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Sight For Success

Leveraging the Private Sector for Disability Inclusion in Learning

Punjab and Khyber Pakhtunkhwa

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Acronyms

AEO	Assistant Education Officer
ASC	Annual School Census
ASDEO	Assistant Sub-Divisional Education Officer
B-TAG	Bridging Technical Assistance for Governments
CEO	Chief Executive Officer
CSP	CSR Support Plan
CSR	Corporate Social Responsibility
DEO	District Education Officer
DHQ	District Headquarter Hospital
Dy. DEO	Deputy District Education Officer
E-PTC/SC	Enhanced PTC/SC
FCDO	Foreign, Commonwealth and Development Office
GBPS	Government Boys Primary School
GGPS	Government Girls Primary School
GOAL	Girls and Out of School Children - Action for Learning
I-SAPS	Institute of Social and Policy Sciences
KP	Khyber Pakhtunkhwa
MHH	Menstrual Health and Hygiene
NC	Neighbourhood Council
NGO	Non-Governmental Organisation
PTC	Parent Teacher Council
RHC	Rural Health Centre
SC	School Council
SDEO	Sub-Divisional Education Officer
SSR	School Self-Reporting
TA	Technical Assistance
THQ	Tehsil Headquarter Hospital
UC	Union Council
UK	United Kingdom
UN	United Nations
VC	Village Council
WASH	Water, Sanitation and Hygiene

Executive Summary

Introduction

The Sight for Success initiative aimed to improve educational outcomes by addressing vision challenges among children with disabilities through active engagement with the private sector in Punjab and KP. The primary objectives of this innovation were to establish an institutional framework that leverages private sector support, develop linkages between education and health departments for regular vision screenings, and pilot a vision screening program in selected schools. The initiative aligns with the government's Corporate Social Responsibility (CSR) goals to drive sustainable societal development by integrating local-district level CSR funds into school health activities.

Key Findings and Outcomes

- A local-district level CSR framework was developed to mobilize resources for Parent Teacher Councils/School Councils (PTCs/SCs), facilitating vision screenings and related health interventions in schools.
- Pilot screening in 40 schools across Punjab and KP identified over 755 students (42.51% Boys and 57.48% Girls) with vision problems; 74% (559) received eyeglasses, while the remaining 26% (196) were referred for further medical care.
- The initiative revealed a significant gap in the data collected through Annual School Census (ASC) and School Self-Reporting (SSR), lacking indicators for school health, water, sanitation, and hygiene (WASH).
- Unintended outcomes included increased awareness among stakeholders about school health needs and the role of the private sector in bridging gaps in service provision.

Recommendations

- Integrate the CSR framework into PTC/SC guidelines to formalize and expand local-level support. This framework provides guidelines to address procedural gaps, enhance awareness of school council roles, and promote transparency in collaboration. Action by Education Departments
- Revise the ASC and SSR templates to include comprehensive school health and nutrition indicators, including water, sanitation and hygiene (school WASH); health screening; health education; menstrual health and hygiene (MHH). Action by Education Departments
- Adopt an Integrated Referral Framework to enhance horizontal and vertical coordination between education and health sectors, ensuring seamless health service delivery for students. Action by Education and Health Departments
- Establish a School Health Task Force to create a theme based holistic, sustainable, and scalable school health and nutrition program, including

nutrition/school feeding programmes to be housed and monitored by this proposed task force. Action by Education and Health Departments, I-SAPS and FCDO

Challenges

- **Administrative and Financial Constraints:** Both the Punjab and KP governments faced challenges related to insufficient funding and inadequate administrative capacity to fully implement school health programs.
- **Lack of a Clear Policy Framework:** Despite the availability of substantial CSR funds, the absence of a formal policy or legal framework limited government access to these resources, resulting in underutilization.
- **Trust and Transparency Issues:** Engaging local traders and private sector entities was challenging due to concerns over transparency, procedural complexity, and mistrust in collaboration with government entities.
- **Limited Parental Compliance:** Post-screening, parental compliance with eyeglass usage was low in some areas, partly due to socio-economic factors and lack of awareness about the importance of vision care.
- **Scalability Limitations:** The pilot's short duration and limited geographic scope make it difficult to generalize findings or fully assess the intervention's long-term impact on educational outcomes.

Sustainability and Scalability

By embedding CSR-driven models within the PTC/SC system, this innovation has the potential to expand beyond vision care to other health interventions. Institutionalizing these frameworks will enable broader private sector engagement and improve overall educational and health outcomes for children across Pakistan.

Beneficiary

This innovation primarily benefits students, offering immediate improvements in vision that enable them to see the board, read books, and complete assignments without eye strain or fatigue. As a result, students face fewer barriers related to vision impairment, leading to increased focus, active participation, and a greater enthusiasm for learning. Beyond academic gains, this initiative has enhanced students' confidence and self-esteem, promoting smoother peer interaction and stringer social connections both inside and outside the classroom. Overall, this innovation has significantly enriched the students' educational experience and well-being, making it a high impact intervention for the learning of children with visual disabilities.

Parents and teachers are the secondary beneficiaries of this innovation. For parents it offered economic, emotional and practical support by alleviating financial burdens while improving their children's learning progress up to **43% in Punjab and 25% in KP.** It also raised awareness about the importance of eye health, motivating regular check-ups and timely interventions. For teachers, the provision of spectacles made teaching more effective, as the students became more attentive and engaged. This reduced the need for special accommodations, increased teaching efficiency and created a positive classroom environment, making the teaching process less stressful and more rewarding for both teachers and students.

Audience

The primary audience includes policymakers, decision-makers and health and education officials who play a key role in scaling up and integrating this framework into national health and education programmes. It also includes the FCDO Internal Team to inform their on-going sector support to both education and health programmes. The secondary audience comprises the Parent Teacher Council/School Council (PTC/SC) members and health professionals who were instrumental in the intervention's implementation and contributed to improving students' eye health. Additionally, philanthropists and local trader associations, who provided financial support and have an interest in the intervention's scalability are also part of the audience.

Scope and Purpose

The goal of this Innovation was to engage the private sector in promoting disability inclusion in education.

The study had three main objectives:

1. To establish an institutional framework that harness the private sector's role in supporting children with visual disabilities.

2. To develop both horizontal and vertical linkages between education and health departments for regular vision screenings and to identify existing and potential CSR opportunities that can be integrated into the education system.
3. To conduct a pilot vision screening in selected schools in Punjab and Khyber Pakhtunkhwa (KP).
4.

Introduction

Physical disabilities significantly impede educational progress and outcomes, making it crucial to establish effective support systems and a conducive environment for students with disabilities. Enhancing these measures are instrumental in advancing educational access and quality in Pakistan. However, the provincial governments of Punjab and KP face ongoing administrative and financial challenges in providing adequate facilities and services for students with disabilities. One potential solution is to tap into Corporate Social Responsibility (CSR) funds from medium and large corporations while leveraging the private sector's support for public education. Despite the availability of substantial CSR funds, the absence of a clear policy or legal framework restricts government access to these resources, resulting in underutilization. Added on page 16

The UK Government through its Foreign, Commonwealth and Development Office (FCDO) has been a vital partner in supporting education reforms in Punjab and Khyber Pakhtunkhwa. The FCDO's financial and technical assistance has played a pivotal role in implementing high-impact interventions, contributing to the progress made in the education sector. The “Decade of Learning” document commissioned by the FCDO reflects valuable insights and lessons from previous initiatives, emphasising the importance of sustaining positive changes and implementing systemic improvements for long-term impact. **Girls and Out of School Children - Action for Learning (GOAL)** will build on the legacy of the UK’s decade-long investment in education in Punjab and Khyber Pakhtunkhwa to further improve access and learning outcomes for girls and marginalised children.

Bridging Technical Assistance for Governments (B-TAG) is contributing towards consolidating previous investments and creating traction with the provincial governments to ensure a smooth transition to the long-term GOAL Technical Assistance (TA). One of the innovations planned under B-TAG is ‘**Sight for Success - Leveraging the Private Sector for Disability Inclusion in Learning – in Punjab & KP’**.

Innovation

As part of the innovation **‘Sight for Success - Leveraging the Private Sector for Disability Inclusion in Learning – in Punjab & KP’**, B-TAG conducted a comprehensive review of the government's existing legal and regulatory framework and CSR

guidelines to explore opportunities for piloting a programme in collaboration with local level private sector organisations. An intervention study was designed to screen and provide support for children with visual disabilities to test leveraging of local level CSR support. The programme was piloted in selected districts of KP and Punjab.

Relation to Output 1 and B-TAG GOAL

Disability inclusion is critical to removing educational barriers and ensuring equal opportunities for all students. The “Sight for Success” innovation focused on addressing vision impairments by providing eyeglasses to students. This helped them see better, read, complete assignments, which enhanced their learning experience and boosted academic performance.

The initiative supported by local CSR and philanthropic efforts reduced costs for parents and engaged PTCs and SCs into the process. Local stakeholders emphasised the need to integrate this model into school policies to sustain its impact, improve retention and reduce dropouts.

Methodology and Approach

This study was designed to develop a framework linking the private sector's role in supporting children with disabilities; and to establish both horizontal and vertical linkages between education and health department, leveraging existing CSR opportunities to integrate health-related initiatives into the education system. Key informant interviews were conducted with relevant stakeholders to assess their understanding of local CSR support and its potential in enhancing health programs in public schools. The framework was tested through a vision screening activity conducted in public schools, evaluating its practical implementation and impact.

Stage I and Stage II:

Study Design: The study had a mix methods study design.

Geographical Areas: The study was conducted in Punjab and KP, specifically targeting two districts in each province vis Gujrat and Layyah from Punjab, and Buner and Khyber from KP. Ten (10) primary stand-alone urban schools were selected from 1-2 Markaz/Circles within each district.

Sampling Strategy: A purposive sampling method was employed (due to logistic reasons) to select the districts in both Punjab (one from south Punjab and one from the rest of the Punjab) and KP (one from Newly Merged Districts and one from the rest of the KP). Subsequently, stratified purposive sampling was utilised to select Circles/Markaz within the selected districts. Following this, random sampling was conducted to choose five girls' and five boys' schools within each circle/Markaz.
Convenient sampling was employed to select two trader associations in each district. Within each association, interviews were conducted with both the president and vice president. Three members- headteacher, parent and community leader were selected from school council/PTC, where parent and community leader were selected randomly.

Data Collection Tool: A comprehensive questionnaire was designed for key informant interviews with both closed and open-ended questions according to the study objectives. Additionally, for the vision screening activity, a screening form for the students along with pre and post assessment questionnaires for students, teachers and parents were created to assess the academic performance before and after the intervention.

Data Collection: Detailed orientation sessions were conducted with the enumerators to thoroughly explain the questionnaire. Similarly, the screening teams received orientation on their respective activities.
Stage I: Data collection involved in-depth interviews. I-SAPS conducted 14 interviews from trader associations, 120 interviews from PTCs/SCs (3 in each school-total 40

schools), 32 interviews from education department duty bearers (AEOs, ASDEOs, SDEOs, DEOs and CEOs) in the four districts from KP and Punjab, ensuring a rich and diverse dataset. Additional interviews were conducted with the Additional Secretaries of Planning and Budget department, as well as Reforms Unit at the provincial level in both provinces, to obtain an insightful policy/strategy analysis.

Stage II: For the vision screening activity, screening teams were deployed in each district, along with enumerators for the pre- and post- assessment. The activity spanned 6 days in each district, covering 1-2 schools every day. The team did visual screening for all the students of grade 3 and 5 who were present that day, collecting data using a pre-designed form. Students identified with vision issues and who required spectacles were referred to enumerators for pre- assessment to find out their learning outcomes.

For teachers, pre-assessment regarding learning outcomes of their students was done before the start of screening activity. For students, the assessment focused only on those diagnosed with vision issues and selected for dispensing of spectacles by the screening team. A telephonic assessment was done with the parents of these students. Post- assessment was carried out with the same respondents after 3 months.

Ethical Considerations:

- **Administrative approval:** Administrative approval from the education department was obtained for all interviews with education officials and screening activity in both KP and Punjab.
- **Informed Consent:** Participants were provided with clear and comprehensive information about the study, and informed consent was obtained before conducting interviews and screening activity.
- **Anonymity:** Strict measures were in place to protect the anonymity of the participants and the reputation of their associations.
- **Confidentiality:** All collected data were securely stored and only accessible to the research team to maintain confidentiality.

Data analysis: Both quantitative and qualitative analyses were conducted to examine both closed and open-ended questions. Thematic analysis was utilised to identify significant emergent themes and patterns within the qualitative data. Quantitative data was analysed using MS Excel and SPSS.

Analysis plan: Frequencies and mean t-test were applied to assess the changes/difference between pre- and post- assessment.

Limitations

- This study cannot be generalised to other districts as the sampling was purposive for the purposes of the innovation and not designed to meet epidemiological

criteria for provincial generalisation. The small population size in Layyah further reduced precision, making the results less representative

- The impact of intervention on the academic performance of the students could not be adequately assessed due to the short duration of the study. Research indicates that a longer minimum intervening duration is recommended to effectively evaluate the impact – this can range from 7 months to 1 year[1, 2].

