACH advisor, REACH ambassadors and others, who have rendered support in implementing the project in the respective school.
- Recognise all the volunteers and other representatives from the local vision centre, NGOs, other community-based organizations who supported the activities.
- Use this opportunity to involve/ honour alumni of the school and engage them actively.

8.2.3 Post evaluation

- Complete screening details of the children including the total number screened, number of spectacle prescriptions, and number of referrals and submit the summary details to the Headmaster / Principal.
- Generate the list of referrals / spectacle prescription by individual class wise and provide this to the respective class teacher.
- Once the follow-up activities are completed, the data need to be synced to the server after reaching the base hospital.
- The counsellor at the base hospital will check that children who are referred at the follow-up evaluation do attend for their hospital appointment and will update this information on REACHSoft.
- After completion of the follow-up, the outreach co-ordinator checks the asset (e.g. equipment) list, records any missing or damaged items, after which the register is signed by the Project Manager.
- Any repairs/ calibration requirement for any equipment need to be documented and completed before the next service delivery activity.

09 CHILD PROTECTION POLICY

9.1 Purpose and Overview

The REACH implementing partner has a commitment towards the safety and protection of all children and has specific responsibilities towards the children with whom it is in contact through its activities. Furthermore, each partner has in place its Child Protection Policy in accordance with local laws and regulations.

The REACH implementing partner:

1. Recognizes the risks faced by children, the difficulties they face in reporting harm they experience, and the right of all children to be free from violence, abuse and exploitation and
2. Undertakes to promote their safety, protection and well-being.

The REACH implementing partner is committed to creating and maintaining a safe environment for children. Their welfare is important, and reasonable steps must be taken to prevent them from being harmed. The REACH implementing partner will not tolerate our staff, partners, or associates, to knowingly engage in, or support, any type of child abuse. The principle of the best interests of the child guides all our interactions with the children we serve.

The REACH implementing partner also recognizes the right of all children to equal protection. This Child Protection Policy applies to all children regardless of gender, ethnicity, disability, sexual orientation, religion, or other defining characteristics. While primarily intended to safeguard children, this policy is also meant to protect individuals from any false allegation of improper conduct towards children. This policy also serves to protect the reputation of the REACH implementing partner.

No person who is prohibited by law or regulation from working with children may take up any role with the REACH implementing partner. Consequences of breaching this Child Protection Policy are explicit and include disciplinary action up to and including dismissal, or termination of contract, along with possible further action as required, e.g., referral to criminal or national authorities.

This policy includes guidance, which is not exhaustive, on appropriate and expected standards of behavior of adults towards children. It has been designed to give all who work with the REACH implementing partner (staff, partners, associates, and volunteers) the confidence to carry out their roles and to ensure positive and appropriate interactions with children.

The principle is that staff, partners, associates and volunteers should avoid actions or behavior that may constitute poor practice or potentially abusive behavior towards children and should ensure that a culture of openness exists wherein actual or potential breaches of the policy may be raised and investigated as appropriate.

While this policy applies to professional/work conduct, the REACH implementing partner expects everyone to apply these good practice principles in their personal lives. It should be noted that should child protection concerns arise in relation to staff and others outside their professional roles (i.e., concerns regarding their behavior towards children that would constitute a breach of this Child Protection Policy), the REACH implementing partner may consider follow up action, including possible disciplinary action.

This policy commits all employees, partners, associates, and volunteers of the REACH implementing partner to abide by any other applicable policy and procedures, and specifically behavior protocols, regarding their interaction with children, use of children's images and information, and reporting concerns.

Relevant REACH implementing partner contracts and agreements will reference the REACH implementing partner's commitment to child safeguarding and require compliance with this Child Protection Policy.

9.2 Definitions

Child

Defined by the United Nations Convention on the Rights of the Child to be any person under the age of 18 years.

Child Abuse

Child abuse constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to a child's health, survival, development, or dignity in the context of a relationship of responsibility, trust or power.

Physical Abuse

Physical abuse of a child results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, trust or power. There may be single or repeated incidents. This abuse may include slapping, punching, poking, shaking, kicking, burning, shoving, or grabbing.

