Knowledge hub
-
Collection of best practices

Summary of the best practice

1. Title of the best practice (e.g. name of policy, programme, project, etc.) *

CBM-PEEK Programme

2. Country or countries where the practice is implemented *

Zimbabwe

3. Please select the **most relevant** Action Track(s) the best practice applies to *

- [x] Action Track 1. Inclusive, equitable, safe, and healthy schools
- [x] Action Track 2. Learning and skills for life, work, and sustainable development
- [ ] Action Track 3. Teachers, teaching and the teaching profession
- [x] Action Track 4. Digital learning and transformation
- [ ] Action Track 5. Financing of education

4. Implementation lead/partner organization(s) *

Zimbabwe Council for the Blind (ZCfB)

5. Key words (5-15 words): Please add key descriptive words around aims, modalities, target groups etc. *

Conduct eye screening using PEEK technology in communities and schools reaching out to whole populace including school children in 5 Provinces of Zimbabwe

6. What makes it a best practice? *

It is a best practise as it has proven effective in reducing number of clients lost to follow up

Description of the best practice

7. Introduction (350-400 words)
   This section should ideally provide the context of, and justification for, the practice and address the following issues:
   i) Which population was affected?
   ii) What was the problem that needed to be addressed?
   iii) Which approach was taken and what objectives were achieved? *

The objective that was achieved was to screen school children of any eye condition and manage the problem. The population where this strategy is working at is at the schools screening. It is easier when a loop is opened during screening and through triage, a child receives the specific solution(should it be refraction or medication) at the same location.

The project learnt that it was easier to have screening, triage and refraction taking place at the same time in the schools. During the implementation of the program an observation was made on how effective it was to conduct all activities at the schools and only refer the under 10 for specialized refraction and children with complex conditions to the hospital. Conducting all activities at the school increases adherence to triage and refraction as opposed to referring clients to the hospital to get those services. Clients also avoid paying consultation fees and transport fares to the hospital, which may be a challenge for many in accessing services.

Collaboration with other programs within and outside the organization, is also a best practice learnt throughout the implementation of this program. The project has come across patients who may need to be referred for other services outside the program such as rehabilitation services and it was noted that it was important to have linkages with other programs so that our clients can get the help they need. Establishing linkages with other eye health programs was also noted to be of importance, for example programs offering surgical services to ensure that the patient's loop has been closed.

During implementation of the school eye health program is was noted that there was a huge number of referrals that were being referred to the Ophthalmologist. Some of the cases referred were patients that the doctor could see at the school and did not necessarily need to visit the hospital. Some of the cases were false positives, and others were patients with allergies referred for review, just mention a few. However the project now conducts regular capacity building activities for the nurses to improve their diagnostics skills, to avoid referring cases that they can handle.

8. Implementation (350-450 words)
   Please describe the implementation modalities or processes, where possible in relation to:
   i) What are the main activities carried out?
   ii) When and where the activities were carried out (including the start date and whether it is ongoing)?
   iii) Who were the key implementation actors and collaborators? (civil society organizations, private sector, foundations, coalitions, networks etc.)?
   iv) What were the resources needed (budget and sources) for the implementation? *

The nurses and other trained staff members conduct the screening. Those who fail the visual acuity test are then referred for triage . If they fail at triage then they are then referred for either medical or ophthalmologist to see or for refraction. The starting point is the sensitization point where a member of team gives instructions to pupils on At screening phase, five screeners would measure visual acuity using the peek acuity, when a child fails the test, they are then referred to the next level where there are OPNs who also examine the child's eyes using a pentorch and also measure the visual acuity. When a child fails the test again they are then move to the next point which is refraction, where they are tested for need for spectacles. If they require spectacles they are then prescribed and an sms is sent to their parents on when they are supposed to go and collect them from Council for the Blind offices. In some instances, the refractionists goes back to the schools to distribute the spectacles. At triage, those with non-refractive conditions such as allergies are then given eye drops for free.

The CBM-PEEK project has been ongoing in the schools since 2018 to date. The project is ending in December 2022.The key implementation actors included ZCfB with funding from CBM and PEEK providing the technology. ZCfB worked with the government ministries which included the Ministry of Primary and Secondary Education (MPSE) and the Ministry of Health and Child Care (MoHCC).The MoPSE gave ZCfB permission to work in the schools , MoHCC provided human resources(ophthalmic nurses) whilst ZCfB provided the core team and coordinated the activities.

