MED MATRIX SERVICES (SMC-PVT. LTD.)

RSPN–ECW FER-PMF
TRAINING MANUAL

School-Based Vision, Hearing and Mobility Screening, Disability Inclusion, Referral, Assistive Device Support and Cascade Training

Prepared for the Rural Support Programmes Network (RSPN)
First Emergency Response: Pakistan Monsoon Flood (FER-PMF)
Prepared by Med Matrix Services (SMC-Pvt. Ltd.)
August 2026

Training coverage: 25 project staff • 540 designated teachers • SMC/PTC members across 180 schools

Table of Contents

Document Control

Field	Details
Document title	RSPN–ECW FER-PMF Training Manual
Implementing firm	Med Matrix Services (SMC-Pvt. Ltd.)
Assignment	School-Based Screening, Assessment and Provision of Assistive Devices for Children with Visual, Hearing Impairments and Wheelchairs
Primary audiences	25 project staff; 540 designated teachers; SMC/PTC members
Core training model	One-day ToT for project staff; cascaded district-wise teacher training; SMC/PTC orientation
Project footprint	180 flood-affected schools in Narowal, Sialkot, Jhang, Chiniot and Swat
Training purpose	Build practical capacity to recognize, screen, refer, support and follow up children with sensory and mobility needs
Status	Final field-ready master manual, expanded following reviewer feedback; RSPN-approved local forms, referral contacts and SOPs must be inserted/confirmed before deployment.

Important use note

This manual is a project-specific adaptation based on the Med Matrix technical proposal and the attached disability-inclusion and WHO screening guidance. It is designed for training and supervised school screening; it does not replace specialist diagnosis or treatment. The final RSPN-approved

screening forms, referral directory, local pathways and any district-specific instructions must be inserted/confirmed before implementation.

Source Basis and Adaptation

The manual uses the attached sources as its primary basis. The Med Matrix proposal specifies a one-day Training-of-Trainers-style module for 25 project staff, cascade training for 540 teachers and SMC/PTC orientation, with emphasis on classroom recognition, screening checklists, referral, inclusive teaching, device care and caregiver engagement.

The attached Disability Inclusion Trainer's Manual provides the training architecture for adult learning, trainer competencies, participatory methods, disability inclusion, barriers, rights, communication and inclusive training. Its training content is organized around getting started, disability concepts, barriers, rights, communication and inclusion.

The attached WHO 2025 Vision and hearing screening for school-age children: Implementation handbook provides the sensory screening pathway, consent, screening environment, vision and eye-health screening, hearing and ear-health screening, referral/follow-up, monitoring, health promotion, equipment and human-resource requirements.

Contents

1. Training Framework and Competency Model

The training is designed as a practical competency-building programme rather than a lecture series. Participants should leave able to perform the specific tasks assigned to them safely and consistently, recognise their limits, and activate the referral pathway when a child requires specialist assessment.

1.1 Core competencies

Competency	Participants should be able to…	Evidence
Disability inclusion	Use respectful language; recognise barriers; avoid stigma; support meaningful participation.	Scenario response / discussion
Screening readiness	Prepare an accessible and child-safe screening station and confirm consent.	Station checklist
Vision screening	Use the age-appropriate chart and occlusion method; record results; recognise referral/red flags.	Observed practical
Hearing screening	Prepare a quiet environment; explain the test; use the approved screening method; record and refer.	Observed practical
Mobility recognition	Observe gait, balance, transfers and functional mobility; identify children needing specialist assessment.	Case exercise
Referral	Explain results without diagnosing; complete referral documentation; track the child to the next step.	Referral simulation
Inclusive teaching	Make simple classroom adaptations for vision, hearing and mobility difficulties.	Micro-teaching
Device support	Explain safe basic care and use of eyeglasses, hearing aids and wheelchairs; identify maintenance/referral needs.	Demonstration
Data quality	Complete forms accurately and protect confidentiality.	Data exercise
Cascade training	Facilitate a short session, demonstrate a skill and give corrective feedback.	Micro-teaching

1.2 Training principles

- Child-centred, respectful and non-stigmatising.
- Practical and competency-based: explain → demonstrate → practise → observe → feedback → repeat.
- Participatory and adult-learning oriented, using participants' experience and real school situations.
- Disability-inclusive in the venue, materials, language, pacing and participation methods.
- Screening is not diagnosis. Referral decisions follow the approved project protocol and specialist pathway.
- Safeguarding and child protection are integral to every screening encounter.
- Data are collected only for the project purpose, kept confidential and handled according to RSPN requirements.

2. Project Context and Training Objectives

The Med Matrix proposal describes the FER-PMF assignment as a 75-day intervention covering 180 schools in five districts, with school-based screening, specialist assessment, fitting/distribution of eyeglasses, hearing aids and wheelchairs, referral and post-distribution follow-up. The proposal anticipates approximately 44,454 enrolled children and identifies the need for systematic screening and structured referral.

The proposal places training at the front of implementation: project staff and teachers are trained before the main screening phase, while SMC/PTCs are oriented to referral tracking and child-support functions that can continue after the assignment.

2.1 Training objectives

- Explain disability, impairment, barriers and inclusion using respectful, functional language.
- Recognise common signs suggesting visual, hearing or mobility difficulty in school-age children.
- Conduct the approved initial screening procedures within the limits of the participant's role.
- Use the correct referral criteria and communicate results appropriately.
- Apply basic inclusive classroom practices so children can participate while awaiting assessment or devices.
- Provide basic user orientation and care messages for eyeglasses, hearing aids and wheelchairs.
- Maintain accurate, confidential records and support referral follow-up.
- Plan and deliver a short cascade session using demonstrations and observed practice.

2.2 Proposed audience-specific outcomes

Audience	Primary outcome
25 project staff	Can supervise screening implementation, coach teachers, verify screening quality, manage referrals/data and cascade training.
540 teachers	Can recognise concerns, perform approved simple classroom screening/checks after training, refer appropriately, support inclusive classroom participation and track referrals.
SMC/PTC members	Can support consent/communication, reduce stigma, encourage referral attendance, help track children and link school/family to the agreed referral pathway.

3. Training Architecture and Delivery Plan

The master manual supports three linked delivery formats. The ToT is the most comprehensive. Teacher training is a practical cascade based on the same core modules. SMC/PTC orientation is shorter and focuses on community/school support rather than clinical screening.

Format	Suggested duration	Participants	Core content
Master ToT	1 full day (approximately 8	25 project staff	Disability inclusion; screening pathway; vision; hearing; mobility; referral; inclusive

	hours including breaks)		teaching; device care; data; facilitation; micro-teaching
Teacher cascade	1 full day	540 designated teachers, district-wise	Disability inclusion; recognition; vision/hearing/mobility screening job aids; referral; classroom inclusion; caregiver communication; device care; data
SMC/PTC orientation	2–3 hours	7–9 members per school group	Disability inclusion; stigma; consent/support; referral tracking; caregiver engagement; school support; follow-up

3.1 Master ToT one-day agenda

Time	Session	Method	Output
08:30–09:00	Registration, pre-test and baseline	Individual test + confidence self-rating	Baseline score and learning needs
09:00–09:20	Opening, safeguarding, PSEA and role boundaries	Interactive discussion + scenario	Learning contract and safe-screening rules
09:20–09:35	Disability inclusion: 10–15 minute overview	Mini-input + barrier prompt	Common language; barrier-focused mindset
09:35–10:00	Screening pathway, consent and referral triage	Pathway simulation	Safe end-to-end workflow
10:00–11:10	Vision screening practical stations	Demonstration → guided practice → peer practice → assessment	Observed vision competency
11:10–11:25	Tea break		
11:25–12:35	Hearing screening practical stations	Audiometry/validated method + whisper contingency + practice	Observed hearing competency
12:35–13:05	Mobility/functional observation	Demonstration + case station	Recognition/referral competency
13:05–13:45	Lunch/prayer break		
13:45–14:25	Referral, caregiver engagement and gender-sensitive communication	Role-play + feedback	Referral conversation competency
14:25–15:00	Inclusive classroom practice	Micro-teaching + peer feedback	Adaptation plan
15:00–15:25	Assistive devices: orientation and safe care	Return demonstration	Device-care competency
15:25–16:00	Post-test, practical verification, action plan and close	Assessment + reflection	Competency record and next steps

4. Trainer Preparation and Disability-Inclusive Facilitation

The disability-inclusion source manual emphasises active participation, relevance to the learner's real work, peer learning, reflection, supportive feedback and a safe learning climate. The trainer should therefore minimize long lectures and maximize demonstrations, practice, scenarios and feedback.