Emotional Abuse

Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potential and in the context of the society in which the child lives. There may also be acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Such acts include restriction of movement, patterns of belittling, name calling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing, or other non-physical forms of hostile or rejecting treatment.

Neglect

Neglect is the failure to provide for the child's development in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions in the context of resources reasonably available to the family or caregivers, causing or having a high probability of causing harm to the child's health or physical, mental, spiritual, moral, or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible. Identifying neglect in resource poor contexts can be especially difficult. Failure to provide adequately for children in situations of extreme poverty does not necessarily constitute neglectful behavior. Rather, it is a case of assessing available resources and the efforts parents and caregivers are making to meet the needs of their children.

Child Sexual Abuse

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or is not developmentally prepared for, or that violates the laws or social taboos of society. Child sexual abuse is any activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, with the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- The inducement or coercion of a child to engage in any unlawful sexual activity
- The exploitative use of child in prostitution or other unlawful sexual practices and
- The exploitative use of children in pornographic performances and materials.

Commercial or Other Exploitation

Commercial or other exploitation of a child refers to use of the child in work or other activities for the economic and/or material benefit of others. This includes, but is not limited to, child labor and child prostitution. These activities are detrimental to a child's physical or mental health, education, or spiritual, moral or social-emotional development.

9.3 Working with Children

Direct contact/working with children or regulated activities:

means being in the physical presence of a child or children in the context of REACH implementing partner's activities, whether contact is occasional or regular, short or long term.

Indirect contact/impact on children or controlled activities:

means having access to information on children in the context of REACH implementing partners' activities, such as children's names, locations (addresses of individuals or projects), photographs, and case studies. It also describes the impact that REACH implementing partner programs or projects may have on children, even if they are not our direct beneficiaries.

When working with children YOU MUST ALWAYS:

- Avoid working alone with a child and plan your work so that at least two adults are present at any time if possible. If working alone is unavoidable, you should move to an area/workstation where another adult can see both you and the child.
- Avoid inappropriate physical contact with a child. If a child is hurt or distressed, do your best to comfort or reassure her/him without compromising her/his dignity or doing anything to discredit your own behavior. Understand local norms about acceptable physical contact between children and adults, and ensure that any appropriate physical contact, such as holding hands, is initiated by the child.
- Behave appropriately; ensure that language is moderated in a child's presence, and refrain from adult jokes or comments that may cause discomfort or offence.
- Be sensitive to local norms and standards of behavior towards children.
- Listen to what the children are saying and respond appropriately.
- Plan activities in advance to take into account the age range and ability of all participants. Supervisors should make certain that the age, gender, and any special needs of children are considered when planning an activity to ensure suitability.
- Be aware of situations that may present risks and manage them appropriately and accordingly.
- Be familiar with REACH implementing partner's procedures for reporting concerns or incidents.
- Immediately report any concerns, based on allegations from the child or from your own suspicions, relating to the welfare of a child in your care to the local manager, or a Designated Person. It is your responsibility to ensure that you are aware of the Designated Person in the office in which you are working and how to contact her/him; if you are unaware, contact your Human Resources representative for the information. An incident form must be completed for any report. (Refer Annexure: 12.18 – Incident form)
- Maintain confidentiality.

When working with children YOU MUST NEVER:

- Hit or otherwise physically assault or physically abuse them.
- Develop physical/sexual relationships with them.
- Develop relationships with them that could in any way be deemed exploitative or abusive.
- Take children to your home.
- Act in ways that may be abusive or may place them at risk of abuse.
- Use language, make suggestions or offer advice that is inappropriate, offensive, or abusive.
- Behave verbally or physically in a manner that is inappropriate or sexually provocative.
- Do things for a child of a personal nature that they can do for themselves.
- Condone, or participate in, behavior with a child that is illegal, unsafe or abusive.
- Act in ways intended to shame, humiliate, belittle or degrade children, or otherwise perpetrate any

form of emotional abuse, discriminate against, show differential treatment, or favor children to the exclusion of others.