[1] Du, K.; Wang, H.; Ma, Y.; Guan, H.; Rozelle, S. Effect of Eyeglasses on Student Academic Performance: What Matters? Evidence from a Randomized Controlled Trial in China. Int. J. Environ. Res. Public Health 2022, 19, 10923. https://doi.org/10.3390/ijerph191710923

[2] Neitzel AJ, Wolf B, Guo X, et al. Effect of a Randomized Interventional School-Based Vision Program on Academic Performance of Students in Grades 3 to 7: A Cluster Randomized Clinical Trial. JAMA Ophthalmol. 2021;139(10):1104–1114. doi:10.1001/jamaophthalmol.2021.3544

Highlights of Key Findings

Stage 1: Consultative Process

Key informant interviews were conducted with local CSR entities (trader associations), education duty bearers (AEOs, ASDEOs, SDEOs, DEOs and CEO) and school council/PTC members, and Additional Secretary Planning and Budget in both Punjab and KP, to assess their understanding on local CSR support and its role in supporting health related programs in public schools. The key findings are as follows: (Detailed results are presented in **Annexure 1**)

Duty Bearers

The findings indicate that current policies and regulations governing PTCs/SCs do not restrict private sector participation, leaving room for enhanced engagement at the grassroots level. Private sector involvement can be strengthened without major regulatory changes, as there are no procedural limitations or audit barriers hindering collaboration. Formal partnerships, transparent accountability mechanisms, and robust audit systems would facilitate local private sector support for school activities beyond existing budgetary constraints. While philanthropic funds can be integrated into PTC/SC accounts, audit concerns exist; hence, in-kind support is a more practical alternative.

In both districts of KP and Gujrat, health-related activities were previously conducted in schools, with 50% supported by the Health Department and the other 50% arranged through community philanthropy. More than 80% of respondents in both KP and Punjab emphasised the importance of private sector engagement to support educational facilities, and 60% (23) reported existing collaborations between their schools and local entities, either informally or through formal agreements. This support primarily involved the provision of learning materials and sports equipment, teachers' capacity building, and facilitation of health-related activities. Moreover, 94% of respondents were aware of private sector philanthropic activities and strongly recommended integrating such support into PTCs/SCs. All respondents advocated for a robust accounting mechanism to ensure transparency and build confidence among local CSR entities, while also identifying potential uses for these funds to support health and educational activities.

The Additional Secretary of the Planning and Budget Department, Punjab emphasised the importance of engaging the local private sector to enhance the effectiveness of School Councils (SC). Demonstrating the benefits and potential positive impact to communities can encourage private sector involvement through various initiatives like sponsorship programs and infrastructure development. Strengthening public-private partnerships and establishing transparent accountability mechanisms are essential for leveraging private sector support.

Key recommendations by the Additional Secretary Planning and Budget Department, KP include raising awareness and training PTC members, compensating their efforts,

and involving them in school planning processes. With no current barriers to private sector engagement, ongoing reforms aim to broaden the scope and impact of PTCs, creating a favourable environment for collaboration to optimise school development and resource allocation.

PTCs/SCs – of 40 schools surveyed

Punjab: Layyah school councils, who were all operational for over two years, primarily relied on government funding to sustain operations, with a strong emphasis on educational materials and supplies. However, a notable absence of health-related activities underscores a pressing need for intervention in this domain, with a keen interest expressed in engaging with the private sector and integrating philanthropic funds to enhance educational and health initiatives. On the other hand, in Gujrat, school councils exhibited a mix of operational durations and benefit from additional funding sources, enabling a broader scope of activities including health-related initiatives. While collaboration with the private sector is acknowledged, transparency issues impede existing partnerships, suggesting a need for policy reforms along with meticulous record-keeping to optimise resource utilization.

KP: In both Buner and Khyber, PTCs have played pivotal roles in school maintenance, procurement of supplies, and organising health-related activities (health screenings, deworming drives, and vision screenings). While government funding covers most expenses, contributions from charitable organisations and the community augment these efforts. Private sector involvement, though recognised, faces obstacles such as transparency issues and existing policies, hindering potential collaborations. Nonetheless, there is consensus on the potential benefits of integrating philanthropic funds into PTCs, with proposed initiatives ranging from supporting children with disabilities to organising health awareness campaigns and facilitating healthy sports activities. These funds are perceived as vital for improving children's well-being and academic performance, with anticipated positive impacts on parental engagement and overall school performance.

Local Traders Associations

Punjab: In both districts of Punjab, trader associations have demonstrated a commendable commitment to charitable activities, particularly in social protection initiatives, sustained over significant periods. While there is a clear interest in extending support to health-related activities and educational initiatives within schools, formal collaboration with local authorities remains lacking due to trust issues. Addressing procedural gaps, increasing awareness of school council roles, and establishing transparent frameworks for collaboration are essential steps toward leveraging the potential of these partnerships. The willingness of trader associations to support health-related activities, coupled with their readiness to provide resources and assistance, presents a promising opportunity to enhance the holistic development

and well-being of students in both districts through effective collaboration with educational institutions.

KP: Over the past two years, trader associations in KP have actively engaged in charitable activities, primarily allocating modest funds towards social welfare and water, sanitation and hygiene (WASH) initiatives. Despite varying funding mechanisms, trader associations in Buner and Khyber demonstrated a higher level of collaboration with local authorities compared to Punjab entities, primarily engaging in charity in kind. However, there's a notable gap in familiarity with standard procedures, such as channelling support through PTCs, indicating a need for enhanced coordination. Looking ahead, members emphasise the importance of proper documentation and procedures for long-term collaboration, particularly in clearly defining school needs and establishing robust monitoring mechanisms. Additionally, there is significant interest among trader associations in supporting health-related activities, highlighting potential avenues for further collaboration and impact in the future.

These findings in Punjab and KP strongly suggests that there is a substantial local CSR potential that is presently untapped for want of a policy or legal framework for collaboration between local CSR entities and education authorities.

The following activities were conducted after the Consultative process:

1. **Local traders and philanthropists were engaged for extending financial support** for eye health screening activities in the piloted schools. Certain challenges were encountered during this engagement. For instance, in Khyber, donations are typically given only during Ramadhan or directed specifically toward madrassa children. Additionally, as previously mentioned, issues of trust and transparency were addressed by requesting in-kind support in the form of spectacles rather than cash donations. Traders were also invited to the schools on screening days, where they personally distributed the spectacles in the presence of PTC/SC members and education officials from the local administration (AEOs/ASDEOs). This approach helped build trust and fostered a connection between local trader associations and school members, paving the way for future collaboration. Overall, philanthropists from Gujrat and Khyber responded positively and generously.
2. A team of optometrists, sponsored by local CSR entities with technical assistance from BTAG were deployed who **conducted vision and eye health screening of school children** in 20 public sector school in KP and 20 in Punjab, **dispensed eyeglasses** to those children who needed them and **established a referral pathway** to the next appropriate level of care e.g. eye unit at tehsil or district headquarter hospital.
3. Reviewed the results of the engagement process with the local authorities and local level CSR entities and **drafted a framework for leveraging local level CSR**

support for consideration and adoption by the provincial government for scaling up (**Annexure 2**).

4. Proposed **amendments to the guidelines of PTCs/SCs** which were being revised. These amendments were approved by the education authorities and incorporated as a revision in the revised guidelines (in KP; under process in Punjab) (**Annexure 3**).
5. Developed an **Integrated Referral Framework for horizontal and vertical referral** of children identified through the screening process for further health care (**Annexure 4**).

Stage 2: Vision Screening

Detailed findings of vision screening are presented in **Annexure 5**.

1. 3473 students were assessed across 40 schools – of these, 755 (22%) had vision problems. 321 were males and 434 were females.
2. Of all those who had an 'vision problem', 74% (559) of all children required spectacles.
3. The remaining children with 'vision problems', 26% (196) were referred to the nearest District Headquarter/Tehsil Headquarter hospitals (DHQ/THQ)
4. Of all school children who had a refractive error and required spectacles, the need of 97% of these school children was addressed onsite (the spectacles were provided onsite at schools by the screening team – only 3% of prescriptions required custom spectacles).

Intervention Assessment Findings

The students who were given spectacles were only assessed for their learning outcomes before and after the intervention.

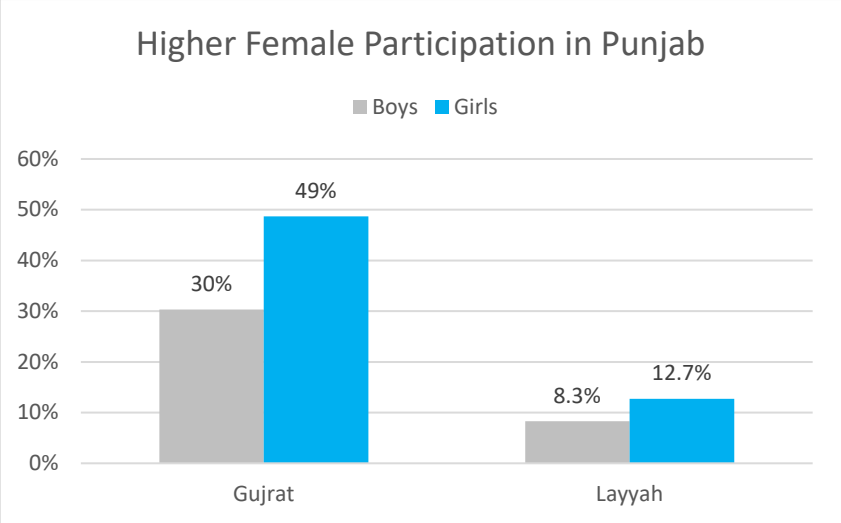
Punjab - Gujrat and Layyah

Demographics

The mean age of the students was 10 years, which aligns closely with the age group that typically has the greatest need for spectacles. The population comprised 46% of students from grade 3 and 54% from grade 5, with a gender distribution of 61% girls and 39% boys. The number of participants were more in Gujrat as compared to Layyah (**Fig 1**).

Parental education levels revealed that the highest proportion had education up to the matriculation level, with 39% of fathers and 24% of mothers achieving this. However, district-level analysis showed that educational attainment in Layyah was approximately 2.5 times lower, with only 21% of fathers and 8% of mothers reaching the matric level, compared to Gujrat, where 43% of fathers and 28% of mothers had this level of education. In terms of household infrastructure, the majority of households had cemented (95%) and owned homes (79%).

Figure 1: Distribution of girls and boys in the assessment in Punjab



Spectacle usage

Pre-Intervention: About 75% of students were neither informed that they needed eyeglasses nor had ever worn them. Among those who had worn eyeglasses (17%), 14% did so on a doctor's advice, while 3% wore them on their own.

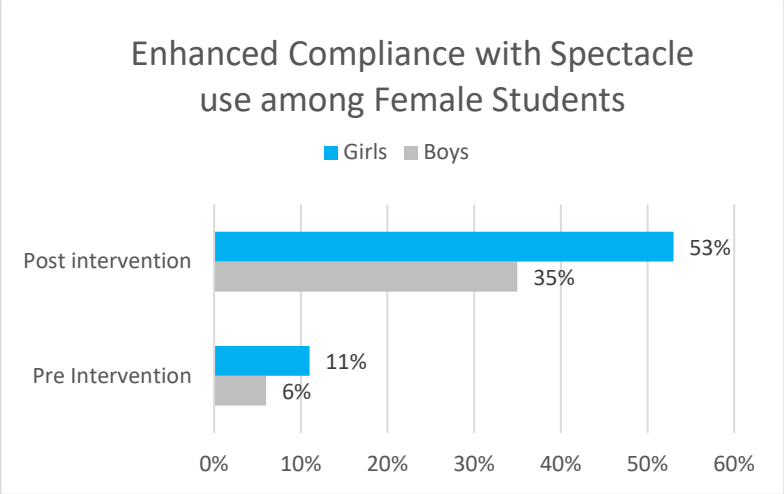
Only 4.2% of students ever worn glasses in Layyah in comparison to Gujrat (20.4%).

Post-Intervention: About 88% of students wore the spectacles after the screening ($p < 0.001$). Female compliance was observed more than boys (**Fig 2**).

69% of students wore the eyeglasses in Layyah as compared to 94% in Gujrat. They either broke/lost it the very first day or didn't like the design and colour of the eyeglasses or had headache and eye pain. The low compliance could be due to the lower educational level among parents[3]. This can also indicate that more attention is required to address the remaining discomforts to improve adherence and overall impact. Another possible reason could be the lower severity of the vision problem. The Layyah students' eyesight was not weak enough to significantly impact their daily routines, leading to a lack of urgency in wearing eyeglasses or a failure to recognise their importance.