4.1 Before the training

- Confirm participant list, roles and language needs.
- Confirm RSPN-approved screening forms, referral directory, consent process and safeguarding contacts.
- Prepare age-appropriate vision charts, occluders, tape measure/3-metre string, torch/penlight, hearing equipment and headphones, otoscope where applicable, mobility measurement tools and device samples.
- Check all equipment, batteries/charging, cleaning materials and data forms.
- Ensure venue is accessible, well lit and suitable for both vision and hearing practice.
- Prepare local-language job aids and large-print/high-contrast materials where needed.
- Arrange a teacher/school representative presence during practical screening simulations.
- Agree emergency/urgent referral arrangements before training begins.

4.2 Inclusive training venue checklist

- Step-free access or an agreed accessible route.
- Accessible toilet where available.
- Clear pathways and adequate space for a wheelchair.
- Good lighting without glare on visual materials.
- Low background noise for hearing demonstrations.
- Seats that allow participants to change position easily.
- Printed and spoken instructions; do not rely on one communication channel only.
- Breaks and pacing appropriate to participants' needs.
- Confidential space for sensitive questions.

5. Module 1 – Getting Started, Expectations and Attitudes

Suggested duration: 30 minutes

Learning objectives:

- Create a safe learning environment.
- Clarify roles, expectations and learning objectives.
- Surface assumptions and attitudes about disability without shaming participants.

Materials:

- Name cards, flipchart, markers, pre-test, ground-rules sheet.

Facilitation sequence

1. Welcome participants and explain the purpose of the programme.
2. Ask each participant to state name, role and one practical expectation.
3. Develop ground rules: respect, confidentiality, participation, punctuality, no ridicule and permission to ask questions.
4. Use an attitude prompt: 'What might prevent a child with a disability from fully participating in our school?'
5. Cluster responses into person-level, environmental, communication and institutional barriers.
6. Link the discussion to the project goal: identify and reduce barriers rather than blame the child.

Key messages

- Disability inclusion starts with attitudes and practical changes.
- People with disabilities have the same rights to education, dignity, information and participation.
- Do not assume inability from appearance; ask the person/child what support is helpful.

Assessment / evidence of learning

- Participant contribution to the barrier exercise.
- Trainer observes respectful language and participation.

6. Module 2 – Understanding Disability and Functional Difficulties

Suggested duration: 15 minutes

Learning objectives:

- Distinguish impairment, activity limitation and participation restriction.
- Recognise common visual, hearing, mobility and learning-related functional difficulties in school settings.
- Understand the social/environmental barriers model used in disability inclusion.

Materials:

- Impairment cards, scenario cards, flipchart.

Facilitation sequence

1. Introduce the concepts of impairment and disability using simple school examples.
2. Small groups classify scenarios: child difficulty, environmental barrier, participation restriction or combination.
3. Discuss visual, hearing, physical/mobility and learning difficulties without using labels as insults.
4. Introduce the principle that barriers can be physical, communication, attitudinal, institutional or information-related.

5. Ask groups to identify one barrier and one practical solution in their school.

Key messages

- Screening identifies a possible need; it does not establish a diagnosis.
- Functional difficulty may be made worse or better by the environment.
- Teachers and SMC/PTCs have an important role in identifying barriers and supporting referral.

Assessment / evidence of learning

- Scenario classification.
- Each group proposes a barrier-removal action.

7. Module 3 – Barriers, Risk, Safeguarding and Inclusion

Suggested duration: 45 minutes

Learning objectives:

- Identify barriers that may prevent children from reaching screening or referral services.
- Apply child-protection principles during school screening.
- Plan safe and dignified interactions with children and caregivers.

Materials:

- Barrier map, safeguarding scenario cards, referral flowchart.

Facilitation sequence

1. Run a 'barrier map' from classroom → screening → referral → device → follow-up.
2. Identify transport, cost, stigma, communication, gender, accessibility and information barriers.
3. Review the screening child-protection requirement: the child should not be left alone with the screener; a teacher or designated suitable person should be present and the room door kept open.
4. Practise responding to a child who is embarrassed, frightened or refuses a procedure.
5. Discuss confidentiality: share information only with authorised people involved in care and programme follow-up.
6. Escalate safeguarding concerns through the approved RSPN/project pathway.

Key messages

- Safety is a programme requirement, not an optional courtesy.
- Consent and assent should be respected within the approved project process.
- Never pressure a child to complete a screening procedure.

Assessment / evidence of learning

- Barrier map.

- Role-play scored against safeguarding checklist.

8. Module 4 – School-Based Screening Pathway

Suggested duration: 45 minutes

Learning objectives:

- Explain the complete pathway from preparation to follow-up.
- Understand consent, pre-screening questions, screening, referral, data entry and follow-up.
- Assign responsibilities to project staff, teachers and SMC/PTCs.

Materials:

- WHO-style screening pathway diagram, consent form, screen form, notification form, follow-up referral list, project database demo.

Facilitation sequence

1. Walk through the pathway: approvals → referral pathway → consent → awareness/group preparation → screening → result → parent/caregiver communication → referral/follow-up → database → reporting.
2. Identify what must be completed before screening day.
3. Map the local referral facility/personnel once approved by RSPN.
4. Practise a screening-day flow using a mock class.
5. Discuss how absent children and children with existing glasses/hearing aids are handled according to the approved protocol.

Key messages

- Referral pathways should be mapped before screening begins.
- Screening results must be recorded immediately and accurately.
- Every referred child needs a mechanism for follow-up.

Assessment / evidence of learning

- Teams complete a mock screening pathway and identify missing steps.

9. Module 5 – Vision and Eye-Health Screening

Suggested duration: 60 minutes

Learning objectives:

- Prepare a suitable vision screening station.
- Use the approved age-appropriate distance visual acuity chart and occlusion method.
- Recognise eye-health red flags and refer appropriately.
- Document results accurately.

Materials:

- WHO-appropriate HOTV/Tumbling E or project-approved chart, pointing card, occluder, chair, tape measure/3-metre string, floor tape, torch/penlight, screen forms.

Facilitation sequence

1. Explain that distance visual acuity screening identifies children who may have a vision problem and need further assessment.
2. Prepare the station: good lighting, no glare/reflections, minimal distraction, chart at child eye level and a 3-metre test distance where the project uses the WHO school-age procedure.
3. For younger school-age children (approximately 5–8 years), demonstrate HOTV with a pointing card; for older children, demonstrate the project-approved Tumbling E/LogMAR/Snellen-equivalent approach.
4. Screen one eye at a time using the occluder; if an occluder is unavailable, the child's palm can be used according to the WHO guidance.
5. Record the result exactly as obtained. Do not coach the child into a better answer.
6. Demonstrate external eye-health observation: eyelids/lashes, discharge, conjunctival appearance, cornea/iris clarity and alignment.
7. Review referral/red-flag findings and practise explaining a referral without diagnosing.
8. Repeat the station with each participant performing the procedure.

Key messages

- WHO's 2025 handbook specifies a 3-metre distance for the school-age screening charts described in the manual.
- Eye-health referral is indicated for significant discharge/crusting, abnormal redness, haziness, misalignment, pain/severe itch, diabetes, inability to cooperate or an abnormal visual-acuity result.
- Any eye injury requires urgent referral.
- Screening is not a full eye examination.