- Allow allegations made by a child or concerns about their welfare to go unrecorded or not acted upon.
- Use any computer or other electronic device to view, download, distribute, or create, indecent or inappropriate images of children (in many countries it is a criminal offence to do so), or in any other way possess or access child pornography.

9.4 Communication and Child Protection Guidelines

The public use of images and stories of children poses potential protection-related risks for the REACH implementing partner. The informed, written consent of the child and/or parent/guardian should always be obtained before a photograph or image of, or information on, a child is used, and its intended and/or possible use(s) explained. Personal information about a child (such as full name and date of birth or full names of family members) and information that could be used to identify his/her specific location within a country (such as village or community names, school, parish, etc.) will not be used, especially where this is linked to an image. Children that have experienced violence, exploitation, have been otherwise abused or are in some way particularly vulnerable or at risk, will not be identified by either personal details or images which represent them in a way that may lead to their identification. The REACH implementing partner will not use inappropriate images of children in a state of undress, or images which could be interpreted as sexually suggestive and impact negatively on their dignity or privacy. All images and stories, along with accompanying details of individuals, will be used and kept according to relevant data and privacy laws.

Associates that work with the REACH implementing partner and how they should adhere to the policy

The REACH implementing partner provides a range of people with access to its work and to children it works with. This is highly privileged access and should only be granted for legitimate work purposes. REACH implementing partner associates include donors, consultants and others brought into contact with children by the REACH implementing partner. Safeguarding children is at highest priority, and it is possible some associates could inadvertently create situations that may impact negatively on children or in worst-case scenario, pose a real risk to children. Even where associates are known and trusted, it is still important that we take great care to ensure communities are not exposed to any inappropriate or harmful conduct on their part, whether intentional or unintentional.

All associates who come into contact with children through the implementing partner's work, whatever their role or status, must have clearance, i.e. permissions from relevant managers. Most importantly, all associates, at the very least, will be provided with, and briefed on, REACH implementing partner Safeguarding Children Policy and Code of Conduct and will at all times be accompanied and supervised by staff when coming into contact with children.

Reporting and responding to child protection concerns, complaints, allegations and incidences

The REACH implementing partner is committed to responding to all reports or indications, including rumors, that suggest a child may be harmed or at risk of harm. Any allegations of abuse made against anyone working for the REACH implementing partner in any capacity will be thoroughly investigated as will any alleged breach of the child safeguarding policy or the Code of Conduct. The REACH implementing partner has a mandatory internal reporting requirement, which means everyone covered by the scope of this policy is duty bound to report any concerns that may arise in the course of their work and is committed to responding appropriately to all reports or indications, including rumors, that suggest a child may be harmed or at risk of harm.

If anyone witnesses, is told of, or suspects actual or potentially abusive or harmful behavior towards a child, or behavior or situations that might place a child at risk of harm, they must report it immediately in line with local reporting procedures.

The REACH implementing partner assures all staff, partners and associates that it will fully support

and protect anyone, who in good faith reports a protection concern. All reports will be treated as confidential, but it must be appreciated that in some situations the investigation or disciplinary processes may not be concluded unless the source of the information and a statement by the individual is produced as part of the evidence.

REACH CHILD PROTECTION HELPDESK

If someone from the community wishes to raise a complaint against anyone from the organization in terms of misconduct against their ward or child, they can contact the organization at this helpdesk:

Information on the use of helpdesk:

A dedicated person would need to be appointed to address calls to the helpdesk.

Every school at which the organization implements its project activities needs to have access to this helpdesk.

The school headmaster/principal should be aware of the helpdesk and should be informed that if s/he/teachers/children's parents report or witness anything untoward in the project team's conduct towards the children, the same can be reported through the helpdesk to the organization. The school headmaster/ principal should also be advised that the helpdesk can receive reports of suspected or known misconduct by any member of the project team.

All REACH project team should sign the following Child Protection Acknowledgment prior to the project implementation. An individual consent should be obtained before using photos and any publications in the media in the format specified below.