The resources needed comprised of a budget of an annual of £200,000.
Inputs included vehicle, fuel, meals, demand creation materials, human resources. The team usually comprises of 20 members and can screen between 800 and 1000 children per day .
The schools provide 2 classrooms or a school hall as a working are for the day.

9. Results – outputs and outcomes (250-350 words)
   To the extent possible, please reply to the questions below:
   i) How was the practice identified as transformative? (e.g., impact on policies, impact on management processes, impact on delivery arrangements or education monitoring, impact on teachers, learners and beneficiary communities etc.);
   ii) What were the concrete results achieved with regard to outputs and outcomes?
   iii) Has an assessment of the practice been carried out? If yes, what were the results? *

The eye screening programme in schools is complementing the Zimbabwe school health policy which was rolled out in 2018. The lauch of the School Health Policy was facilitated by the realisation that education and health are inseperable and that many ailments can be prevented through appropriate interventions at the earliest stages of human life , which is also the aim of the CBM-PEEK schools screening programme. School screening provides schoolchildren with opportunities in catching any eye condition when they are young and enables them to have an opportunity to have the eye problems corrected at an early stage when most of them are still treatable and reversible.

Using PEEK technology makes management easy as one can come up with decisions by simple looking at the dashboard which also provides real time data. The visual acuity outcomes are also instant and this helps learners and communities to make prompt decisions about their eye health and come up with solutions there and then.

A study has been done through the use of PEEK data and will be published in August 2022.Results will be shared after the article has been published.

From 2018 to date, 84500 school children have been screened and 8407 (10%) have a positive outcome; meaning they have either refractive and non-refractive conditions.

10. Lessons learnt (300 words)
    To the extent possible, please reply to the following questions:
    i) What were the key triggers for transformation?
    ii) What worked really well – what facilitated this?
    iii) What did not work – why did it not work? *

Conducting all activities at the school increases adherence to triage and refraction as opposed to referring clients to the hospital to get those services. Clients also avoid paying consultation fees and transport fares to the hospital, which may be a challenge for many in accessing services.

Collaboration with other programs within and outside the organization, is also a best practice learnt throughout the implementation of this program. The project has come across patients who may need to be referred for other services outside the program such as rehabilitation services and it was noted that it was important to have linkages with other programs so that our clients can get the help they need. Establishing linkages with other eye health programs was also noted to be of importance, for example programs offering surgical services to ensure that the patient's loop has been closed.

During implementation of the school eye health program is was noted that there was a huge number of referrals that were being referred to the Ophthalmologist. Referring children under 10 years old for refraction at the hospital did not work well as most of the children became loss to follow up. Some of the cases referred were patients that the doctor could see at the school and did not necessarily need to visit the hospital. Some of the cases were false positives, and others were patients with allergies referred for review, just mention a few. However the project now conducts regular capacity building activities for the nurses to improve their diagnostics skills, to avoid referring cases that they can handle.

What also did not work well was working with only one refractionist as it meant that there would be a long queue at the refraction station.

11. Conclusions (250 words)
    Please describe why may this intervention be considered a "best practice".
    What recommendations can be made for those intending to adopt the documented "best practice" or how can it help people working on the same issue(s)? *

It is essential for the implementing partner to coordinate activities with their health and education ministries , as these are pivotal ministries in the school eye screening programme. Community and caregivers buy-in is also an essential . Having a one stop shop outreach where people do not need to be referred unnecessarily is also important as it reduces clients lost to follow up .

Another recommendation is sending consent forms prior to the screening and also smses to parents reminding them about spectacle collection, ophthalmologist referrals has also proven to be effective ways to improve adherence.

The programme should capitalise on non exam weeks and also during the school term as schools would be closed during the holidays. This will be the time to create demand through social mobilization activities, demand creation and promotional material distributions in terms of posters and pamphlets so as to gain buy in the project and yield high acceptance.

12. Further reading

Please provide a list and URLs of key reference documents for additional information on the “best practice” for those who may be interested in knowing how the results benefited the beneficiary group/s. *

Rono, H. K., Bastawrous, A., Macleod, D., Wanjala, E., Tanna, G. L. D., Weiss, H. A., & Burton, M. J. (2018). Smartphone-based screening for visual impairment in Kenyan school children: A cluster randomised controlled trial. The Lancet Global Health, 6(8), e924–e932. https://doi.org/10.1016/S2214-109X(18)30244-4