Assessment / evidence of learning

- Observed practical using a standard checklist.
- Participant completes one normal case and one referral case.

10. Module 6 – Hearing and Ear-Health Screening

Suggested duration: 60 minutes

Learning objectives:

- Prepare a quiet hearing-screening environment.
- Explain and conduct the project-approved hearing screen.
- Recognise ear-health and hearing red flags.

- Document results and initiate referral.

Materials:

- Calibrated portable audiometer where available/approved, headphones, sound-level meter or validated app, otoscope where trained personnel are authorised, screen forms.

Facilitation sequence

1. Explain the importance of a quiet environment and test each ear separately.
2. Seat the child so they cannot see the screener's hand operating the audiometer.
3. Explain and demonstrate the response method.
4. For the WHO audiometric procedure: practice at 1000 Hz/40 dBHL, then test the target threshold at 1000, 2000 and 4000 Hz; the WHO handbook proposes 20 dBHL as the target threshold, while noting that programmes may adopt another threshold through expert agreement.
5. Demonstrate the pass/refer logic and recording.
6. Review alternative validated app-based methods only where the project protocol permits them.
7. Review ear-health red flags: discharge/bleeding, abnormal or non-visible tympanic membrane, malformed pinna/canal, no response, inability to cooperate and urgent symptoms such as acute pain, mastoid swelling, red/bulging tympanic membrane or foul-smelling discharge.
8. Practise referral communication.

Key messages

- Use the project-approved device and threshold consistently.
- Do not screen in an excessively noisy room.
- Parent/teacher concern about hearing, speech/language, attention or learning can justify referral even if a screening result is otherwise reassuring.
- An abnormal ear finding may require referral even if the child responds to sounds.

Assessment / evidence of learning

- Observed hearing-screening station.
- Participant correctly identifies pass, refer and urgent-referral scenarios.

11. Module 7 – Mobility and Wheelchair Needs: Recognition and Functional Observation

Suggested duration: 45 minutes

Learning objectives:

- Recognise classroom signs suggesting mobility limitation.
- Use simple functional observation without attempting to diagnose.
- Identify children who require specialist rehabilitation/wheelchair assessment.

Materials:

- Mobility observation checklist, chair/wheelchair sample, measuring tape, scenario cards.

Facilitation sequence

1. Explain the role boundary: teachers/project staff identify and refer; rehabilitation specialists determine detailed functional needs and wheelchair specifications.
2. Observe walking/gait, balance, transfers, ability to sit safely, classroom movement and fatigue/pain reports.
3. Observe environmental barriers: stairs, narrow aisles, inaccessible toilets, uneven surfaces and seating arrangements.
4. Practise a functional case: child struggles to move between classroom and toilet.
5. Complete the mobility referral section and discuss how the rehabilitation specialist assesses suitability and sizing.
6. Demonstrate respectful communication: speak to the child, ask permission before assisting and do not move a wheelchair without consent.

Key messages

- Functional observation is not a medical diagnosis.
- Wheelchair selection must be based on the child's assessed needs and appropriate measurements.
- Environmental accessibility is part of inclusion.

Assessment / evidence of learning

- Case-based identification of referral need.
- Completion of a mobility observation checklist.

12. Module 8 – Referral, Caregiver Engagement and Follow-Up

Suggested duration: 45 minutes

Learning objectives:

- Explain screening results clearly and respectfully.
- Complete referral documentation.
- Reduce referral loss through tracking and caregiver engagement.

Materials:

- Referral form, notification form, follow-up list, local referral directory, role-play cards.

Facilitation sequence

1. Demonstrate the three-part communication: what we observed → what it may mean → what happens next.

2. Practise avoiding diagnostic language such as 'your child is blind/deaf' when only a screening result is available.
3. Use simple language and the caregiver's preferred language.
4. Complete a referral form and explain where, when and why the child should attend.
5. Enter the child into the follow-up list and assign responsibility.
6. Role-play a caregiver who is hesitant because of stigma, cost or fear.
7. Discuss children who already use glasses/hearing aids and need follow-up with their existing provider.

Key messages

- Referral is a process, not just a paper.
- Follow-up should be tracked until the agreed endpoint.
- Respect confidentiality and minimise stigma.

Assessment / evidence of learning

- Referral role-play.
- Completed mock referral and follow-up record.

13. Module 9 – Inclusive Teaching and Classroom Support

Suggested duration: 45 minutes

Learning objectives:

- Apply practical classroom adaptations while a child is awaiting specialist care or a device.
- Support participation of children with vision, hearing and mobility difficulties.
- Use strengths-based, non-stigmatising classroom practices.

Materials:

- Classroom scenario cards, board/marker, seating plan template.

Facilitation sequence

1. Groups receive one case each: reduced distance vision, mild hearing difficulty, wheelchair user, child with fatigue/mobility limitation.
2. Identify the participation barrier.
3. Design low-cost adaptations: seating position, clear board writing, larger/high-contrast material, facing the child while speaking, reducing background noise, buddy support by choice, accessible routes and flexible task completion.
4. Micro-teach a 3-minute classroom strategy.
5. Peers provide one strength and one improvement suggestion.

Key messages

- Inclusion means participation, not merely presence.

- Ask what works for the child rather than assuming.
- Simple environmental changes can reduce barriers immediately.

Assessment / evidence of learning

- Micro-teaching scored on accessibility, dignity and feasibility.

14. Module 10 – Assistive Devices: Orientation, Basic Care and Maintenance

Suggested duration: 30 minutes

Learning objectives:

- Explain basic safe use and care of eyeglasses, hearing aids and wheelchairs.
- Recognise device problems that require specialist or supplier support.
- Reinforce that detailed fitting is a specialist responsibility.

Materials:

- Sample eyeglasses, hearing aid/device case, batteries if applicable, cleaning cloth, wheelchair sample and basic maintenance kit.

Facilitation sequence

1. Explain the purpose of each device and the importance of individual fitting.
2. Eyeglasses: clean lenses with appropriate material, store safely, avoid bending frames and report damage.
3. Hearing aids: demonstrate correct placement only after fitting, keep dry, follow battery/device instructions, clean as instructed and report discomfort, feedback or malfunction.
4. Wheelchairs: demonstrate safe brakes, footrests, seating, transfers and basic cleaning/maintenance; do not alter critical components without authorisation.
5. Explain device handover documentation and caregiver/child orientation.
6. Discuss post-distribution follow-up and referral for fit, discomfort, breakdown or changing needs.

Key messages

- Devices support function but do not remove all barriers.
- Children need orientation and follow-up, not only distribution.
- Any device causing pain, injury or unsafe function should be referred for assessment.

Assessment / evidence of learning

- Return demonstration of basic care messages.

15. Module 11 – Data Capture, Quality Assurance and Reporting

Suggested duration: 30 minutes

Learning objectives:

- Complete screening and referral records accurately.
- Apply confidentiality and data-protection principles.
- Understand quality checks and the RSPN-owned database.

Materials:

- Mock screen forms, referral forms, sample database/tablet, error-identification worksheet.

Facilitation sequence

1. Explain unique child identification and the minimum required fields.
2. Demonstrate one complete record from screening to referral.
3. Ask pairs to identify intentional data errors: missing result, inconsistent sex/age, duplicate record, missing referral date.
4. Explain offline capture and later synchronisation where connectivity is limited.
5. Review weekly internal data-quality checks and spot verification.

Key messages

- Data quality is part of clinical quality.
- Record what was observed, not what was assumed.
- Project data remain subject to RSPN requirements and should not be shared or published without approval.

Assessment / evidence of learning

- Data accuracy exercise with a target of zero critical errors.

16. Module 12 – Training of Trainers and Cascade Planning

Suggested duration: 45 minutes

Learning objectives:

- Deliver a short participatory training segment.
- Demonstrate a screening skill clearly.
- Give supportive corrective feedback.
- Prepare a district-wise cascade plan.

Materials:

- Micro-teaching rubric, cascade planning template, job aids.