CHILD PROTECTION POLICY ACKNOWLEDGMENT

I, _____, acknowledge that I have received and read the Child Protection Policy, and I understand and agree to abide by all aspects of it. I understand I have a duty to report any breaches of any aspect of the policy to a Designated Person (as outlined) to ensure that appropriate action in accordance with all applicable policies and procedures will be taken.

Signature: _____ Date: _____

9.5 Media Consent Form & Photography Release Form

Thank you for agreeing to share your story with <Implementing Partner Name Here>.

We use stories like yours to raise awareness of the issue of avoidable blindness and demonstrate the life changing impact that access to the right treatments can have.

By signing this form, you are giving permission to use your story and any video footage and photographs taken of you.

We might use your story, photographs and film in different ways, including:

- in publications
- on our website
- on TV
- on radio
- in newspapers or magazines
- on social media (e.g. Twitter and Facebook)
- in reports to donors

- I understand the information given and know that I can ask questions if I have them.
- I understand that my information might be used more than once, for different things.
- I agree and give my permission to use any written material/video footage/photographs of me as described above.
- I give the right to use my real name.

we promise to use your story, image or footage responsibly at all times. We will never use a surname/ family name or any information that could reveal where you live. We will not use images of children after a period of 5 years.

Please include any exceptions or additional information here:

<p>I hereby give consent that I/my child/my ward is happy to appear in the organisation’s publicity materials, including use of photographs or video footage.</p> <p>I/my child/my ward should be referred to as:</p> <p>-----</p> <p>Signed by: ----- (parent/guardian if under 16)</p> <p>Print name: -----</p> <p>Date: -----</p> <p>contact details: -----</p>	<p style="text-align: center;">Office use</p> <p style="text-align: center;">Signed by staff member:</p> <p style="text-align: center;">-----</p> <p style="text-align: center;">Print name:</p> <p style="text-align: center;">-----</p> <p style="text-align: center;">Date:</p> <p style="text-align: center;">-----</p>
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10 MONITORING AND EVALUATION

Monitoring

Monitoring is a continuous assessment that aims at providing all stakeholders with early detailed information on the progress or delay of the ongoing assessed activities. It requires oversight of the various stages of program implementation. Its purpose is to determine whether the planned outputs, deliveries and schedules have been achieved so that action can be taken to correct any deficiencies as quickly as possible. The project should be reviewed on a weekly basis by the implementation team to track all ongoing aspects.

Project monitoring is to be led by the responsible Project Manager through various means such as REACHSoft, field visits, and project expense sheets. The progress of the project is monitored in all relevant aspects such as training, equipment procurement and utilization, systems implementation, service delivery and outreach activities. A monitoring report covering all aspects is prepared each month by the Project Manager and the weekly review conducted at the project site should feed into this monthly report to capture all relevant issues. This report should highlight key findings in terms of successes, gaps, challenges and learnings in the project. Discussions should be held on the basis of these findings in the monthly review meeting with the implementation and management team and action items identified should then be implemented. The Project Coordinator, Project Head and Finance Manager provide support with internal reviews of the project, including finances.

Utilization of Project Data for Monitoring

Below is a hypothetical example of the use of project data in project monitoring:

In a given area, the expectation is that 4.5% of school children have a significant uncorrected refractive error. The target is to screen 10,000 children, of which 450 are expected to need spectacles. 8000 children of the target were screened, and 640 (8%) failed screening. In the set-up where primary screening and secondary evaluation takes place together on the same day, all 640 (100%) of these attended secondary evaluation, 192 (30%) of these had normal vision on retesting. 320 (50%) children were given a prescription for spectacles, and 128 (20%) were referred for cycloplegic examination. 385 (86%) of these 448 children (given prescription for spectacles and referred for cycloplegic examination) obtain spectacles. Of these, 173 were wearing them during compliance assessment and 138 of them reported better vision with the spectacles.