Figure 2: Pre- and post- intervention usage of eyeglasses in Punjab

[3] Gogate, P., Mukhopadhyaya, D., Mahadik, A., Naduvilath, T., Sane, S., Shinde, S., & Holden, B. (2013). **Spectacle compliance amongst rural secondary school children in Pune district, India**. *Indian Journal of Ophthalmology*, *61*(1), 8-12. doi:10.4103/0301-4738.107185



In both districts, 51% of the school children who received eyeglasses reported wearing them all the time, while 39% wore them most of the time. Additionally, 87% found the eyeglasses comfortable, provided positive feedback, and expressed happiness and gratitude for their provision. Those who gave negative feedback, they complained of headaches, dizziness, irritation in the eyes or didn't like it due to older design.

Vision Challenges

Pre-Intervention: About 94% of students had difficulty in seeing their surroundings before the intervention. 51% of students struggled to see the blackboard and 38% had trouble viewing display charts.

Moreover, 83% of students complained of headaches or eye strain before the intervention in both districts

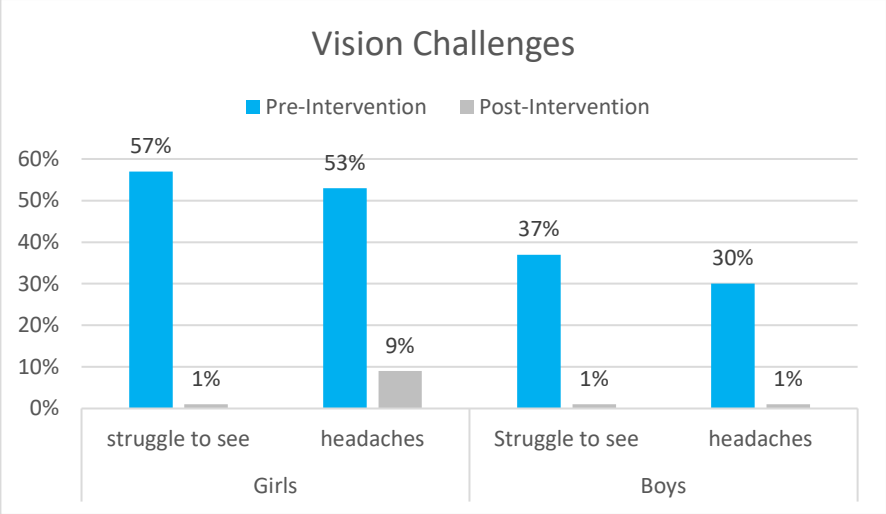
Post-Intervention: Only 2% still found difficulty in seeing the surroundings. ($p < 0.001$). However, the teachers' observations differed in this case, with 15% reporting that students still experienced difficulties in seeing their surroundings after the intervention, for instance, viewing the blackboard.

After the intervention, only 10% complained of headaches ($p < 0.001$).

However, 41% of students in Gujrat district only complained about other discomforts like eye pain, redness, watery eyes and burning. The reason can be eye allergy/infection in Gujrat at the time of the survey.

Gender analysis for the vision challenges is shown in **Fig 3**

Figure 3: Vision challenges in Punjab

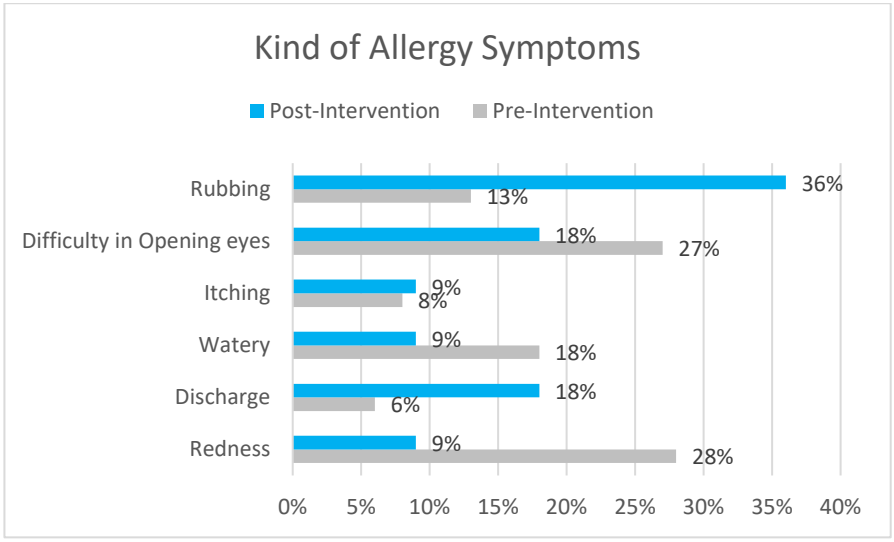


Allergy Symptoms

Pre-Intervention: In the case of allergy symptoms before the intervention, parents (64%) reported more allergy symptoms in their children as compared to teachers (27.5%). Particularly, the parents from Gujrat reported almost 2 times (71%) higher allergy symptoms as compared to Layyah parents (37%).

Post-Intervention: 8% of parents ($p < 0.001$), and 15% of teachers reported allergy symptoms. The allergy symptoms showed that the rubbing, itching and discharge were increased after the intervention (**Fig 4**)

Figure 4: Allergy symptoms in Punjab



Learning Progress

Difficulty in routine work

Pre-Intervention: Different perspectives were reported by students, parents, and teachers regarding difficulties in routine tasks. In Gujrat, 96% of students faced challenges, compared to 92% in Layyah. Among the students, 43% had trouble seeing

the blackboard, 24% took longer to complete their work, 14% lost concentration, and 16% struggled due to inadequate lighting. Teachers also reported almost same results in both districts. However, marked difference was observed especially in Layyah where only 15% of parents observed difficulties in their children.

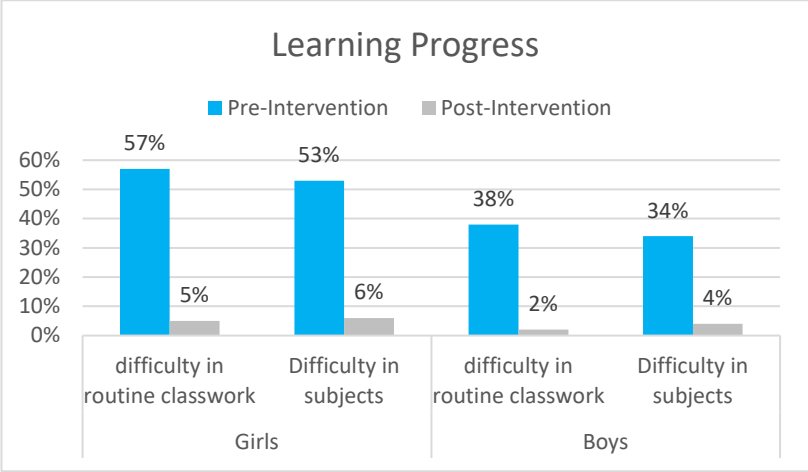
Post-Intervention: Across all groups, significant improvements were seen after the intervention ($p < 0.001$). 93% of students reported no difficulty in their routine work. Similarly, 82% of teachers also observed improvement in their students. The remaining difficulties were mainly observed among students who did not wear the provided spectacles.

Difficulty in major subjects

Pre-Intervention: 87% of students with refractive errors found difficulty in major subjects before the intervention. Out of these, 21% struggled in Urdu, 32% in Mathematics and 46% in English.

Post-Intervention: After the intervention, only 10% of students struggled with the above-mentioned subjects ($p < 0.001$). Gender disaggregation is given in **Fig 5**

Figure 5: Learning progress in Punjab



- All the Likert scale questions demonstrated significant improvement in the post intervention assessment ($p < 0.001$) regarding test performance, handwriting, understanding of all subjects, concentration and interest in studies and participation in class activities

Daily Activities

Pre-Intervention: 10% of parents reported their children avoiding certain activities due to vision issues - 28% reported avoidance of visual activities, 37% said that their

children only played during the day, and 22% took the help of their friends while playing. The parent from Gujrat stated, “She Plays Less”.
Post-Intervention: After the provision of spectacles, 3.6% of students continued to avoid certain activities, predominantly in Layyah (16%) ($p > 0.005$), as they did not wear their spectacles at all.

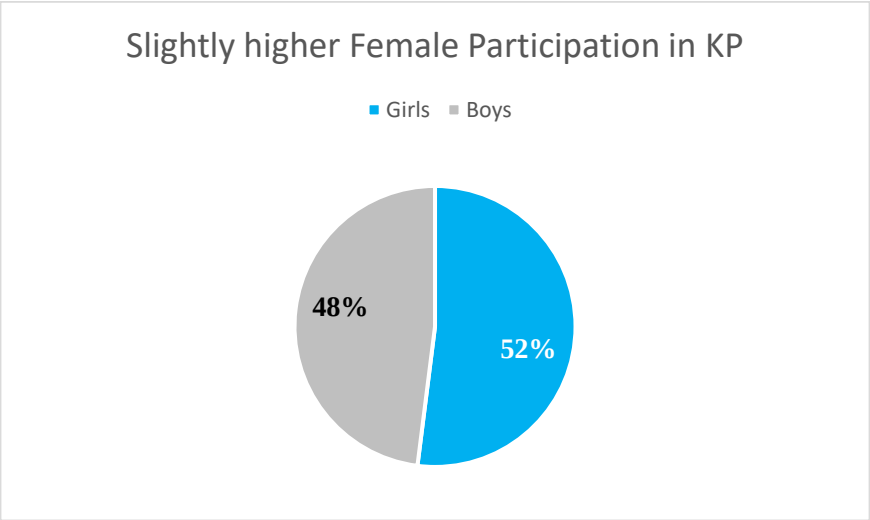
Classroom Accommodations
Pre-Intervention: 97% of teachers stated that they made classroom accommodations to facilitate the students with vision issues in the form of seating arrangements (58%), adequate lighting (21%), large print material (15%) and giving increased time to complete the work (5%).
48% of teachers in each district believed that these accommodations were adequate in the current circumstances.
Post-Intervention: After the provision of spectacles, only 5% of teachers were required to make classroom accommodations ($p < 0.001$).

Further Recommendations (done till here)
79% of teachers gave the following recommendations:
- Follow up with the current students, who are still facing the issues
- Develop a mechanism to re-provide a new pair or repair the broken spectacles
- Continue this initiative by adding new students from other classes and other schools of the district
- Some also stated to include teachers and other school staff as well
- Contact lenses should be provided to girls who don’t like the eyeglasses
- The students should be given the choice to choose the colour, design and shape of the glasses

KP - Buner and Khyber

Demographics
The mean age of the students was 11 years, which aligns closely with the age group that typically has the greatest need for spectacles. The population comprised 40% of students from grade 3 and 60% from grade 5, with a gender distribution of 52% girls and 48% boys. (**Fig 6**) In KP, there was marked difference in terms of parents’ educational status. In Khyber, the highest proportion of fathers (53%) had a Master’s degree, whereas the mothers were up to the middle level (36%).
In Buner, the highest percentage of fathers (32%) had bachelor’s degrees and mothers were illiterate (37%). In terms of household infrastructure, in Buner, most parents lived in uncemented houses (69%) and shared residences (47%), however in Khyber, the majority of houses were cemented (77%) and owned by the parents (57%).

Figure 6: Distribution of girls and boys in the assessment in KP



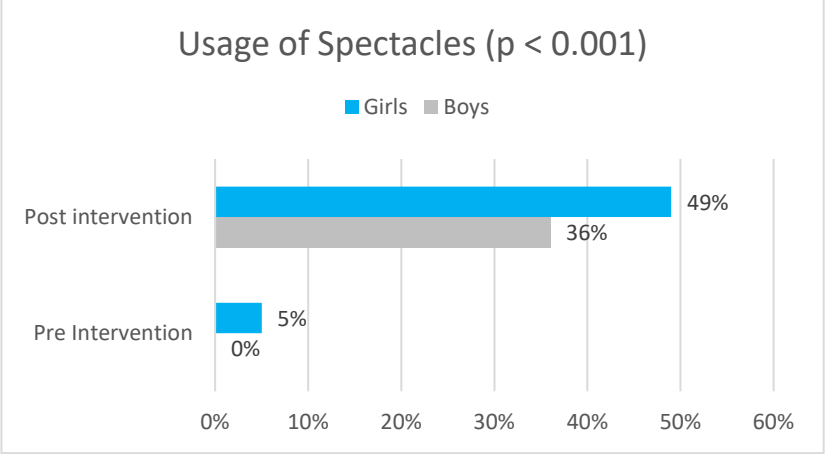
Spectacles Usage

Pre-Intervention: About 84% of students reported that they were neither being told that they needed eyeglasses nor were they wearing them. 29% of parents reported that their children had difficulty in seeing. Among the ones who were told by the doctor to wear spectacles (15.5%), only 5% of girls were actually wearing the spectacles (**Fig 7**).

Post-Intervention: After the screening and provision of eyeglasses, 77% of students in Buner and 100% in Khyber wore glasses ($p < 0.001$). The compliance was much higher in both districts as compared to Punjab as only 11% reported broke/lost them and 2% didn't find them useful.