Facilitation sequence

1. Explain the cascade model: master trainers → district teacher groups → school-level practice → supervision/backstopping.

2. Demonstrate the 'tell–show–do–review' method.
3. Each participant delivers a 5-minute micro-session on one topic.
4. Peers score the micro-session using the rubric.
5. Trainer gives feedback: one strength, one correction, one next practice.
6. Teams prepare a cascade plan including dates, participants, venue, materials, trainer, practical stations and follow-up supervision.

Key messages

- Training quality depends on observed competence, not attendance alone.
- Use the same approved tools and messages across districts.
- Cascade trainers need backstopping and quality checks.

Assessment / evidence of learning

- 5-minute micro-teaching assessment.
- Completed cascade plan.

17. Module 13 – SMC/PTC Orientation

Suggested duration: 2–3 hours

Learning objectives:

- Explain why school-based disability inclusion matters.
- Support caregiver communication, consent and referral attendance.
- Track children referred through the agreed school mechanism.
- Help reduce stigma and practical barriers.

Materials:

- Simple Urdu/local-language handout, referral pathway, school action-plan sheet.

Facilitation sequence

1. Opening discussion: what prevents children with disabilities from attending and learning?
2. Explain the screening and referral pathway in simple terms.
3. Clarify what SMC/PTC members do and do not do: support, communicate, track and facilitate; they do not diagnose.
4. Practise a caregiver-support scenario.
5. Develop a school-level referral tracking plan.
6. Agree one inclusion action for the next month.

Key messages

- SMC/PTCs are part of the support system, not clinical screeners unless separately trained and authorised.
- Respect confidentiality.

- Do not publicly identify or label children as ‘disabled’.

Assessment / evidence of learning

- Group action plan and verbal demonstration of referral-support steps.

18. Competency Assessment and Certification Recommendations

The training should combine knowledge, observed practical performance and facilitation ability. Attendance alone should not be treated as proof of competence.

Assessment component	Suggested weight	Minimum expectation
Pre/post knowledge test	20%	Improvement from baseline and acceptable post-test score set by RSPN/Med Matrix
Vision practical station	20%	Correct setup, explanation, occlusion, recording and referral recognition
Hearing practical station	20%	Correct setup, explanation, test sequence/approved method, recording and referral recognition
Mobility/referral case	10%	Correct identification of need and referral
Inclusive teaching micro-session	10%	Practical, respectful and feasible adaptation
ToT micro-teaching	10%	Clear demonstration, participation and feedback
Data quality exercise	10%	No critical errors in the mock record

Recommended status categories: Competent; Competent with targeted coaching; Not yet competent—repeat practical assessment. Final certification criteria should be approved by the project before certificates are issued.

19. Field Job Aids and Checklists

19.1 Screening-day master checklist

- School approval/coordination confirmed.
- Consent process completed and recorded.
- Referral pathway and contact persons confirmed.
- Accessible, adequately lit screening space prepared.
- Hearing screening area quiet enough for the approved method.
- Equipment checked, clean and functional.
- Forms/tablets charged and available.
- Child-protection arrangement in place; child not left alone with screener.
- Teacher/designated adult available to supervise waiting children.
- Results recorded immediately.
- Parent/caregiver notification completed for referral/pass result as required.
- Referral entered into follow-up tracking.

- Data quality checked before team leaves school.

19.2 Vision station quick guide

Step	Check
1	Chart is correct size, mounted at child eye level, good lighting/no glare.
2	Measure and mark 3-metre test distance where the approved WHO school-age procedure is used.
3	Explain test in child-friendly language; practise with both eyes before one-eye testing.
4	Test each eye separately using the approved occluder/hand method.
5	Record result exactly; do not coach.
6	Conduct external eye-health observation if included in the authorised role.
7	Apply approved referral/red-flag criteria.
8	Explain result and next step to parent/caregiver.

19.3 Hearing station quick guide

Step	Check
1	Quiet room; check ambient noise where required.
2	Seat child so hand/button operation is not visible.
3	Explain and demonstrate response method.
4	Use only the approved calibrated device/app and project threshold.
5	Screen each ear separately for the approved method.
6	Record result immediately.
7	Check external ear/otoscopy only if trained and authorised.
8	Apply referral and urgent-referral criteria.
9	Explain result and next step; enter follow-up record.

19.4 Mobility/wheelchair quick guide

- Observe function in the actual school environment where possible.
- Ask about difficulty, pain, fatigue and preferred support.
- Observe walking/gait, balance, sitting, transfers and classroom movement.
- Identify environmental barriers.
- Do not diagnose or prescribe a wheelchair from observation alone.
- Refer for specialist functional assessment and appropriate measurement/fitting.
- Respect the child's autonomy and ask before assisting or moving a wheelchair.

19.5 Referral communication script

Suggested wording: "Today we completed a screening check. The result suggests that your child should have a more detailed assessment by the appropriate specialist. This screening is not a diagnosis. We will explain where the referral is made, what to take with you and how the school/project will follow up."

20. Annexes

Annex 1 – Pre-Test / Post-Test

Question	Answer key
1. A school screening result is the same as a diagnosis. True/False	False
2. Name two barriers that can prevent a child with disability from participating in school.	Examples: physical, communication, attitudinal, information, institutional or financial barriers.
3. What should be established before screening begins?	Approvals, consent process, accessible screening site, equipment, referral pathway and responsibilities.
4. What is the school-age vision screening distance used in the WHO procedure described in this manual?	3 metres.
5. Why is an occluder used?	To assess each eye separately.
6. Name two eye-health findings that require referral.	Examples: significant discharge/crusting, abnormal redness, haziness, misalignment, pain/severe itch, etc.
7. Why must hearing screening be conducted in a quiet environment?	Background noise can interfere with reliable responses.
8. In the WHO audiometric procedure, what target threshold is proposed?	20 dBHL, with project/country variation possible if formally agreed.
9. Give two urgent hearing/ear red flags.	Examples: acute ear pain; mastoid swelling; red/bulging tympanic membrane; foul-smelling discharge.
10. Who decides the detailed wheelchair specification?	The qualified rehabilitation/appropriate specialist after functional assessment.
11. What should a teacher do if a child fails screening?	Communicate appropriately, complete referral documentation and support follow-up according to the pathway.
12. Why is data quality important?	It supports safe referral, accountability, monitoring and accurate reporting.
13. Name one inclusive classroom adaptation for a child with reduced hearing.	Face the child when speaking, reduce background noise, improve seating/visual access, etc.
14. Name one safe hearing-aid care message.	Keep it dry, follow battery/device instructions, clean as instructed and report malfunction/discomfort.
15. Should a child be left alone with the screener?	No; the WHO handbook specifies a teacher/designated suitable person should be present for child protection.

Annex 2 – Practical Observation Checklist: Vision

Competency	Yes	Needs coaching
Explains procedure to child in simple language		
Confirms correct chart and distance		
Positions child correctly		
Uses occlusion correctly		
Tests each eye according to protocol		
Records result accurately		
Recognises referral/red flags		
Explains next step without diagnosing		

Annex 3 – Practical Observation Checklist: Hearing

Competency	Yes	Needs coaching
Prepares quiet screening environment		
Explains response task and demonstrates		
Positions child so hand/button operation is not visible		
Uses approved equipment/method		
Screens both ears as required		
Records result accurately		
Recognises referral/urgent red flags		
Explains referral appropriately		

Annex 4 – Referral Form Template

Field	Entry
Child name / ID	
School / class	
District	
Date of birth / age	
Sex	
Parent/caregiver contact	
Consent status	
Reason for referral	Vision / Eye health / Hearing / Ear health / Mobility / Other

Screening findings	
Urgency	Routine / Priority / Urgent
Referral facility/person	
Referral date	
Follow-up due date	
Follow-up outcome	
Notes	

Annex 5 – Teacher Classroom Inclusion Action Plan

Issue identified	Barrier	Immediate classroom action	Referral/follow-up needed	Responsible person	Date