In the set-up where secondary evaluation takes place on another day, only 384 (60%) of these children attended for secondary evaluation. 96 (25%) of these had normal vision on retesting. 173 (45%) children were given a prescription for spectacles, and 115 (30%) were referred for cycloplegic refraction. At follow-up 230 (80% of 288 children given prescription for spectacles and referred for cycloplegic refraction) had obtained their spectacles. 115 (50%) were wearing them, and 92 (80%) of them reported better vision with the spectacles.

Actual need	Primary Screening and Secondary Evaluation on same day	Primary Screening and Secondary Evaluation on separate days
Total number of children	10,000	10,000
4.5% have significant RE	450 need spectacles	450 need spectacles
Monitoring data		
Total number of children	10,000	10,000
Screened	8,000 (80%)	8,000 (80%)
Fail screening	640 (8%)	640 (8%)
Attend for secondary evaluation	640 (100%)	384 (60%)
Normal vision on retesting	192 (30%)	96 (25%)
Given prescription for spectacles	320 (50%)	173 (45%)
Referred for cycloplegic examination	128 (20%)	115 (30%)
Outcome data		
Obtain spectacles	385 (86% of 448)	230 (80% of 288)
Wear spectacles	173 (45%)	115 (50%)
Impact data		
Report better vision	1138 (80%)	92 (80%)

This data set should raise questions and action points. The coverage of the project has been reported to be 80%. It needs to be understood why this is so, and possible solutions should be considered. For example, conducting screening at the school on another day would enable some of the remaining children who did not attend initially to be screened. The number of false positives shows that the screeners might need to be re-trained or other factors may need to be explored. 14%/20% of children needing spectacles did not obtain them. Reasons for the same should be explored. 45%/50% of children who obtained their spectacles were actually wearing them. Children found not wearing spectacles should be asked why this was the case and solutions should be based on the children's individual responses.

Developing a monitoring framework

A monitoring framework is a tool which lists and defines the indicator set, their source of information, frequency and person responsible for data collection and reporting. A plan is developed which lists short, medium and long-term objectives of the project and its corresponding indicators. Outcomes, outputs and activities for each of the objective are listed out.

The short term objectives in REACH project could be training staff in refractive services; establishing service delivery aspects, conducting awareness raising activities. Medium term objectives may include institutionalizing coverage for compliance and follow-up visits. Long term objectives could entail – inculcating eye- health seeking behaviour amongst children and parents, developing and using evidence for eye- health issue, facilitate scalability and sustainability to improve eye health and education outcomes in children, integration of the REACH as model school eye health project in hospital's optometric curriculum.

A list of recommended indicators for REACH project are shown below.

Monitoring - recommended indicators disaggregated by gender

Output indicators

Indicator	Indicator Definition
Number of schools covered	# of schools covered in the defined catchment area for screening (government/ private/ others)
Screeners trained	Project staff including vision screeners, optometrists trained for preliminary vision screening in school going children (clinical/ non-clinical)
Children screened	This indicator will only count the # of screenings/ examinations conducted for children ≤ 17 years of age by an eye health professional in the school (the initial point of contact at the school before the child goes for any type of service)
Spectacle prescriptions given	# of children ≤ 17 years of age who were provided prescription by an eye health professional in the school. Prescriptions for both new and already-wearing spectacles are included
Spectacles provided	# of children ≤ 17 years of age who were provided spectacles to the children (free/ subsidized/ paid)
Children referred	# of children ≤ 17 years of age who were referred to fixed facilities (vision centre/ base hospital)
Children avail eye care services	# children ≤ 17 years of age who accessed eye care services at the fixed facilities
Surgeries done	# of children ≤ 17 years of age whose surgeries were conducted at base hospital
Children exposed to health education	# of children ≤ 17 years of age exposed to health education during giving of prescriptions, undergoing surgery, or undergoing treatment at base hospital
Spectacle wear	# of children found wearing spectacles of those provided spectacles, during compliance visit

Outcome indicators

Indicator	Indicator Definition
Percentage of schools covered in catchment area	# of schools covered in the defined project area for screening/ # of schools identified in the defined project area
Percentage of children enrolled in schools who are screened	# of children who underwent screening in the school/ # of children enrolled in school
Percentage of children receiving spectacles who wear them	# of children found wearing spectacles during compliance visit/ # of children provided with spectacles
Percentage of children referred who avail eye care services	# of children who access eye care services at fixed facility / # of children referred for further evaluation or treatment. Calculated as cumulative value till date