Among the ones who wore the eyeglasses, 98% found it comfortable to wear, gave positive feedback and said that they were very happy, thankful, confident, and tranquil with the eyeglasses. 26% and 45% of students were observed wearing the spectacles all the time and most of the time respectively. Those who gave negative feedback, they complained of pain and irritation in the eyes or said that they didn't need them.

Figure 7: Pre- and post- assessment usage of eyeglasses in KP



Vision Challenges

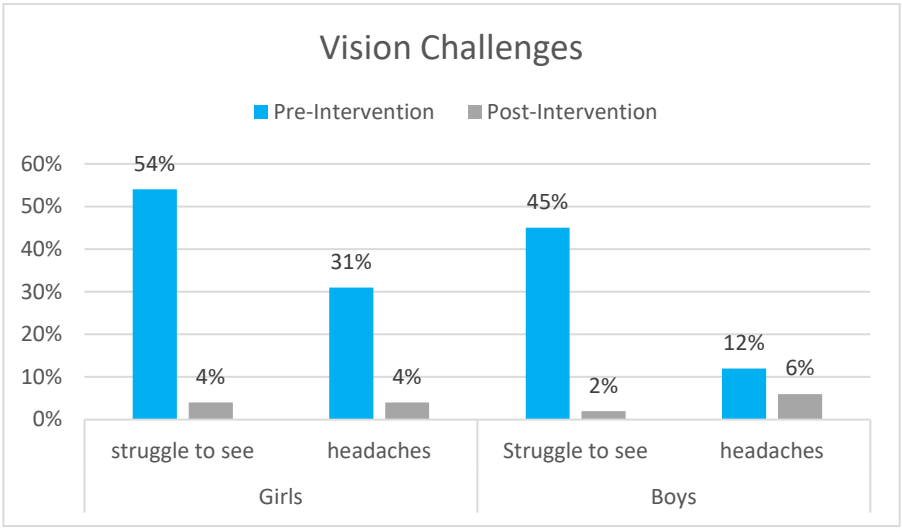
Pre-Intervention: 99% of students, who received spectacles, had difficulty in seeing in their surroundings before the intervention.

Moreover, 59% of students in Khyber and 34% in Buner complained of headaches or eye strain before the intervention.

Post-Intervention: Only 6% of students in Buner still found difficulty in seeing the surroundings. ($p < 0.001$).

After the intervention, only 10% complained of headaches ($p < 0.001$). Some students said that they experienced headaches for the first couple of days and then felt fine. Vision challenges with gender disaggregation are given in **Fig 8.**

Figure 8: Vision challenges in KP



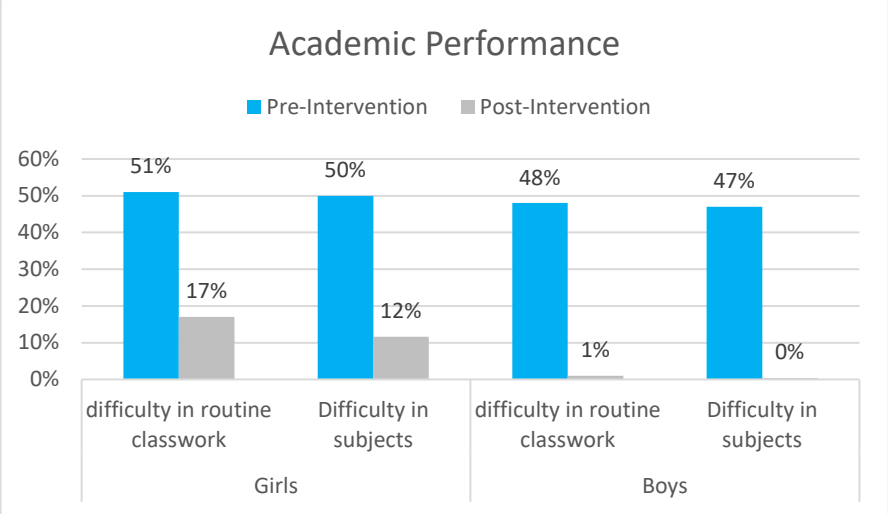
Allergy symptoms:

Pre-Intervention: In case of allergy symptoms before the intervention, 72% of parents and 49% of teachers reported some kind of allergy symptoms in their children. The students wearing the eyeglasses (1.8%) had fewer allergy symptoms as compared to those who were not wearing them (71%). Major symptoms included redness or pink eye (24.5%), discharge (23%) and watery eyes (28%).
Post-Intervention: After the intervention, only 1.3% of parents and 5% of teachers reported allergy symptoms ($p < 0.001$).

Learning Progress
Difficulty in routine work
Pre-Intervention: Different perspectives were reported by students, parents, and teachers regarding difficulties in routine tasks. 99% of students faced challenges in their routine work in both districts. Among those, 39% couldn't see the blackboard, 19% took more time to finish their work, 19% lost concentration and 22% couldn't manage their routine work because of less light in the classroom. Almost similar observation was noted by the teachers. However, only 25% of parents reported that their children faced difficulty in class.
Post-Intervention: Across all groups, significant improvements were seen after the intervention ($p < 0.001$). 84% of students reported that they didn't find any difficulty after the provision of spectacles. The remaining difficulties were mainly observed among students who did not wear the provided spectacles.

Difficulty in Major subjects
Pre-Intervention:
97% of students found difficulty in major subjects before the intervention. Out of these, 17% struggled in Urdu, 48% in Mathematics and 33% in English.
Post-Intervention: 12% female students in Buner still struggled with the above-mentioned subjects ($p < 0.001$) (**Fig 9**)

Figure 9: Learning progress in KP



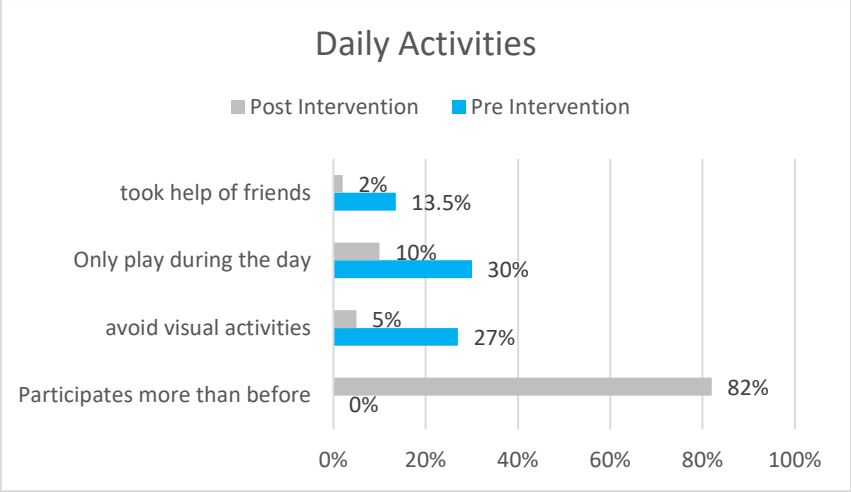
All the Likert scale questions showed significant improvement in the post intervention ($p < 0.001$) questions regarding test performance, handwriting, understanding of all subjects, concentration and interest in studies and participation in class activities.

Daily Activities

Pre-Intervention: About 11.5% of parents reported that their children avoided certain activities due to vision issues. 27% reported avoidance of visual activities, 30% said that their children only play during the day, and 13.5% took the help of their friends while playing.

Post-Intervention: After the provision of spectacles, 7% of parents still reported that their children avoided certain activities ($p < 0.001$). Regarding coping strategies for poor vision, the majority of children (30%) preferred playing only during the day. However, the provision of spectacles improved their ability to cope, and 82% began participating more actively in extracurricular activities (**Fig 10**). One of the parents said "She takes part in every sports. It is due to "you". Another said "Before this screening drive, we did not know if he/she needed eyeglasses. Really grateful"

Figure 10: Pre- and post- assessment of daily activities in KP



Classroom Accommodations

Pre-Intervention: About 93.5% of teachers stated that they made classroom accommodations to facilitate the students with vision issues in the form of seating arrangements (43%), adequate lighting (24%), large print material (12%) and giving increased time to complete the work (21%).

Prior to intervention, 57% of teachers believed that these accommodations were adequate in the current circumstances. In response to less satisfaction, the teachers in Khyber highlighted the requirement of large font books and more funds for the provision of proper lighting in the classrooms

Post- Intervention: After the provision of spectacles, only 17% of teachers stated that had to make classroom accommodations ($p < 0.001$).

After the intervention, 75% of teachers said that no further accommodation was required.

Further Recommendations

57.5% of teachers made the following recommendations:

- Follow up with the current students, who are still facing the issues
- Continue this initiative by adding new students from other classes and other schools of the district
- Quarterly check-ups should be done, and a proper record should be maintained
- Children with such issues should be taken care of preferentially
- Doctors should carry the latest technology along with them

Key Outcomes of the Innovation

Framework for local level CSR for Enhanced PTCs

A formal framework for local-level CSR was developed that would enhance the role of PTCs/SCs in mobilising local CSR and philanthropy for school education and school health-related activities (**Annexure 2**).

Amendments to the guidelines of PTCs/SCs

Specific explicit amendments were proposed to the existing PTC/SC guidelines that would assist and provide guidance to PTCs/SCs to leverage local CSR and philanthropy (**Annexure 3**).

Integrated Referral Framework for School Health

An Integrated Referral Framework for School Health was developed as part of the vision screening process in the Innovation (**Annexure 4**).

Unintended Outcomes

One of the key unintended outcomes of the Innovation was the identification of a major gap in the data collected on the Annual School Census (ASC) and School Self-Reporting (SSR) templates. While the ASC has indicators on disability (which are subjective and not based on assessment), there are none on school WASH; school health screening; health education; and menstrual health and hygiene (MHH). The Innovation proposed a set of new indicators to be incorporated into the ASC and SSR (**Annexure 6**).

Recommendations

Leverage local level CSR/Philanthropy

The scope of PTCs/SCs can be enhanced by incorporating a mechanism to mobilise local level CSR/philanthropy to support school health activities.

Recommendations:

1. **Integrate** a 'Framework for local level CSR/Philanthropy' as an integral part of PTC/SC guidelines (Annexure 2). This framework provides guidelines to address procedural gaps, enhance awareness of school council roles, and promote transparency in collaboration. Action by Education Departments
2. **Incorporate** explicit amendments to PTC/SC guidelines to leverage local level CSR/philanthropy to support school health activities (Annexure 3). Action by Education Departments

Referral Framework

A systematic and system-based referral pathway is essential for school children identified with health conditions that require further health assessment.

Recommendation:

3. **Adopt/Adapt** an 'Integrated Referral Framework' that aims to strengthen horizontal and vertical linkages between the education and health sectors (Annexure 4). Action by Education and Health Departments

Annual School Census and School Health

The ASC is a regular reporting requirement for all public sector schools. The existing template does not include school health indicators. There is a need to revise the template and add indicators for school health.

Recommendation:

4. **Revise** the existing ASC and SSR to integrate school health indicators on school water, sanitation and hygiene (school WASH); school health screening; health education; and menstrual health and hygiene (MHH) (Annexure 6). Action by Education Departments

School Health

Currently, there is no school health programme in public sector schools. The learning from the innovation pilot strongly suggests the development and operationalisation of a structured and thematic school health programme.

Recommendation:

5. **Constitute** a School Health Task Force to formulate a theme-based, comprehensive and integrated school health and nutrition programme that encompasses holistic health screening components including nutrition/school feeding programmes to be housed and monitored by this task force, using UN agency guidelines on school health and pilot in other districts to test and establish operationalisation on a wider scale, to improve learning outcomes. Action by Education and Health Departments and I-SAPS and FCDO

Conclusion and Next Steps

Conclusion

The project has made significant strides in developing institutional frameworks for adoption by the Education Departments, including a Local CSR Framework and an Integrated Referral Framework. Efforts have also been made to build consensus at the administrative level on leveraging local CSR and philanthropy, with the District Education Authorities actively engaged in operational processes. These frameworks have already been approved by the KP Education authorities and are under review in Punjab. Additionally, revisions to PTC/SC guidelines have been approved in KP, with the process ongoing in Punjab. Joint meetings between the Education and Health Departments in KP are underway to integrate school health screening initiatives.

A sustainable operational environment has been established by identifying and proposing amendments to the PTC/SC guidelines, which do not have financial implications and therefore do not require Cabinet approval. These amendments are currently under administrative review by Education authorities. Furthermore, there is an opportunity to revitalise a Memorandum of Understanding (MoU) between the Health and Education Departments for collaboration on school health. The project also identified the need for revising the ASC and SSR to incorporate school health indicators, including menstrual health, vision, physical health, hearing, oral health, skin health, and nutrition. These indicators have been approved for inclusion in the ASC and SSR by KP Education authorities and are under review in Punjab.