Annex 6 – Cascade Training Plan

District	Trainer(s)	School/venue	Date	Participants	Practical stations	Materials	Supervision date

Annex 7 – SMC/PTC School Referral Tracking Template

Child ID	School/Class	Referral area	Referral date	Caregiver contacted	Appointment attended	Outcome	Follow-up action

Annex 8 – Trainer Micro-Teaching Rubric

Criterion	1 – Needs improvement	2 – Developing	3 – Competent
Accuracy	Major errors	Minor errors	Accurate and within role
Clarity	Difficult to follow	Mostly clear	Clear and structured
Demonstration	Not demonstrated	Partial	Correct and visible
Participation	Mostly lecture	Some participation	Active participation
Inclusion	Barriers not addressed	Some adaptations	Accessible and respectful

Feedback	Judgmental/unclear	Basic feedback	Specific, supportive and corrective
Time	Poor control	Minor overrun	Within time

Annex 9 – Training Evaluation Form

Item	Excellent	Good	Fair	Needs improvement
Relevance to my role	☐	☐	☐	☐
Trainer facilitation	☐	☐	☐	☐
Practical demonstrations	☐	☐	☐	☐
Screening practice	☐	☐	☐	☐
Job aids/materials	☐	☐	☐	☐
Accessibility/inclusion	☐	☐	☐	☐
Confidence after training	☐	☐	☐	☐

What was most useful? _____

What should be improved? _____

What will you apply in your school/work within two weeks? _____

20. Expanded Field-Ready Facilitator Guide and Operational Tools

Purpose. This expanded section converts the manual from a content guide into a consistent field-delivery package. Every practical activity uses the same sequence: purpose → preparation → briefing → demonstration → guided practice → participant performance → observation/feedback → repeat practice → assessment → debrief and key takeaways.

20.1 Standard Facilitation Protocol for All Practical Activities

Step	Facilitator action	Participant action	Expected evidence
1. Prepare	Set up equipment, privacy/safety arrangements, forms, timing and observer checklist.	Review station instructions.	Station ready; no safety gaps.
2. Brief	State objective, role boundary, safety rules and success criteria.	Listen; ask clarifying questions.	Participants can explain what they must do.
3. Demonstrate	Perform the skill once slowly while verbalising critical steps.	Observe without interrupting except for clarification.	Correct sequence visible.
4. Guided practice	Coach participants through each step; stop unsafe actions immediately.	Perform the skill with prompts.	Correct technique emerging.
5. Peer practice	Pair participants; one performs, one observes using checklist, then swap.	Perform and give structured feedback.	Each participant practices at least once.
6. Competency check	Repeat without prompts using the formal checklist.	Perform independently.	Competent / coaching required / not yet competent.
7. Debrief	Ask what was easy, difficult and what could cause an unsafe/false result.	Reflect and identify improvement.	Common errors identified.
8. Takeaway	State 2–3 non-negotiable messages and next action.	Repeat key message/action.	Consistent message across districts.

20.2 Activity: Barrier Mapping – "Where Is the Barrier?"

Item	Facilitator instructions
Purpose	Shift the focus from "what is wrong with the child?" to barriers that restrict participation.
Time	10 minutes within the condensed disability-inclusion overview.
Materials	Four barrier cards: attitudinal, physical, communication/information, institutional/financial.
Steps	1) Give each group a school scenario. 2) Ask: "What prevents participation?" 3) Classify the barrier. 4) Identify one low-cost immediate solution and one system-level solution. 5) Each group reports one example. 6) Facilitator corrects victim-blaming language.

Expected outcome	Participants identify at least one environmental/social barrier and one practical inclusion action.
Key takeaways	Disability is not a reason for exclusion; barriers can be changed; ask the child/family what support works; inclusion means meaningful participation.

20.3 Activity: End-to-End Screening Pathway Simulation

Item	Facilitator instructions
Purpose	Practise the full sequence before participants learn individual screening stations.
Time	15 minutes.
Materials	Mock school roster, consent/assent status, screening form, referral form, referral directory, tracker.
Steps	1) Assign roles: school focal person, screener, teacher, caregiver, data assistant. 2) Give the team a mock class of five children with mixed scenarios. 3) Ask the team to prepare the site. 4) Confirm consent/assent and child-safety arrangements. 5) Screen/observe according to role. 6) Classify pass/refer/urgent. 7) Communicate with caregiver. 8) Enter referral and follow-up responsibility. 9) Debrief where the pathway could fail.
Expected outcome	Participants can describe who does what, when, and how a child moves from identification to follow-up.
Key takeaways	No screening without a referral pathway; document immediately; screening is not diagnosis; every referral needs an owner and follow-up date.

20.4 Practical Station A – Vision Screening

Item	Field-ready instruction
Purpose	Standardise distance visual-acuity screening and eye-health observation within authorised roles.
Equipment	WHO/project-approved distance chart (Tumbling E or approved age-appropriate equivalent), occluder, 3-metre tape/string and floor mark, chair, good lighting, screen form, pen.
Set-up	Chart at child eye level, well illuminated and free from glare. Measure and mark exactly 3 metres for the WHO school-age distance procedure. Provide enough space for safe movement.
Briefing	Explain the task in simple language. Demonstrate the response method. Confirm consent/assent. Ask about existing spectacles and use them as required by the approved SOP.
Procedure	1) Seat/stand child at marked distance. 2) Practise binocularly. 3) Cover one eye without pressing it; use approved occluder or palm if authorised. 4) Test the right eye then left eye. 5) Record the actual VA for each eye. 6) Repeat an unexpectedly poor result once after repositioning/re-instruction, according to SOP. 7) Complete authorised external eye-health observation. 8) Apply decision matrix. 9) Explain next step.
Near vision	If included in the approved project tool, use the WHO near chart at 40 cm in good light and record the result; do not substitute an unvalidated distance.

Competency standard	Correct set-up, 3 m distance, correct occlusion, one-eye-at-a-time testing, no coaching, accurate recording, correct referral decision and respectful explanation.
Debrief	Ask: “Which step most affects validity?” “What would make you repeat the test?” “Which findings require urgent referral?”

20.5 Practical Station B – Hearing Screening by Approved Audiometric/Validated Method

Item	Field-ready instruction
Purpose	Train authorised screeners to use the approved calibrated/validated method consistently.
Environment	Quiet room, minimal distraction. Where maximum permissible ambient noise level for the selected equipment is not specified, WHO advises ambient room noise below 40 dBHL. Check with a sound-level meter/validated app where available; reduce noise or relocate if excessive.
Equipment	Calibrated portable audiometer or approved automated/validated screener, suitable headphones, sound-level meter/validated noise app, cleaning materials and screen form.
Set-up	Seat child so the screener’s controls/hand movements cannot be seen. Explain that each time a beep is heard the child gives the agreed response. Demonstrate before testing.
WHO audiometric sequence	Practice: 1000 Hz at 40 dBHL in each ear. Then, for the WHO school-age procedure, test 1000, 2000 and 4000 Hz at the target screening threshold. WHO proposes 20 dBHL, while allowing a different threshold if formally agreed by the programme/experts.
Pass/refer	Pass when the child responds at the target threshold at least 2 of 3 presentations at each required frequency in each ear. Refer if the criterion is not met or the practice screen is not passed, after ensuring the child understood the task and the test environment/equipment are valid.
Competency standard	Quiet environment; correct headphones; child understands response; correct ear sequence; correct frequencies/threshold; accurate recording; correct referral decision.
Debrief	Ask participants to identify one equipment error, one child-instruction error and one environmental error that could create a false result.

20.6 Practical Station C – Whisper Test (Contingency Method)

Important: The technical proposal identifies whisper testing as a classroom-applicable method. WHO guidance states that the whispered voice test should be used when other hearing-screening methods are unavailable. It is therefore a contingency/initial functional screen, not a substitute for validated audiometry when the latter is available.

Item	Field-ready instruction
Environment	Use a quiet room away from traffic, fans, conversations and playground noise. If the examiner cannot reliably whisper and hear the response, do not proceed—reduce noise or use a validated method.
Distance	Stand an arm’s length behind the seated child, approximately 2 feet/60 cm, following the WHO whispered-voice method.