Impact

Indicator
Change in quality of life/ visual functioning in children wearing spectacles

Quality

Indicator
%age of false positive cases of children screened
%age of false negative cases of children screened
%age replacement of spectacles
%age of spectacles provided of incorrect power
%age of spectacles frames of incorrect specifications
%age of spectacles provided that are broken within 3 months of delivery

Operational

Indicator
Cost per screening/ examination¹¹
spectacles booked versus spectacles cost incurred
surgeries performed versus surgeries cost incurred

¹¹ Disaggregated for inference at three points of reference- primary screening, secondary evaluation and annual follow-up

Process

Indicator
%age of glass prescriptions found without errors by the senior optometrist
%age of spectacles delivered within two weeks of secondary evaluation
%age of parents informed on spectacle delivery

Evaluation

An evaluation is a systematic and objective examination concerning the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives. The idea in evaluating projects is to isolate errors not to repeat them and to underline and promote the successful mechanisms for current and future projects. An important goal of evaluation is to provide recommendations and lessons to the project manager and implementation team that have worked on the projects and for the ones that will implement and work on similar projects in the future.

Evaluation is also indirectly a means to report to the donor about the activities implemented. It is a means to verify that the donated funds are being well managed and transparently utilized.

An evaluation is conducted in a planned manner and shall ideally be done by individuals external to the project with suitable expertise. The purpose of an evaluation is to assess the extent of completion of goals and objectives, and corresponding project insights. The impact of the project can also be assessed through evaluation. Impact in terms of change in quality of life of children and visual functioning of children given spectacles; whether teachers are willing to support the REACH project can be assessed. Also, compliance rates should be determined to know whether children who have been given spectacles have continued to wear them and document the reasons for non-compliance.

Evaluation reports should be shared with all relevant stakeholders. The learnings and the findings can be published in order to disseminate best practices and learnings.

11

PROJECT SUSTAINABILITY

Sustainability is the ability of a project to continue its mission far into the future. All projects have to end eventually, but a well thought sustainability plan ensures that the work continues to perform and deliver benefits to the primary target group even after the funding ends.

To ensure sustainability of a REACH project, several approaches might be needed which requires engagement of diverse stakeholders such as government, corporates, community and volunteers. A list of suggested sustainability approaches or strategies is provided below but these may not work across all partners as certain strategies might be area or partner specific:

11.1 Financial sustainability

11.1.1 Sale of spectacles

Sale of spectacles may be considered as a major source for financial sustainability. The revenue generated may support a major portion of operational cost. It is understood that many of the families may not be able to afford spectacles and hence sale should be limited to certain sections of the community. It is recommended to follow the following criteria in sale of spectacles and partners are free to use their discretion:

- Spectacles should be provided free to all children of government schools.
- Spectacles may be dispensed for a price in private schools, but the price should be lower than the market price. Pricing of spectacles would be decided by the partners.
- Timely delivery of spectacles must be ensured.

One expected outcome of a REACH project is an increase in pediatric outpatient and surgery cases. The fees collected from paid surgeries could also be one of the sources for financial sustainability.

11.1.2 User fee at base hospital and vision center

A nominal fee for all patient registrations is recommended but left to the discretion of service providers.

11.1.3 Support from Corporates/Local donors

- Project partners should create a donor database including sources likely to fund the project. The database could include corporate houses, foundations, and individual donors from the catchment area. It is important to diversify the donor base and to look beyond traditional donor agencies. Once the database is ready, it is good to be in touch with them by sharing regular updates on the project and inviting them to project events as they could be potential donors in future.
- New opportunities should be explored such as inviting school alumni to support the initiative either by adopting the school for eye health activities or to seek support for spectacles / surgery for the children in need.
- Collaborate and explore the possibilities of spectacle support for the school children from the spectacle manufacturers and other large companies as part of their corporate social responsibility initiatives

11.2 Building a strong referral linkage through multi stakeholder engagement

The REACH program is highly human resource intensive and it is very important to engage with various stakeholders and orient each stakeholder on their role in contributing to sustainability of the project as far as possible. Mapping of stakeholders should be undertaken and each stakeholder should be engaged in the program in some way from the initiation stage.