The findings of the vision screening activity highlighted a pressing need for a structured and holistic school health programme in which the local philanthropists can play an impactful role by supporting school health activities to enhance the learning experience of students in school.

Next Steps

The following next steps are planned/proposed or are already in process.

1. **PTC/SC Guidelines and Local CSR and Integrated Referral Frameworks**:
    - Engage with the Education authorities for inclusion of amendments in revision of Guidelines – Action by I-SAPS
    - Develop an orientation programme/training of PTCs/SCs and Local CSR entities – in selected districts to operationalise the process before wider adoption and scaling-up – Action by I-SAPS with support from FCDO

2. **Education and Health**:
    - Develop a Working Paper with operational plan on Health Screening in Schools – Action by Education Departments and I-SAPS
    - Build consensus on the operational mechanism for health sector support for school health screening – planning meetings are already under way in KP - Action by I-SAPS

- Education and Health authorities to develop an operational plan for health screening of children across KP in selected schools – discussions between Education and health authorities are already under way in KP - Action by Education Departments and I-SAPS
- Revitalise a Collaboration MoU between Education and Health – this will require a high-level policy meeting between Education and Health Departments to formulate and formalise this – Action by Education and Health Departments with facilitation by I-SAPS and FCDO

3. **Annual School Census and School Self Reporting**:
   - Obtain consensus from Education and Health Departments on additional mandatory School Health indicators – these have already been approved by the KP Education authorities for implementation - Action by Education Departments
   - Develop explanatory guidelines on new indicators – these have already been developed. Urdu translation is still pending – Action by I-SAPS
   - Operationalise their use in selected districts before wider adoption and scaling-up – Action by Education Departments

4. **Long Term Aim**:
   - Advocate to Education and Health authorities for constitution of a Task Force on School Health – Action by I-SAPS and FCDO
   - Undertake a consultative process to develop a viable strategy and plan for School Health – Action by Education and Health Departments with facilitation by I-SAPS and FCDO
   - Pilot the School Health strategy and plan in selected areas for policy advocacy – Action by Education and Health Departments with facilitation by I-SAPS and FCDO

Annexures

Annexure 1: Detailed Results of Consultative Process

Consultative Process

Key informant interviews were done with CSR entities (trader associations), education bearers and school council/PTC members, and additional secretary planning and budget in both Punjab and KP. The key findings are presented below.

Punjab

CSR Entities: Layyah and Gujrat

In both districts, all trader associations were found to be actively engaged in supporting charitable activities, with 75% of them sustaining these efforts for over four years. Primarily, their focus was on social protection initiatives, although a quarter of them also extended support to health-related endeavours. The majority (75%) allocated funds exceeding 50,000 annually, directly aiding beneficiaries.

Remarkably, none had engaged with local authorities or sought collaboration for charitable ventures, citing trust issues with governmental entities. Nevertheless, there was a keen interest in contributing to educational endeavours within schools. Over 80% expressed willingness to provide reading materials, while approximately 63% indicated support for health-related activities. However, only a quarter were aware of the customary procedure of channelling community support through school councils. When queried about facilitating long-term collaboration with school councils, respondents stressed the importance of comprehensive engagement, clear documentation of school needs, and the establishment of a robust monitoring and verification system. Regarding support for health-related activities in schools, more than half were open to assisting with vision screening and providing glasses. Additionally, 25-50% expressed willingness to offer funds and medicines.

Education duty bearers: Layyah and Gujrat

The education bearers included both male and female AEOs, Dy. DEOs, DEOs and CEO in both districts. The CEO holds the responsibility of ensuring the establishment of school councils in each school, as well as overseeing and evaluating the funds transferred to the council accounts. DEOs are tasked with monitoring activities and ensuring transparent handling of funds. Deputy DEOs plays a role in planning and implementing activities identified by school council members, working alongside AEOs.

Most interviewees revealed that SCs receive annual funds ranging from 50,000 to 200,000 rupees, primarily allocated towards purchasing learning materials, school supplies, and maintaining playgrounds. However, additional responsibilities of school council also include hiring ad hoc teachers, paying utility bills, and fostering community engagement.

In terms of health-related efforts, only officials responsible in Gujrat reported that schools within their jurisdiction had conducted such initiatives in the past year. Among these activities, 50% were organised by the health department, involving health

screenings, vaccination campaigns, and deworming programs. A small portion (11%) included vision screening. The other 50% of health-related activities were arranged by the community, such as private companies and local benefactors. However, all schools in Layyah did not engage in any health-related activities and expressed a strong desire to take part in such initiatives.

All interviewees in Gujrat and Layyah acknowledged the involvement of local private companies in supporting SCs, either through financial contributions or the provision of learning materials. Approximately 89% of respondents highlighted the potential role of the private sector in supporting health-related activities within schools. Remarkably, 72% of the interviewees reported existing collaborations between their schools and local entities, either informally or through formal agreements. This support primarily involved the provision of learning materials and facilitating health-related activities.

When asked about enhancing private sector participation, education officials emphasised the need for policy changes and increased transparency in the process. Additionally, nearly all respondents (94%) were aware of private sector entities engaged in philanthropic activities and agreed that they could be integrated into SC funds, further enhancing their support for school initiatives.

When considering the allocation of funds in school council for health-related activities, the consensus among participants leaned towards the importance of maintaining accurate records in school council accounts. This ensures transparency and accountability in managing the funds, ultimately leading to better use of resources to improve students' physical and mental health and academic performance. Moreover, these funds can foster healthy competition among the private sector, thus contributing towards the overall health of school children. Notably, the CEO from Layyah suggested that these funds could be accessed directly by the private sector through the SC, offering facilitation for interested organisations. Officials highlighted potential uses for these funds, including facilitating medical camps, health screenings, healthy sports activities, providing school meals, and organising various health and hygiene awareness campaigns.

School Council Members:

Layyah

All surveyed schools have been operational for over two years. Participants unanimously stated that SC responsibilities entail school maintenance, the provision of educational materials, sports equipment, settlement of utility bills, and fostering community engagement. Government funding, typically ranging from 50,000 to 200,000 per year, sustains these operations, with over 90% of allocated funds dedicated to purchasing educational materials and supplies.

Despite this robust operational framework, no health-related activities have been conducted in the past by either governmental bodies or external organisations. As a result, there is a notable eagerness among schools to engage in such activities,

including health screenings, vaccination campaigns, deworming programs, and vision screenings.

In terms of collaboration, all participants recognise the potential role of the private sector in supporting SC initiatives, including financial backing, provision of sports equipment, and involvement in health-related activities. However, existing collaborations are hindered by transparency issues. Moreover, there is a consensus among 90% of participants that philanthropic funds could be integrated into SC funds, suggesting an openness to diversifying funding sources to enhance educational and health-related endeavours.

When addressing the question about the accumulation of philanthropic funds in the school council, members stressed the importance of meticulous record-keeping to guarantee transparency and accountability. They also highlighted the need to involve representatives from the private sector in the school council and develop a comprehensive action plan for health activities. This approach is seen as essential for boosting private sector involvement, ultimately leading to improvements in overall child health.

Gujrat

Of the surveyed schools, 67% had been functional for more than one year but less than two years, while 33% had been operational for more than two years. Additionally, participants from Gujrat highlighted the practice of hiring teachers on an ad hoc basis, alongside responsibilities such as school maintenance, provision of supplies, payment of utility bills, and community engagement.

In terms of funding, 70% of the schools received financial support from sources beyond the government, including the community, parents, and charity organisations. This additional funding, present in 40% of the schools, often exceeded 400,000, supplementing government allocations. Predominantly, these funds were allocated towards acquiring learning materials and school supplies.

A majority (more than 70%) of participants reported the implementation of health-related activities within the past 1-2 years, facilitated either by the health department or private companies. These initiatives predominantly included vaccination and deworming drives (65%), with approximately 13% involving vision screening. However, only 13% of participants mentioned interacting with health and nutrition supervisors, primarily in relation to health screenings and provision of first aid.

School council members largely recognised the importance of the private sector, with 80% acknowledging its value and 60% expressing support for its involvement in health-related activities. Informal agreements with the private sector were reported by nearly half of the participants, particularly for the provision of learning materials and some assistance in health-related endeavours. Participants suggested that policy changes could enhance collaboration further. As for the incorporation of philanthropic funds

into SC resources, 53% agreed to this addition and suggested to be done at district level with proper SOPs

Additional Secretary- Planning and Budget:

The following key points were extracted from the interview:

- Mobilising local private sector participation to support School Councils (SC) and Parent-Teacher Councils (PTC) involves active engagement with businesses and organisations in the education process. By demonstrating the benefits to communities and potential for positive publicity, their involvement can be encouraged through initiatives such as sponsorship programs, infrastructure development, or contributions to educational resources. Collaboration is key to enhancing the effectiveness of SCs and PTCs.
- While current policies and regulations governing SCs and PTCs do not significantly limit their participation, there is room for improvement in mobilising efforts at the grassroots level. Strengthening public-private partnerships without major regulatory overhauls can enhance engagement. This involves making it easier for the private sector to contribute to school processes and outcomes, enriching the educational environment for students.
- Facilitating formal interaction between duty bearers, local traders/associations, and SCs/PTCs can be achieved through a structured framework including regular meetings, collaborative projects, and clear communication channels. Engaging local philanthropists and traders to address minor gaps in facilities and resources can create a supportive network directly impacting student success.
- Local private sector support towards public sector school activities beyond existing budgetary constraints is possible through contributions channelled through School Councils. Establishing transparent accountability mechanisms is crucial to ensure effective use of contributions aligned with schools' needs and goals.
- Facilitating financial support from local private entities towards public sector schools involves implementing robust audit mechanisms similar to those used in government sectors. This ensures transparency and accountability, allowing contributions without being hindered by financial and audit procedural limitations. Providing a clear and trustworthy process encourages more private sector engagement, benefiting educational programs and infrastructure

Khyber Pakhtunkhwa

CSR Entities: Buner and Khyber

Over the past two years, all trader associations have actively participated in charitable activities, primarily allocating less than 50,000 rupees annually towards social welfare and Water, Sanitation, and Hygiene (WASH) initiatives. Funding mechanisms varied, with one-third of associations directly supporting beneficiaries, while the remaining two-thirds channelled funds through their own charitable organisations or trader associations. Surprisingly, trader associations in Buner and Khyber demonstrated a higher level of collaboration with local authorities compared to Punjab entities, with

33% working through the Deputy Commissioner's office and 67% with local departments, primarily engaging in charity in kind. Despite their willingness to support local public schools by providing school supplies and assisting in health-related activities, only a third of associations were familiar with the standard procedure for channelling community support through Parent-Teacher Committees (PTCs).
When discussing the facilitation required for long-term collaboration, members emphasised the importance of proper documentation and procedures in the engagement process. This includes clearly defining school needs, developing a phased plan of support, and establishing robust monitoring and verification mechanisms. Additionally, there was keen interest among trader associations in supporting health-related activities, particularly in providing medicines and eyeglasses to deserving children.

Education duty bearers: Buner and Khyber

Among the duty bearers, ASDEOs held the responsibility of providing general guidance to PTC members, communicating identified needs to higher-ups, and managing funds records, including disbursement according to each school's rooms. SDEOs were tasked with directing and monitoring PTCs, opening accounts for funds, and providing specifications for fund utilisation. DEOs generally supervised overall operations and allocated funds based on school needs.

Regarding annual fund allocation to PTCs, officials provided varied responses, with some schools receiving set amounts ranging from 50,000 to 200,000 rupees, while others received funds based on the number of rooms, ranging from 5,000 to 11,000 rupees per class per year. These funds primarily supported construction projects and the purchase of learning materials and school supplies.
Over 50% of officials confirmed health-related activities in schools over the past year, funded either by the health department or local NGOs. Activities included vaccination and deworming drives, with some schools also conducting vision screening. Additionally, more than two-thirds of officials recognised the private sector's significant role, particularly in providing learning materials, sports equipment, and support for health-related activities. Half of the duty bearers confirmed existing collaborations, often formalised through agreements, focusing on teacher capacity building, provision of sports equipment, and health-related support.
Suggestions for improving commitment included changes in policies and increased transparency in the process. However, most officials were unaware of any philanthropic activities in their catchment areas. Nonetheless, half of the duty bearers agreed that philanthropic funds could be integrated into PTC funds, suggesting separate accounts for such activities. Proposed activities included WASH initiatives, vaccination campaigns, medical camps, vision screenings, nutrition-related programs, awareness campaigns, and provision of first aid kits. Officials emphasised the potential benefits of private sector involvement, foreseeing improvements in children's health and participation in learning activities.

Parent Teacher Council Members:

Buner

Two-thirds of PTCs had been operational for over two years, primarily focusing on school maintenance (83%) and the procurement of school supplies (73%). Government funding covered 100% of their expenses, with an additional third coming from charitable organisations. However, the allocated funds, typically less than 50,000 rupees annually, were primarily directed towards school building construction and the purchase of supplies.

All members acknowledged recent health-related activities in schools, carried out either by the health department or NGOs. These activities included health screenings, deworming drives, and vision screenings, with the health department taking the lead.