Preparation	Explain that one ear will be tested at a time. The child covers the non-test ear by placing one finger over the tragus and gently moving it in a circular motion. Do not press painfully or occlude both ears.
Procedure	1) Tester takes a breath and exhales fully. 2) Whisper a different number-letter-number combination for each ear. 3) Ask the child to repeat what was heard. 4) If unsuccessful, repeat with a different combination once. 5) WHO's described method considers a pass when at least 3 of 6 letters/numbers are correctly repeated after the second attempt. 6) Record Pass/Refer for each ear.
Referral	Refer if the child fails the whisper screen in either ear, the result is unreliable, the child cannot cooperate, or there is persistent communication/speech-language concern. Urgent medical/ENT referral is required for acute severe ear pain, significant trauma, bleeding/discharge with acute concern or other serious red flags.
Key limitation	Whisper testing is not calibrated and can be affected by tester voice, distance and background noise. When in doubt, refer for validated assessment.

20.7 Practical Station D – Mobility and Functional Observation

Item	Facilitator instructions
Purpose	Identify functional difficulty and environmental barriers without diagnosing or prescribing a mobility device.
Materials	Mobility observation checklist, wheelchair/walker sample if available, school map/scenario cards.
Steps	1) Ask permission before assisting. 2) Observe gait/walking, balance, sitting, transfers and movement in the classroom. 3) Ask about pain, fatigue, instability and difficult school locations. 4) Observe stairs, toilets, doorways and seating. 5) Review any existing device for obvious damage/unsafe function without altering it. 6) Record functional concern. 7) Refer for specialist assessment where indicated.
Expected outcome	Participants distinguish observation from diagnosis and can identify when specialist rehabilitation assessment is required.
Key takeaways	Do not size or prescribe a wheelchair from appearance; ask the child; preserve autonomy; environmental accessibility is part of the intervention.

20.8 Role-Play – Caregiver Referral Conversation

Item	Facilitator instructions
Purpose	Build respectful communication after a refer result without diagnosing or blaming the family.
Roles	Screener/teacher, caregiver, observer; rotate roles so each participant practises.
Scenario	Child has a refer result. Caregiver is worried about stigma, transport cost or being blamed.
Steps	1) Give role cards privately. 2) Screener starts with a strength/positive observation. 3) Explain exactly what was observed and state that screening is not diagnosis. 4) Explain where/when the specialist assessment will occur. 5) Ask about barriers. 6) Agree a practical follow-up action. 7) Observer scores the checklist. 8) Repeat the role-play after feedback.

Expected outcome	Participant communicates the result clearly, avoids diagnostic labels, identifies barriers and establishes follow-up responsibility.
Key takeaways	Referral is a process, not just a form; families should be supported, not blamed; confidentiality and dignity are essential.

20.9 Micro-Teaching – Inclusive Classroom Strategy

Item	Facilitator instructions
Purpose	Prepare cascade trainers to teach a simple classroom adaptation.
Time	5–7 minutes per participant.
Steps	1) Participant chooses one case: reduced vision, hearing difficulty, mobility limitation or communication difficulty. 2) State one measurable learning objective. 3) Explain the barrier. 4) Demonstrate one low-cost adaptation. 5) Ask learners to practise. 6) Observe and give one specific correction. 7) Close with one action message.
Assessment	Use the micro-teaching rubric: accuracy, clarity, demonstration, participation, inclusion, feedback and time. No critical safety error; minimum project score should be approved before certification.
Key takeaways	Inclusion means participation; use strengths-based language; simple environmental changes can reduce barriers immediately.

20.10 Assistive-Device Return Demonstration

Device	Participant must demonstrate	Escalate when…
Eyeglasses	Safe handling, appropriate cleaning, case storage, avoiding lens-down placement, reporting damage.	Broken frame/lens, discomfort, sudden change in vision, poor function.
Hearing aid	Safe handling after individual fitting, keeping dry, battery/charging instructions, cleaning as instructed, safe storage.	No sound, repeated feedback, discomfort/skin problem, malfunction.
Wheelchair/mobility aid	Safe brakes, safe movement/transfer principles, basic cleaning and reporting damage; no unauthorised modification.	Poor fit, pressure area, instability, damaged brakes/components or change in function.

Facilitation: demonstrate once → participants practise in pairs → observer uses checklist → repeat after correction → ask each participant to state the “stop and refer” message. Never use training samples to teach independent fitting or prescription.

20.11 Data-Quality Error-Finding Exercise

Step	Facilitator instruction	Expected outcome
1	Give each pair a mock screening form containing 8–10 deliberate errors: missing eye result, impossible date, duplicate Child ID, missing referral date, wrong urgency, inconsistent sex/age, absent consent status, missing follow-up owner.	Participants identify all critical errors.

2	Ask pairs to classify errors as safety-critical, referral-critical or administrative.	Participants understand why not all errors have equal risk.
3	Correct the form using source documentation; do not guess missing clinical findings.	Clean record with traceable correction.
4	Debrief the consequences of each error.	Link data quality to clinical safety, referral and reporting.

20.12 Case Studies – Detailed Facilitation Guides

Case	Scenario	Facilitation steps	Expected outcome	Key takeaway
Case 1 – Child sits at the front	Child sits close to the board and copies slowly. Teacher thinks the child is inattentive.	Ask groups to list 3 possible explanations; separate observation from diagnosis; ask what classroom action can be taken immediately; decide whether approved screening/referral is indicated.	Possible vision difficulty identified; no diagnostic label; appropriate screening/referral and seating adaptation.	Observe → screen if authorised → record → refer if indicated → support inclusion.
Case 2 – Hearing or attention?	Child frequently asks for repetition and struggles in a noisy classroom.	Ask groups to identify environmental and functional clues; redesign the classroom response; choose the appropriate hearing-screen method; decide follow-up.	Participants avoid attributing the problem to “poor attention” and identify hearing referral plus noise reduction.	Reduce noise; face child; use visual cues; screen/refer according to protocol.
Case 3 – Wheelchair request	Parent asks teacher to arrange a wheelchair immediately based on height.	Ask what information is missing; demonstrate role boundary; identify specialist assessment steps; practise caregiver explanation.	Participants refuse unsafe sizing and initiate rehabilitation referral.	Wheelchair specification requires functional assessment and appropriate measurement/fitting.

Case 4 – Stigma	Students use a disability label as a nickname and exclude the child.	Ask participants to role-play a teacher response; identify immediate safeguarding/anti-bullying action; develop a peer inclusion message.	Participants address stigma without humiliating students and restore participation.	Use respectful language; challenge exclusion; support the child and monitor.
Case 5 – Referral loss	Family has not attended referral because the facility is far away and transport is costly.	Map the barrier; practise a non-blaming caregiver call; identify project/SMC/PTC support options; update tracker and due date.	A concrete follow-up owner and action are recorded.	Track barriers; never blame families; escalate unresolved access problems.

20.13 SMC/PTC Action-Planning Exercise

Step	Facilitator instruction	Output
1	Ask: “What prevents children with disabilities from accessing or participating in our school?”	Top 3 barriers.
2	Prioritise barriers by impact and feasibility.	One high-priority barrier.
3	Identify a responsible person and low-cost action.	Named owner and action.
4	Add referral/follow-up support where relevant.	Referral-support step.
5	Set a 30-day review date.	Dated action plan.
6	Groups present and receive one improvement suggestion.	Final school action plan.

21. Operational Screening Protocols

This section standardises the field method while preserving the clinical boundary. Where the final RSPN-approved SOP differs, the approved SOP prevails. Numerical thresholds and methods identified as “project operational” must be confirmed by the RSPN/Clinical-Technical Lead before deployment.