Provided below is a list of key stakeholders to be engaged:

Local Non-Government Organisations:

A detailed mapping of other NGOs/CBOs and their area of work in the project area must be undertaken. Interactions with these agencies must be held to explore possible areas of collaboration or how they could contribute to the project. Some of these agencies might be working in relevant fields such as health, education, water and sanitation and they can play a key role in spreading awareness of the REACH project among communities, schools and frontline health workers and support service delivery.

Teachers:

Teachers have the potential to play a major role in ensuring spectacle compliance and referral compliance. They can also be engaged in ensuring participation of parents during screening or spectacle distribution. Contact details of PMOAs/vision centres/Base hospitals must be made available at all schools for teachers to facilitate referrals.

REACH clubs:

Partners could initiate REACH clubs in the schools to promote better eye health practices among the school children. Refer to the REACH club guidelines attached in the annexure 5. If implemented properly, REACH clubs have the potential to increase spectacle and referral compliances.

Para Medical Ophthalmic Assistants (PMOAs):

PMOAs can have a key role in ensuring sustainability of the project as there are many common activities they perform such as testing vision and prescribing glasses, surveying communities for early detection and organising eye care education activities. PMOAs should be oriented on REACH project and they can play a part in referring children to the base hospital and in improving referral compliance. Schools could also be provided with contact details of their respective PMOAs.

Frontline health workers – ASHA workers and Anganwadi workers:

Frontline health workers play a key role in the communities in spreading awareness on health-related issues and delivering health services. ASHA and Anganwadi workers should be oriented on the REACH project as well as on symptoms of common eye ailments. They should refer children with suspected eye disorders identified during their regular home visits to the nearest vision centres/base hospital. Necessary permission from health department must be obtained to involve ASHA with any additional responsibility.

11.3 Schemes and programs to be leveraged

Pradhan Mantri Jan Arogya Yojana (PM-JAY):

Under the ambit of Ayushman Bharat, a Pradhan Mantri Jan Arogya Yojana (PM-JAY) has been conceived to reduce the financial burden on poor and vulnerable groups arising out of catastrophic hospital episodes and ensure their access to quality health services.

Pradhan Mantri Jan Arogya Yojana (PM-JAY) will provide financial protection (Swasthya Suraksha) to approximately 50 crore beneficiaries. It will offer a benefit cover of Rs. 500,000 per family per year. PM-JAY will cover medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures. PM-JAY has defined 1,350 medical packages covering surgery, medical and

day care treatments including medicines, diagnostics and transport.

The scheme will be cashless & paperless at public hospitals and empanelled private hospitals. The beneficiaries will not be required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. Partner hospitals should try to get registered as one of the empanelled hospitals under the scheme to be eligible for reimbursements.

12 ANNEXURE

- 12.1 [Target setting planning tool](#)
- 12.2 [Sample Job description of various positions involved in REACH project](#)
- 12.3 [Basic Equipment list for primary screening and secondary evaluation](#)
- 12.4 [Sample communication plan](#)
- 12.5 [REACH Club Activities](#)
- 12.6 [Project Information Sheet](#)
- 12.7 [REACH Common Guidelines](#)
- 12.8 [Framework for Role Mappings](#)
- 12.9 [School permission letter](#)
- 12.10 [Parent Consent Form](#)
- 12.11 [Thank you and eye screening report](#)
- 12.12 [Spectacle prescription summary list](#)
- 12.13 [Sample Certificate of Appreciation](#)
- 12.14 [REACH Club Training Guide](#)
- 12.15 [Case Story Template](#)
- 12.16 [Compliance Questionnaire](#)
- 12.17 [Annual Followup](#)
- 12.18 [Incident Form](#)

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