Approximately two-thirds of respondents recognised the role of the private sector, with 50% reporting existing ad hoc collaborations. These collaborations mainly involved support in providing learning materials, sports equipment, and health-related activities. Participants suggested that incentives such as policy changes and increased transparency could further encourage private sector involvement.

Interestingly, 93% of members expressed the belief that philanthropic funds could not be integrated into the PTC system.

Khyber

The vast majority, 97%, of PTCs had been operational for more than two years, primarily focusing on school maintenance and the procurement of school supplies and learning materials. Members noted that funds for these activities came not only from the government (100%) but also from charitable organisations (17%) and the community (7%), totalling more than 400,000 rupees annually.

Regarding health-related initiatives, over 50% of members acknowledged such activities in their schools over the past 1-2 years, primarily funded by the health department, with additional contributions from NGOs and local philanthropists. These activities typically included vaccination and deworming drives.

Ninety percent of participants recognised the private sector's role, particularly in providing financial support to PTCs and learning materials to students. Despite this recognition, none reported existing collaborations due to issues with transparency and existing policies. However, 80% agreed that philanthropic funds could be incorporated into PTC funds.

When asked about the potential use of these funds within PTCs, members offered various suggestions, including support for differently-abled children, medical camps, WASH facilities, purchasing emergency medicines, health awareness campaigns, and providing school meals. Some also proposed the recruitment of a school nurse and facilitating healthy sports activities. The provision of these funds was seen as crucial for creating a healthy environment for children, improving their physical and mental well-being, and enhancing their ability to learn. Additionally, it was believed that increased parental interest and improved school performance would result from such initiatives.

Additional Secretary - Planning and Budget:

The following key points were extracted from the interview:

- **Enhancing Awareness and Training:** It's crucial to increase awareness among PTC members about their roles and responsibilities. Conducting proper training sessions can help them understand their mandate better. This includes having a say in school development and enrolment processes.
- **Compensation for PTC Members:** Since many PTC members come from financially constrained backgrounds, providing compensation for their time and effort can incentivise them to actively participate. This can help them fulfil their duties effectively and reach out to potential donors or private sector entities for support.
- **Streamlined Procedures for Private Sector Engagement:** The process for private sector organisations to work with PTCs should be clear and streamlined. This involves sharing mandates and objectives, obtaining necessary approvals, and ensuring alignment with school policies and objectives.
- **Involvement of PTCs in School Planning:** PTCs should be actively involved in the development of the school's annual plan. This ensures that their input and perspectives are considered in decision-making processes related to school development and resource allocation.
- **No Current Limitations but Room for Improvement:** As of now, there are no policies that limit the participation of PTCs with private organisations. However, ongoing efforts are being made to revise and broaden the scope of PTCs to enhance their effectiveness.
- **Reforms Underway:** Work is being done to revise policies and regulations governing PTCs to broaden their scope and effectiveness. This includes ensuring that PTCs have a say in the overall development of the school and in the enrolment process.
- **Need for Systematic Approach:** While there are no specific restrictions, there is a systematic approach to engaging with private entities. This ensures that support is better coordinated and aligned with school policies and objectives.
- **Establishing Clear Communication Channels:** To facilitate formal interaction between duty bearers, local traders/associations, and SCs/PTCs, establishing clear communication channels and dedicated platforms is essential. This can involve regular meetings, forums, or the appointment of liaison officers to ensure transparency and accountability in the engagement process. Moreover, directing attention towards PTCs is imperative, considering their direct involvement with schoolchildren and nuanced understanding of their needs. Efforts should focus on highlighting the effectiveness of PTCs in utilising funds and resources efficiently for school development, particularly to philanthropy associations. Emphasising how PTC members can execute infrastructure projects at lower costs compared to government departments can be achieved through targeted communication channels such as emails or other platforms. This ensures that potential supporters

are aware of the impactful role PTCs play in enhancing school infrastructure and resource allocation.

- **No Audit Procedural Limitations:** There are no audit procedural limitations that restrict engagement between PTCs and private sector entities. This suggests that there are no formal barriers hindering private sector support to PTCs.

Annexure 2: Framework for local level CSR for Enhanced PTCs

Terms of Reference

The local level Corporate Social Responsibility (**CSR**) Framework can be applied to a Union Council (**UC**), Village Council (**VC**), Neighbourhood Council (**NC**) or adapted for sub-district and district level.

The following recommendations are made:

- The scope of **existing Parent Teacher Councils (PTCs) or School Councils (SCs)** can be enhanced to incorporate CSR support – **Enhanced PTC/SC (E-PTC/SC)**
- The **E-PTC/SC** will facilitate engagement between **local CSR and philanthropic entities** and the local education authorities and public sector education facilities in the UC
- The **E-PTC/SC** will develop an annual CSR Support Plan (**CSP**)

Terms of Reference for the Enhanced PTCs/SCs

- Develop, implement and support achievement of an annual CSP for the UC/VC/NC contributing towards overall health and education of school children in public sector facilities in the UC/VC/NC
- Review annual school health and education needs plans developed by local Parent Teacher Councils/School Councils and identify opportunities for support through the CSP
- Develop an annual work plan specifying areas of support
- Coordinate with local health and education authorities and non-governmental organisations (**NGOs**) and civil society organisations (**CSOs**) to determine specific areas of work to be undertaken
- Each **E-PTC/SC** within the UC/VC/NC can utilise their existing bank account for receiving monies from local CSR entities to ensure accountability and audit
- Local CSR entities can be represented on the **E-PTCs/SCs** and extend their support in kind

Composition of the Enhanced PTC/SC

The Chief Executive Officer Education (**CEO-Education**) through the office of the District Education Officer (**DEO**) will facilitate the enhanced role of the **E-PTCs/SCs** for receiving CSR support.

The composition of the expanded PTC/SC can include the following:

- UC/VC/NC Chair or their representative – Chair
- Representative(s) of local Traders Association(s) and philanthropists
- Representatives of local Parent Teacher Councils/School Councils
- Local health practitioner/ health educator
- A prominent elder preferably an alumnus of the concerned school.
- A qualified nutritionist (from public or private sector) if available at the local level

Scope of Work

This can entail the following.

- **E-PTC/SC Management Plan**:

- The **E-PTC/SC** will develop an annual action plan indicating its areas of support and work plan
- Monitor execution of activities supported by the local CSR entities
- Coordinate with other interested philanthropic parties and donors interested in extending financial and in-kind support to local Parent Teacher Councils/School Councils for health and nutrition, education and water, sanitation and hygiene (**WASH**) activities
- Commission an annual external audit of funds (income-expenditure audit) donated to **E-PTCs/SCs**
- Present an annual report to the DEO, DHO, CEO Education and CEO Health of achievements against the agreed work plan for the year

- **Health-related activities**:
  - Liaise with and collaborate with health stakeholders and service providers for specific activities that include school health screening for:
    1) vision and eye health and provision of eyeglasses
    2) ear and hearing care
    3) dental care
    4) skin care
    5) general nutrition, health and hygiene
    6) provision of medicines for health ailments identified in the screening activities
    7) any priority health programme for school children
- **Education activities**:
  - Liaise with and collaborate with education stakeholders and service providers for specific activities that include:
    1) provision of schoolbooks/reading material for students
    2) provision of sports equipment
    3) provision of school supplies (stationery)
    4) infrastructure support like whitewash, minor repairs, lighting, fans
    5) furniture support like desks, tables, chairs, blackboards
- **School WASH**:
  - Liaise with and collaborate with education and **WASH** stakeholders and service providers for specific activities that include:
    1) provision of safe drinking water access points
    2) provision of handwashing and face-washing facilities
    3) construction or installation of water tank for school
    4) construction or rehabilitation of school latrines with safe sanitation

Annual Orientation Meeting

At the start of every financial year, the UC/VC/NC Chair will invite the chairs of local Parent Teacher Councils/School Councils and head teachers at those schools in the UC/VC/NC for a briefing meeting with local traders associations in which the scope and purpose of the CSR activities will be explained. The local Parent Teacher

Councils/School Councils will be invited to develop and submit their proposals for support on specific areas as per the Terms of Reference using a **standard project proposal template** together with a copy of their **school development plan** for the year. The project proposals seeking support should for activities that can be executed within a period of 3 months.

Project Proposals

The E-PTCs/SCs will review project proposals developed by the local Parent Teacher Councils/School Councils for CSR support and a set of proposals will be selected for consideration by the CSR entities every quarter. In this way the proposals submitted at the start of the financial year will be distributed over the 4 quarters in the financial year for review and support.

In the next financial year, the process will be repeated.

Functioning of E-PTC/SC

The **E-PTC/SC** will meet quarterly to discuss proposals identified for support for the respective quarters and to monitor progress. The **E-PTC/SC** shall maintain minutes and a record of the meetings.

For those proposals identified for support in the respective quarters, the chairs of the local Parent Teacher Councils/School Councils and the head teachers at those schools will discuss their proposals with the local CSR entities. The broad terms of support and work plan will be defined and agreed upon, followed by signing of a formal **Letter of Agreement** between the **E-PTC/SC** and the respective **local CSR entities**.

The Offices of the DEO and DHO, CEOs Education and Health will liaise with and assist the respective **E-PTC/SC** in their functioning, and for planning and coordination of activities.

Letter of Agreement

The Letter of Agreement will define the activities that will be supported, include a brief work plan, and the amount of financial assistance and in-kind support. Before any monies are transferred, the **E-PTC/SC** will provide details of their dedicated bank account approved by the provincial government/local administration.

Financial Management

The local Parent Teacher Councils/School Councils will maintain a **complete, comprehensive and separate record** with receipts for expenses made for the agreed activities supported by CSR/philanthropy. At the end of the quarter, they will submit a **Project Completion Report** with a complete account of monies disbursed and brief narrative on activities completed. The report will also be supported by a copy of the bank statement for the respective quarter under review.

The **E-PTC/SC** can at its discretion commission an external income-expenditure audit of the project supported.

The local CSR entities can provide support **in-kind** to the respective schools or **pay directly to service providers and vendors** for activities agreed with the **E-PTCs/SCs** without having to transfer funds to the **E-PTC/SC** accounts.

Project Completion Report

At the end of the project, a formal Project Completion Report will be prepared by the **E-PTC/SC** who will submit copies to DEO, CEO Education and CEO Health.

Template for a Project Proposal

Date of submission of project proposal			
Name of School			
Address of School			
Union Council			
Tehsil		District	
Activities for which support is being requested	1. 2. 3. 4. 5.		
Estimated cost of Activities for which support is being requested	Activities		Cost in Rupees
	1.		
	2.		
	3.		
	4.		
	5.		
Brief Work Plan for execution of Activities			
Signed by			
	Chair of local Parent Teacher Councils/School Councils		Head Teacher

For completion by E-PTC/SC

Review and Comments by E-PTC/SC	

Decision by E-PTC/SC	
Date	

Template for Project Completion Report

Date of submission of Project Completion Report				
Name of School				
Address of School				
Union Council				
Tehsil		District		
Activities for which support was requested	1. 2. 3. 4. 5.			
Estimated cost of Activities on completion	Activities		Cost in Rupees	
	1.			
	2.			
	3.			
	4.			
	5.			
Brief report on execution and completion of Activities				
Signed by				
	Chair of local Parent Teacher Councils/School Councils		Head Teacher	

For completion by E-PTC/SC

Review and Comments by E-PTC/SC	

Decision by E-PTC/SC	
Date	

Template for Letter of Agreement

Letter of Agreement
Date: [Insert Date]
Parties Involved:
Local Parent Teacher Council/School Council (First Party)

- Name: [Insert Local Parent Teacher Council/School Council Name]
- Address: [Insert Local Parent Teacher Council/School Council Address]
- Contact Person: [Insert Contact Person's Name]
- Phone: [Insert Contact Person's Phone Number]
- Email: [Insert Contact Person's Email]

Local Traders Association (Second Party)

- Name: [Insert Traders Association Name]
- Address: [Insert Traders Association Address]
- Contact Person: [Insert Contact Person's Name]
- Phone: [Insert Contact Person's Phone Number]
- Email: [Insert Contact Person's Email]

Purpose: This agreement outlines the terms and conditions for collaboration between the Local Parent Teacher Council/School Council and the Local Traders Association to support itemised charitable activities in schools within our community.