21.1 Vision Screening Protocol

Element	Standard
Chart	Use the RSPN-approved WHO school-age distance chart. The WHO procedure described in the supplied handbook uses a Tumbling E chart at 3 metres. Use an age-appropriate alternative only where formally approved.
Distance	3 metres, measured and marked on the floor.
Lighting	Good, even illumination; no glare or shadow across the chart.
Position	Chart at the child’s eye level; child correctly positioned at the marked distance.

Occlusion	Test one eye at a time using an occluder; do not press the eye. If no occluder is available, the child's palm may be used according to WHO guidance.
Existing spectacles	Follow the approved SOP; WHO school-age guidance asks the person to wear existing distance spectacles during distance testing.
Recording	Record the actual VA for right and left eyes, not simply "pass/fail".
Near vision	Where included, use the WHO near chart at 40 cm in good light and record the result.
Operational threshold	Proposed project threshold: VA ≥6/12 (20/40) in each eye with no persistent symptoms/red flags = Pass. VA worse than 6/12 in either eye = Refer. This threshold must be approved by the RSPN/Clinical-Technical Lead before field use.

21.2 Hearing Screening Protocol

Element	Standard
Preferred method	Use calibrated/validated audiometric or approved digital screening where available and authorised.
Ambient noise	Quiet room, minimal distraction. If the selected equipment has no stated MPANL, WHO advises ambient room noise below 40 dBHL. Measure with a sound-level meter/validated app where available.
Audiometric method	WHO school-age sequence: practice at 1000 Hz/40 dBHL; then target threshold at 1000, 2000 and 4000 Hz; WHO proposes 20 dBHL as target, subject to formal programme agreement.
Audiometric pass	At least 2 correct responses out of 3 presentations at each required frequency in each ear.
Whisper contingency	Use only when validated/approved methods are unavailable. Arm's length ≈2 ft/60 cm behind the child; non-test ear covered; whisper number-letter-number combination; repeat once with a different combination if needed; pass at ≥3 of 6 items correct after the second attempt, per the WHO-described whispered voice method.
Recording	Record each ear separately and note method used.
Red flags	Acute severe ear pain, painful swelling behind ear, significant trauma, bleeding/acute discharge, serious abnormal ear finding or other urgent medical concern → urgent external medical/ENT pathway.

21.3 Safe and Gender-Sensitive Screening Protocol

- Before screening, confirm the approved consent/assent process and explain what will happen in simple language.
- Never force a child who refuses. Record the reason and follow the approved safeguarding/referral process.
- A teacher/designated suitable adult should be present during child screening; do not isolate a child with a screener. Maintain privacy without creating an unsafe closed-door situation.
- For adolescent girls and culturally sensitive situations, use a female screener or same-gender support person where practicable and requested/appropriate. Avoid unnecessary physical contact.

- Ask permission before any physical assistance. For mobility observation, speak to the child directly and ask before touching or moving a wheelchair/device.
- No disrobing is required for routine school sensory screening. If a clinical examination requires different arrangements, it must be conducted by the appropriately qualified professional under the approved clinical protocol.
- Use a private area that remains safe and observable. Do not discuss results publicly or label a child in front of peers.
- Use respectful, person-centred language and the child's preferred name. Do not use disability as a nickname.
- If a safeguarding concern, suspected abuse, exploitation or PSEA concern is disclosed or observed, stop the non-essential interaction and activate the approved reporting pathway immediately.
- Provide reasonable communication support: interpreter/sign-language support, visual instructions, extra time or accessible materials where required.

22. Pass / Refer / Priority / Urgent Referral Decision Matrix

Domain	Pass / Routine	Refer / Specialist	Priority	Urgent – immediate pathway
Vision	VA ≥6/12 in each eye, no red flag, no persistent concern (subject to approval).	VA <6/12 in either eye; persistent board/reading difficulty; significant symptoms; ≥2-line inter-eye difference.	Suspected strabismus/misalignment or obvious abnormality without acute red flag.	Sudden visual loss; severe eye pain; significant eye trauma; severe red eye; white pupil/leukocoria or other serious red flag. Same-day/urgent external eye/health referral as clinically appropriate.
Eye health	Normal-appearing eyelids/lashes, white conjunctiva, clear coloured part/cornea, eyes aligned.	Significant crust/pus, excessive watery/sticky discharge, abnormal redness/lesion, haziness, misalignment, pain/severe itch, diabetes, untestable.	Marked abnormality requiring rapid specialist assessment.	Any eye injury or serious acute red flag.
Hearing – audiometry	Meets approved threshold in both ears at all required frequencies.	Fails target threshold in either ear; failed practice after correct instruction; unreliable result.	Marked unilateral/bilateral concern or strong persistent communication concern.	Acute severe pain, significant trauma, bleeding/acute discharge, mastoid swelling or other urgent medical/ENT concern.
Hearing – whisper	Passes both ears using approved contingency method and no persistent concern.	Fails either ear, unreliable, or persistent communication/speech concern.	Marked concern despite screening result.	Acute medical/ENT red flag.
Mobility	No functional limitation or participation restriction identified.	Persistent abnormal gait/balance/transfer or classroom mobility concern.	Obvious deformity or significant functional limitation.	Acute injury, severe pain or safety-critical deterioration requiring urgent medical assessment.

Action and follow-up rule: Pass → routine classroom support/monitoring. Refer → enter referral within the same working day and schedule the earliest available specialist assessment within the project referral window. Priority → flag to the Team/Clinical Lead the same day and obtain the earliest specialist slot. Urgent → activate the approved external facility pathway immediately/same day as clinically appropriate. Exact project timeframes must be populated in the RSPN-approved referral directory/SOP before deployment.

22.1 Referral Follow-Up Timeframe Matrix

Category	Action by screener/team	Tracker requirement	Escalation
Pass	Give routine advice and document if required.	No referral; retain screening record.	Re-screen/refer if concern later develops.
Routine referral	Inform caregiver; issue referral; assign focal person.	Referral date, facility, contact, due date and linkage status.	Escalate if not linked within the approved project window.
Priority referral	Notify Team/Clinical Lead; arrange earliest specialist slot.	Flag as priority; same-day team review.	Escalate unresolved access barrier promptly.
Urgent referral	Immediate approved external referral; inform caregiver and responsible focal person.	Record urgent action and destination; follow up to confirm linkage.	Immediate escalation through clinical/safeguarding pathway.

23. Screening Equipment and Inventory Checklist

Item	Required/available	Safe-use check	Cleaning/storage	Maintenance / action
Distance vision chart	☐	Correct chart, undamaged, correct size	Keep flat/clean; protect from moisture	Replace if faded/damaged
Occluders	☐	No sharp edges; no pressure on eye	Clean between children according to approved method	Replace if damaged
3-m tape/string + floor tape	☐	Accurately measured	Store dry	Re-measure if damaged
Near vision chart	☐	Correct chart and 40-cm reference	Keep clean/dry	Replace if print quality poor
Torch/penlight	☐	Working battery/light	Wipe handle; store safely	Battery/charging check
Audiometer/validated screener	☐	Calibrated/status checked; correct settings	Clean exterior; store protected	Calibration/service status documented
Headphones	☐	Correct fit; cables intact	Clean contact surfaces between children	Replace if damaged
Sound-level meter/validated noise app	☐	Working and correctly configured	Protect device	Battery/validation check

Whisper-test prompt card	☐	Number-letter combinations prepared	Keep dry	Refresh prompts periodically
Otoscope (authorised staff only)	☐	Working light; appropriate speculum	Disinfect/clean according to manufacturer/SOP	Battery and service check
Wheelchair/mobility sample	☐	Brakes/components safe for demonstration	Clean and store safely	Do not modify without authorisation
Forms/tablets	☐	Correct approved versions	Secure from unauthorised access	Backup/charge/sync check
Hand hygiene/cleaning materials	☐	Available	Store safely	Replenish before deployment
Consent/referral materials	☐	Current approved versions	Confidential storage	Replace outdated forms

Pre-deployment rule: Team Lead signs the inventory before leaving for the school. Any equipment that is damaged, uncalibrated, missing or unreliable is not used to make a referral decision until corrected or replaced. Document any substitution and obtain technical approval where required.