Agreed-Upon Terms:

1. **Objective:**
    - The parties agree to jointly contribute to specific charitable initiatives in local public sector schools.
2. **Charitable Activities:**
    - The support will focus on the following itemised activities (*this is a complete list – only those activities should be shown below that are agreed for support*):

- **Health-related activities**:
    1) vision and eye health and provision of eyeglasses
    2) ear and hearing care
    3) dental care
    4) skin care
    5) general nutrition, health and hygiene

6) provision of medicines for health ailments identified in the screening activities
7) any priority health programme for school children

- **Education activities**:
  1) provision of schoolbooks/reading material for students
  2) provision of sports equipment
  3) provision of school supplies (stationery)
  4) infrastructure support like whitewash, minor repairs, lighting, fans
  5) furniture support like desks, tables, chairs, blackboards
- **School WASH**:
  1) provision of safe drinking water access points
  2) provision of handwashing and face-washing facilities
  3) construction or installation of water tank for school
  4) construction or rehabilitation of school latrines with safe sanitation

3. **Financial Contributions:**
   - The local traders association commits to providing financial support of [Insert Amount] for the quarter.
   - The Local Parent Teacher Council/School Council will indicate if it has any matching funds from any other source.
4. **Timeline:**
   - The agreement is valid for [Insert Duration] quarter, starting from the effective date.
5. **Reporting and Accountability:**
   - Both parties will maintain transparent records of their contributions.
   - A quarter report will be submitted to track progress and utilisation of funds.
6. **Coordination:**
   - A joint committee comprising representatives from both parties will oversee the implementation of charitable activities.
   - Regular meetings will be held to discuss progress and address any issues.
7. **Public Recognition:**
   - Both parties agree to acknowledge each other's support in relevant communications and events.

Signatures:

Local Parent Teacher Council/School Council:

[Signature] [Insert Name] [Title] [Insert Local Parent Teacher Council/School Council Position] [Date]

Local Traders Association:

[Signature] [Insert Name] [Title] [Insert Traders Association Position] [Date]

This letter serves as a formal agreement between the Local Parent Teacher Council/School Council and the Local Traders Association. It outlines our joint commitment to making a positive impact on our community's schools through charitable efforts. Please review and sign accordingly.

Sincerely,

[Your Name] [Your Title] [Your Organisation]

Annexure 3: Amendments to the guidelines of PTCs/SCs

The following amendments were proposed to specific sections of the guidelines for PTCs/SCs.

Enhancing Student Health and Well-being by collaborating with the Health Department.

The current policy lacks provisions for collaborating with other departments to promote student health and hygiene.

- *It is proposed that under section 3.1 on membership to SC, the scope of membership to the SC should be augmented to include a health practitioner/health educator, and a qualified nutritionist (from public or private sector) if available at the local level.*
- *It is proposed that section 4 of the SC guide should include an additional function for SCs to collaborate with the health department for a holistic and integrated approach to school health specifically targeting health concerns such as students' eye health and vision, ear and hearing care, oral health, water, sanitation and hygiene (WASH), nutrition and cognitive issues.*

Enhance support for the SCs from local philanthropy and local level CSR

The SC policy does not include provisions for mobilising local support for SC activities, especially for school health, from local philanthropy and local level CSR. It is recommended to augment the scope of section 3.1 on membership to SC and add a new sub-section under section 4 on responsibilities of SCs to the policy focusing on local philanthropy and CSR. This section should outline the following interventions:

- *It is proposed that under section 3.1 on membership to SC, the scope of membership to the SC should be augmented to include a local trader representative/philanthropist(s) and a prominent elder preferably an alumnus of the concerned school*
- *The SC should actively collaborate with local level philanthropists and CSR entities to mobilise support for school health related activities – it is recommended that the SC should prepare an annual activity plan for school health activities and coordinate support and implementation through SC meetings where local philanthropists/traders are represented*
- *The new sub-section should make provision for SC to keep account of any monies received for dedicated activities for school health and report back to local donors on activities and expenses – the provision can be extended to include in-kind support or direct payment by local philanthropists/traders to agencies/organisations providing school health screening activities*

Annexure 4: Integrated Referral Framework for School Health

Context

According to the definition of the World Health Organization (WHO), "referral can be defined as a process in which a health worker at a one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case".

School Health is one of the priorities of the provincial government as it has a direct impact on school attendance and learning outcomes. School Health is imparted through several mechanisms like health education, practising health behaviours, improving nutrition, and improving hygiene and sanitation practices. It is also augmented through specific campaigns like deworming and nutrition supplementation.

One of the most effective means of promoting school health is through **school health screening programmes**. These can include screening for vision and eye health, ear and hearing health, and oral health among others.

School Eye Health – as an example

In school eye health screening, for example, the vision (visual acuity) of the school children is assessed followed by an external eye examination. School children whose vision is below a certain threshold have a refraction to determine if they need eyeglasses.

The vision and eye assessment are conducted by a **trained eye health professional** like a trained ophthalmic technician or trained optometrist. Refraction is conducted by a trained optometrist.

The school eye health screening team can have an '**Eyeglasses Kit**' of frequently required prescriptions of eyeglasses of simple numbers (dioptric power). In those school children with simple prescription numbers, the school eye health team dispenses the eyeglasses on the spot. School children who have compound prescription numbers or require further eye examination and assessment are referred to the next appropriate level of health care for detailed refraction and ophthalmic assessment.

School health screening programmes e.g., school eye health, can be co-sponsored by local corporate social responsibility (CSR) and philanthropy entities like Local Traders or their associations. They can also be an active member of Parent Teacher Councils (PTCs).

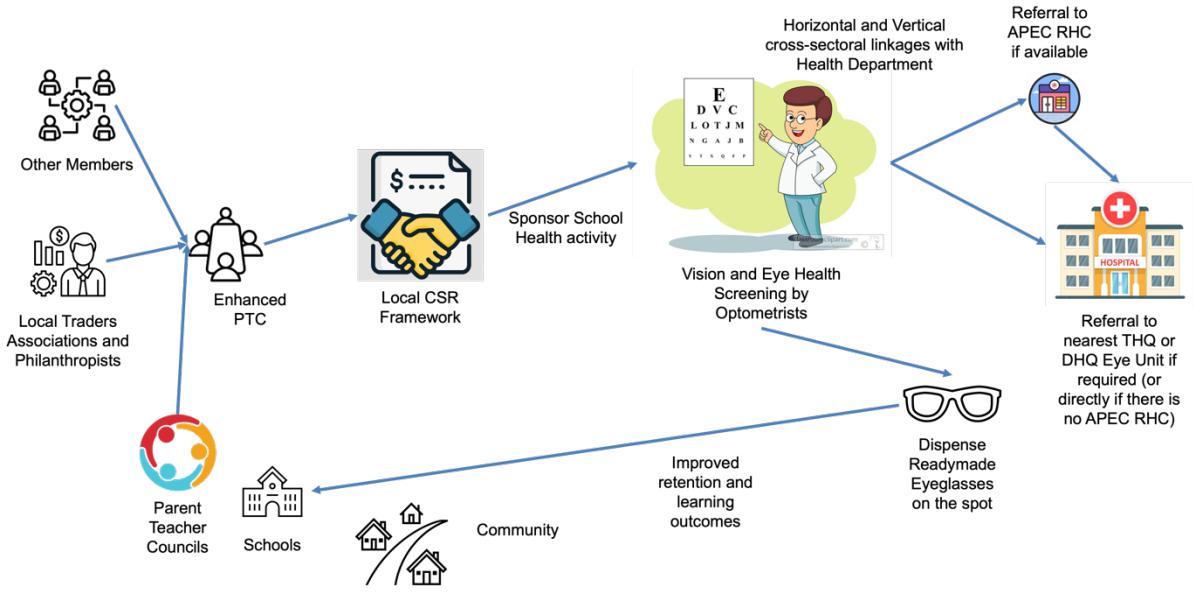
Appropriate levels of Health Care

Schools are generally located in Union Councils (UCs). Each UC generally has a **Basic Health Unit** (BHU). A cluster of UCs and their BHUs are supported by a **Rural Health Centre** (RHC). BHUs and RHCs are called **First Level Health Facilities** (FLHFs). These are usually staffed by medical officers and nurses and allied health personnel. In some RHCs, optometrists are also deployed through support by international and national eye care partners. These RHCs provide **Advanced Primary Eye Care** (APEC) and are

called APEC RHCs. They have basic diagnostic and assessment equipment for refraction and detailed eye examination. Most refractive errors can be adequately addressed at this level with only a small percentage requiring referral to the secondary level health facilities.

At the sub-district level, there are **Tehsil Headquarter Hospitals** (THQs), while there is a **District Headquarter Hospital** (DHQ) for the district. The THQs and DHQs are secondary level health facilities. Most DHQs and some THQs have an eye unit with an ophthalmologist and an optometrist (in some cases).
Usually, in each division, there is a **Tertiary Referral Hospital** which may also be a teaching hospital. The tertiary referral hospital has an eye department which provides tertiary level/specialist eye care.
The usual referral pathway is from the community (community health workers) to BHUs; from BHUs to RHCs; from RHCs to THQs/DHQs; and from THQs/DHQs to tertiary referral hospitals.
Depending on the nature of the health condition of the school children, the referral pathway may bypass some levels.

Referral Pathway Schematic – School Eye Health as an example



Referral Note Template

PROFILE

Serial Number		Date of Referral				
Name of Student						
Age in Years		Sex	Male		Female	
Name of School						
Union Council		Tehsil				
District		Province				
Name of Head Teacher						

TYPE OF SCREENING PROGRAME

Type of Screening		Tick as appropriate	Conducted by	Date
1	Vision and Eye Health			
2	Ear and Hearing Health			
3	Oral Health			
4	Adolescent Health			
5	Nutritional Health			
6	Neglected Tropical Disease (e.g. Deworming)			
7	Disability Assessment			
8	Other – please specify _ _ _ _ _ _ _ _ _ _ _ _			

FUNCTIONAL LIMITATION

Does the child have any functional limitation	Tick as appropriate
Vision Impairment	
Hearing Impairment	
Speech Impairment	
Physical Impairment	
Learning Impairment	
Other – please specify _ _ _ _ _ _ _ _ _ _ _ _	

HEALTH CONDITION

Diagnosis (health problem)	
Indicate if any treatment provided at time of screening	
Reason for Referral	

REFERRAL PATHWAY

Tick health facility to which child is being referred									
BHU		RHC		THQ		DHQ		Other – please specify _ _ _ _ _ _ _ _ _ _ _ _	

REFERRING PERSON

Name	
Designation	
Signed	
Copy to District Health and Education Authorities	

Referral Feedback Template

PROFILE

Serial Number		Date of Review					
Name of Student							
Age in Years		Sex	Male		Female		
Name of School							
Union Council		Tehsil					
District		Province					
Name of Head Teacher							

REFERRAL PATHWAY

Tick health facility at which child was examined for further assessment									
BHU		RHC		THQ		DHQ		Other – please specify _____	

HEALTH CONDITION

Diagnosis (health problem)	
Feedback on Referral	
Indicate what treatment was given at the health facility	

ACTIONS

Actions recommended to parents and child	
Actions recommended to Head Teacher and Class Teacher	

PERSON PROVIDING FEEDBACK AFTER REFERRAL

Name	
Designation	

Signed	
Copy to District Health and Education Authorities	

Annexure 5: Vision Screening

Table 1: Distribution in districts – Summary Table

Districts	Schools	No. of students present on the day of screening	No. of students identified with eye problems and V/A worse than 6/12	No. of students already wearing spectacles	Refraction performed and new spectacles provided (partial met need)	Continued with same spectacles (met need)	Refraction performed and spectacles provided (un-met need)	No. of students referred	Referred for cycloplegic refraction (including Squint assessment and amblyopia which also require refraction)	Diagnosed with redness and discharge
Buner	10	1755	306	23	15	8	216	90	7	65
Khyber	10	560	137	2	1	1	103	34	3	30
Gujrat	10	923	236	6	2	4	189	47	6	43
Layyah	10	235	76	0	0	0	51	25	1	24
Total	**40**	**3473**	**755**	**31**	**18**	**13**	**559***	**196**	**17**	**162****
%			**21.7%**	**0.9%**	**0.5%**	**0.4%**	**16.1%**	**5.6%**	**0.5%**	**4.7%**

*495 provided by screening team, remaining provided by local philanthropists/donors.
**162 diagnosed with redness and discharge – Screening carried out from 6th May – 17th May when there was an intense heat wave and wheat harvesting season in Punjab. Seasonal allergies are on the peak at this time of the year. These 162 children were referred as they needed primary eye care services.

The 17 cases referred for squint assessment and amblyopia treatment needed secondary eye care services. while those referred for refraction under cycloplegia also needed secondary eye care services. There was only 1 child identified with cataract.

Total number of children with **all refractive error** (partial met need, met need, unmet need and referral) **= 18 + 13 + 559 + 17 = 607**
Total number of children with **uncorrected refractive error** (partial met need, unmet need and referral) **= 18 + 559 + 17 = 594**

Therefore, the frequency of:

- All refractive error (n = 607) = 607 / 3473 = 17.5%
- Uncorrected refractive error (n = 594) = 594 / 3473 = 17.1%
- Proportion of uncorrected refractive error that can be corrected onsite in schools (18 + 559) = 577 out of 594 = 97.1%

Gender – 321 (42.51%) male and 434 (57.48%) female affected students in all 40 schools in 4 districts.

Table 2: Distribution of schools in Buner district, students enrolled, screened, with eye problems, spectacles provision and referrals

District	Schools	No. of students enrolled in class 3	No. of students enrolled in class 5	Total	No. of students identified with eye problems and V/A worse than 6/12	Refraction performed and spectacle provided	No. of students referred for cycloplegic refraction and other management
Buner	GGPS Chinglai	150	130	280	27	10	16
	GGPS Totalai	90	80	170	51	24	27
	GGPS Jafar Khel	85	79	164	41	30	11
	GGPS Kass Korona 2	56	50	106	10	10	0
	GGPS Kass Korona 1	51	69	120	18	8	10
	GBPS Kitawer	61	74	135	19	19	0
	GBPS Daggar no 1	101	99	200	54	36	18
	GBPS Krappa	123	129	252	47	45	2
	GBPS Daggar no 2	62	83	145	14	12	2
	GBPS Elai	90	93	183	26	22	4
Total	**10**	**869**	**886**	**1755**	**307**	**216***	**90**
%					**17.5%**	**12.3%**	**5.1%**

*216 spectacles prescribed - 196 provided by team, 20 prescriptions (10 GGPS Chingalai and 10 GGPS Kass Korona 2) were handed over to I-SAPS team members to provide from local donors on the last day of screening. 915 male and 840 female students present on the day of screening. 147(47.88%) females and 160 (52.11%) male students affected.

Table 3: Distribution of schools in Khyber district, students enrolled, screened, with eye problems, spectacles provision and referrals

District	Schools	Number of students enrolled in class 3	Number of students enrolled in class 5	Total	No. of students identified with eye problems and V/A worse than 6/12	Refraction performed and spectacle provided	Number of students referred for cycloplegic refraction and other management
Khyber	GGPS Wazir Dhand 2 Jamrud	32	28	60	13	10	3
	GGPS Farooq Jan Killi Jamrud	29	28	57	2	2	0
	GGPS Jamrud	46	39	85	28	19	9
	GGPS Ghariza No 1	20	18	38	7	5	2
	GGPS Anwar Shah Killi Shahkas	21	18	39	6	5	1
	GBPS Wazir Dhand	25	23	48	8	7	1
	GBPS Jamrud Bazar 2/Teddi Bazar	22	20	42	8	7	1
	GBPS Jamrud Bazar	30	29	59	15	8	7
	GBPS Hashim Abad Jamrud	34	31	65	26	18	8
	GBPS Lalmat Killi Jamrud	30	37	67	24	22	2
Total	**10**	**289**	**271**	**560**	**137**	**103**	**34**
%					**24.5%**	**18.4%**	**6.1%**

279 female and 281 male students were present on the day of screening. 81(59%) male and 56 (41%) female students affected.

Table 4: Distribution of schools in Gujrat district, students enrolled, screened, with eye problems, spectacles provision and referrals

District	Schools	Number of students enrolled in class 3	Number of students enrolled in class 5	Total	No. of students identified with eye problems and V/A worse than 6/12	Refraction performed and spectacle provided	Number of students referred for cycloplegic refraction and other management
Gujrat	GGPS Dinga 3	28	33	61	15	10	3
	GGPS Dinga 2	34	36	70	21	20	1
	GGPS Railway station Dinga	58	55	113	42	35	7
	GGPS No 3 Kharian city	35	20	55	15	14	3
	GGPS No 2 Kharian city	46	45	91	35	30	6
	GBPS Railway colony 1 Dinga	60	65	125	26	19	7
	GBPS Nabipura Dinga	60	60	120	23	22	6
	GBPS MC 2 Lalamusa	55	84	140	23	15	8
	GBPS Verowal	35	52	87	16	11	3
	GBPS Budhu Kalas	21	40	61	15	13	3
Total	**10**	**432**	**490**	**923**	**231**	**189***	**47**
%					**25.0%**	**20.5%**	**5.1%**

*Total spectacles prescribed 189 - screening team provided 150, remaining were provided by a local donor. 390 female and 533 male students were present on the day of screening. 128 (55%) female and 103 (45%) male students affected.

Table 5: Distribution of schools in Layyah district, students enrolled, screened, with eye problems, spectacles provision and referrals

		Number of students enrolled in class 3	Number of students enrolled in class 5	Total	No. of students identified with eye problems and V/A worse than 6/12	Refraction performed and spectacle provided	Number of students referred for cycloplegic refraction and other management
Layyah	GGPS Ward no 2 Chowk Azam	10	13	23	5	5	0
	GGPS Ward no 9 Chowk Azam	11	15	26	9	7	2
	GGPS Ward no 6 Chowk Azam	9	10	19	4	3	1
	GGPS MC 1	7	11	18	2	2	0
	GGPS MC 2	12	11	23	6	5	1
	GBPS Ward no 1 Chowk Azam	9	16	25	7	2	5
	GBPS Asghar Abad	12	17	29	12	9	3
	GBPS Ward no 3 Chowk Azam	16	18	34	19	9	10
	GBPS MC 3 Railway Station	10	12	22	8	6	3
	GBPS Ward no 5 Qasim ul Uloom Eid Gah	8	8	16	4	3	1
Total	**10**	**104**	**131**	**235**	**76**	**51**	**26**
%					**32.3%**	**21.7%**	**11.1%**

103 female and 126 male students were present on the day of screening in Layyah. 26 (34%) females and 50 (66%) male students affected.

Annexure 6: Proposed School Health Indicators for ASC and SSR

Drinking Water

1	Basic Drinking Water Service (**Tick one option**) *Urdu*	No drinking water service *Urdu*		Improved drinking water source but water not available *Urdu*		Improved drinking water source with water available at the school *Urdu*	
2	Drinking water source accessible for children with disabilities (**Tick one option**) *Urdu*	No drinking water service *Urdu*		Any water source available *Urdu*		Drinking water source accessible for children with disabilities *Urdu*	

Notes:

Improved: The main drinking water source is of an "improved" type. An "improved" drinking water source is one that, by the nature of its construction, adequately protects the source from outside contamination, particularly faecal matter (JMP definition10). "Improved" water sources in a school setting include: piped, protected well/spring (including boreholes/tube wells, protected dug wells and protected springs), rainwater catchment, and packaged or delivered water. "Unimproved" sources include: unprotected well/spring, and surface water (e.g. lake, river, stream, pond, canals, irrigation ditches) or any other source where water is not protected from the outside environment.

Available: There is water from the main drinking water source available at the school on the day of the survey or questionnaire.

Disability: Long-term impairments that affect the functioning of a person and which in interaction with attitudinal and environmental barriers hinder the person's full and effective participation in society on an equal basis with others.

Accessible: Children with physical disability or impaired vision can access the drinking water service – this can include a handrail and ramp to the drinking water source for a wheelchair user.

Sanitation

3	Basic Sanitation Facility (**Tick one option**) *Urdu*	No sanitation facility *Urdu*		Improved and usable facility available *Urdu*		Improved, usable and single-sex facility available *Urdu*	
4	Toilets accessible for children with disabilities (**Tick one option**) *Urdu*	No sanitation facility *Urdu*		Any toilet available *Urdu*		Toilet accessible for children with disabilities *Urdu*	

Notes:

Improved: The sanitation facilities are of an "improved" type. An "improved" sanitation facility is one that hygienically separates human excreta from human contact (JMP definition10). "Improved" facilities in a school setting include: flush/pour-flush toilets, pit latrines with slab, and composting toilets. "Unimproved" facilities include: pit latrines without slab, hanging latrines, and bucket latrines, or any other facility where human excreta is not separated from human contact.

Usable: Toilets/latrines are available to students (doors are unlocked or a key is available at all times), functional (the toilet is not broken, the toilet hole is not blocked, and water is available for flush/pour-flush toilets), and private (there are closable doors that lock from the inside and no large gaps in the structure) on the day of the survey or questionnaire. Note: lockable doors may not be applicable in pre-primary schools.

Single-sex: There are separate toilet facilities dedicated to female use and male use at the school. Note: may not be applicable in pre-primary schools.

Accessible: Children with physical disability or impaired vision can access the toilet. Toilets for children with special needs include ramp, handrail, wide door for wheelchair entry and support structure inside toilet.

Hygiene

5	Hand Washing Facility (**Tick one option**) *Urdu*	No handwashing facility *Urdu*		Handwashing facility with water available *Urdu*		Handwashing facility with water and soap available *Urdu*	
6	Handwashing Facilities accessible for children with disabilities (**Tick one option**) *Urdu*	No handwashing facility *Urdu*		Any handwashing facility *Urdu*		Handwashing facility accessible for children with disabilities *Urdu*	

Notes:

Handwashing facility: A handwashing facility is any device or infrastructure that enables students to wash their hands effectively using running water, such as a sink with tap, water tank with tap, bucket with tap, tippy tap, or other similar device. Note: a shared bucket used for dipping hands is not considered an effective handwashing facility.

Soap and Water: Both water and soap are available at the handwashing facilities for girls and boys on the day of the questionnaire or survey. Soapy water (a prepared solution of detergent suspended in water) can be considered as an alternative for soap, but not for water, as non-soapy water is needed for rinsing. Note: ash or mud may be available for hand cleansing but is not an acceptable alternative to soap for monitoring.

Accessible: Children with physical disability or impaired vision can access the handwashing facility – this can include a handrail and ramp to the drinking water source for a wheelchair user.

Menstrual Health and Hygiene (only for schools with girls) (questions are not applicable in pre-primary schools)

	Indicator ***Urdu***	**Yes** ***Urdu***	**No** ***Urdu***
7	School provides menstrual health and hygiene education (**Tick one option**) *Urdu*		
8	Schools have bins for menstrual waste in girls' toilets (**Tick one option**) *Urdu*		
9	Schools have menstrual materials available for free or purchase (**Tick one option**) *Urdu*		

Notes:

Menstrual Hygiene Management (MHM): Various components are considered essential to MHM: (1) clean materials to absorb or collect menstrual blood, (2) space to change materials in privacy as often as needed, (3) soap and water for washing as required, (4) safe and convenient facilities to dispose of used materials, and (5) basic information about the menstrual cycle and how to manage it with dignity and without discomfort or fear.

School Health

	Health Screening Programme ***Urdu***	**Vision and Eye Health** ***Urdu***		**Physical Health** ***Urdu***		**Hearing Health and Speech** ***Urdu***		**Oral Health** ***Urdu***		**Skin Health** ***Urdu***		**Nutrition and Growth Monitoring** ***Urdu***	
10	**Number** of health screening activities conducted by a school health screening team in reporting period *Urdu*												
11	**Number** of children detected with specific health conditions by school health screening team in reporting period *Urdu*												
12	**Number** of children with health conditions treated on the spot by school health screening team in reporting period	# of children given Medicines *Urdu*		# of children given Medicines *Urdu*		# of children given Medicines *Urdu*		# of children given Medicines *Urdu*		# of children given Medicines *Urdu*		# of children given Medicines *Urdu*	

	Urdu												
		# of children given Eyeglasses *Urdu*		# of children given Assistive Products *Urdu*		# of children given Assistive Products *Urdu*		# of children given 'Other' *Urdu*		# of children given 'Other' *Urdu*		# of children given 'Other' *Urdu*	
13	**<u>Number</u>** of children with health conditions referred to a health facility by school health screening team in reporting period *Urdu*												

Notes:

Vision and Eye Health: Includes checking the vision of the child and examination of the eye.

Physical Health: Includes physical examination of the general body and mobility to determine any impairment like physical disability or any deformity.

Hearing Health and Speech: Includes hearing assessment and ear examination; and assessment for speech and ability to communicate.

Oral Health: Includes screening of the mouth and lips, and dental screening of teeth and gums.

Skin Health: Includes screening for skin infections and allergies.

Nutrition and Growth Monitoring: Includes assessment of the nutritional status of the child including undernutrition (wasting or stunting), inadequate vitamins or minerals, overweight, obesity, and resulting diet-related noncommunicable diseases; and assessment of growth standards like height, weight, Body Mass Index etc.

Eyeglasses: Spectacles provided to correct impaired vision.

Assistive Products: Assistive products help maintain or improve an individual's functioning related to cognition, communication, hearing, mobility, self-care and vision, thus enabling their health, well-being, inclusion and participation. Assistive products can range from physical products such as wheelchairs, glasses, prosthetic limbs, white canes, low vision devices and hearing aids to digital solutions such as speech recognition or time management software and captioning.
'Other': Any 'other' treatment provided on the spot during the screening activity which is not covered under 'medicines', 'eyeglasses' or 'assistive devices'.

Health Education

	Health Education Topics ***Urdu***	**Vision and Eye Health** ***Urdu***	**Physical Health** ***Urdu***	**Hearing Health and Speech** ***Urdu***	**Oral Health** ***Urdu***	**Skin Health** ***Urdu***	**Nutrition** ***Urdu***	**Injury and First-Aid** ***Urdu***	**Water, Sanitation and Hygiene** ***Urdu***	**Menstrual Health and Hygiene (only for schools with girls) (question not for pre-primary schools)** ***Urdu***
14	**Number** of health education sessions held in reporting period on specified topics *Urdu*									