24. Practical Skills Checklists

24.1 Vision Screening Competency Checklist

Critical step	Observed	Needs coaching	Critical error?	Comments
Explains procedure and confirms consent/assent	☐	☐	☐	
Correct chart and 3-m distance	☐	☐	☐	
Good lighting/no glare	☐	☐	☐	
Correct child positioning	☐	☐	☐	
Correct occlusion without pressure	☐	☐	☐	
Tests each eye separately	☐	☐	☐	
Does not coach child	☐	☐	☐	
Records actual result accurately	☐	☐	☐	
Recognises red flags	☐	☐	☐	
Applies Pass/Refer/Urgent decision correctly	☐	☐	☐	
Explains next step without diagnosing	☐	☐	☐	

24.2 Hearing Screening Competency Checklist

Critical step	Observed	Needs coaching	Critical error?	Comments
Confirms safe, quiet environment	☐	☐	☐	
Checks equipment/status	☐	☐	☐	
Explains response task clearly	☐	☐	☐	
Positions child so controls are not visible	☐	☐	☐	
Uses approved method and threshold	☐	☐	☐	
Tests each ear as required	☐	☐	☐	
Records method and result correctly	☐	☐	☐	
Recognises failed/unreliable screen	☐	☐	☐	
Recognises urgent ear red flags	☐	☐	☐	
Explains referral without diagnosis	☐	☐	☐	

24.3 Referral and Follow-Up Competency Checklist

Step	Observed	Needs coaching	Comments
States screening is not diagnosis	☐	☐	
Explains finding using neutral language	☐	☐	
Selects correct referral category	☐	☐	
Completes referral form fully	☐	☐	
Gives facility/contact/date information	☐	☐	
Checks family barriers and preferences	☐	☐	
Assigns follow-up owner and due date	☐	☐	
Protects confidentiality	☐	☐	

25. Teacher Classroom Observation and Initial Screening Tool

Use this tool for early identification. A teacher observation alone is never a diagnosis. Where the project SOP authorises a teacher to conduct a simple screen, the approved screening procedure must be followed and recorded separately.

Domain	Observe / ask	Yes/No	Action
Vision	Sits very close to board/books; squints; closes one eye; tilts head; copies slowly; misses visual information; headaches/eye discomfort; frequent bumping/tripping.		Observe → approved screen/referral as indicated.
Hearing	Asks for repetition; turns one ear; difficulty in noise; misses verbal instructions; speech/language concern; caregiver concern.		Reduce noise → approved screen/referral.
Mobility	Falls; balance difficulty; trouble standing/transferring; avoids school areas; difficulty using existing device; pain/fatigue.		Remove barrier → functional referral if persistent/marked.
Communication/learning	Difficulty understanding instructions; needs extra response time; communication access barrier; possible learning difficulty.		Adapt classroom; refer only through approved pathway when indicated.
Participation/stigma	Excluded by peers; bullying; inaccessible route; teacher expectations limiting participation.		Address barrier and safeguarding; document action.

Teacher decision: ☐ Routine classroom support ☐ Monitor/re-screen ☐ Refer for specialist assessment ☐ Urgent escalation. Record reason and responsible person. Never write a diagnosis unless it is an existing documented diagnosis being reported by the authorised source.

26. Common Screening Errors and Corrective Actions

Error	Why it matters	Correction
Wrong chart or incorrect chart size	Invalid visual result.	Use the approved chart and verify setup before each session.
Unmeasured visual distance	Changes visual acuity result.	Measure and mark 3 m; do not estimate.
Poor lighting/glare	Can reduce visibility and create false referral.	Improve lighting/angle and repeat.
Covering both eyes or pressing on covered eye	Invalid one-eye result.	Use correct occlusion without pressure.
Coaching or giving clues	Inflates performance and masks difficulty.	Use standard instructions; do not prompt answers.
Not recording actual VA	Prevents audit and specialist interpretation.	Record right/left eye result exactly.
Testing hearing in noisy room	Background noise can mask signals.	Reduce noise/relocate; use noise measurement where available.
Child sees audiometer controls	Can create conditioned responses unrelated to hearing.	Position child so controls are not visible.
Using unvalidated phone/app for hearing	May produce unreliable results.	Use only approved validated method/device.
Whisper too loud/too close	Can mask mild hearing difficulty.	Follow the standard arm's-length method and quiet environment.
Changing threshold without approval	Destroys standardisation.	Use project-approved threshold only.
Calling a refer result a diagnosis	Creates stigma and clinical risk.	Say "screening suggests further assessment is needed."
Selecting a wheelchair from height alone	Unsafe/inappropriate fit.	Refer for specialist functional assessment and measurement.
Screening child alone with screener	Safeguarding risk.	Teacher/designated adult present; safe visible arrangement.
Publicly announcing results	Confidentiality/stigma risk.	Communicate privately to authorised caregiver/child.
Missing follow-up owner/date	Referral may be lost.	Every referral has an owner, date and status.

27. Quality Assurance, Observation and District Cascade Control

QA point	Minimum standard	Responsible	Evidence
Trainer readiness	Trainer demonstrates all core stations before cascade.	Technical/Training Lead	Trainer readiness checklist
Participant competence	Attendance alone is insufficient; practical checklist completed.	Trainer	Signed skills checklist
Cascade consistency	Same approved manual, SOP, tools and messages in all districts.	Project Coordinator/Technical Lead	District training pack and spot-check
Spot-check	Random observation of selected cascade sessions/screening stations.	Technical Lead/QA	Spot-check form
Data quality	No critical missing referral/safety fields.	MEAL/Data staff	DQ checklist
Referral quality	Correct category, facility, urgency and follow-up owner.	Team Lead	Referral review log
Equipment QA	Inventory, cleanliness and status verified daily.	Team Lead	Signed inventory
Safeguarding	Child not isolated; consent/assent and confidentiality followed.	All trainers/team	Safeguarding checklist

Recommended cascade rule: a trainer who has not demonstrated the required practical competency should not independently teach that station. Provide coaching and repeat assessment before cascade delivery.

28. Updated Competency Assessment and Remediation

Component	Weight	Minimum evidence	If not competent
Knowledge pre/post test	15%	Post-test meets project-approved threshold and demonstrates improvement.	Targeted review and repeat test.
Vision practical station	20%	No critical safety error; all critical steps competent.	Immediate coaching + repeat station.
Hearing practical station	20%	Correct environment/method/recording/referral.	Coaching + repeat station.
Mobility/referral case	10%	Correct role boundary and referral decision.	Repeat case with facilitator.
Referral/caregiver role-play	10%	No diagnosis/blame; clear referral and barrier check.	Repeat role-play.
Inclusive teaching micro-session	10%	Feasible, respectful adaptation and learner practice.	Re-plan and re-teach.
ToT micro-teaching	10%	Clear objective, demonstration, practice and feedback.	Coaching + repeat micro-teach.
Data-quality exercise	5%	No critical errors.	Repeat with supervised data exercise.

Competency status: ☐ Competent ☐ Competent with targeted coaching ☐ Not yet competent – repeat assessment. Final certification criteria and any minimum score should be approved by RSPN/Med Matrix before certificates are issued.

29. Expanded Annex Index

- Annex 1 – Participant Pre/Post-Test (existing manual tool, retain and update with revised protocol questions)
- Annex 2 – Detailed Case Studies and Facilitator Guides
- Annex 3 – Caregiver Referral Role-Play and Observer Checklist
- Annex 4 – Micro-Teaching Plan and Rubric
- Annex 5 – Attendance Register
- Annex 6 – Participant Feedback Form
- Annex 7 – Trainer Session Preparation Sheet
- Annex 8 – Child-Level Screening Form / Referral Form (use RSPN-approved version)
- Annex 9 – School Daily Screening Tally Sheet and District Referral Tracker
- Annex 10 – Detailed Facilitation Guides for Practical Exercises, Role-Plays, Case Studies and Stations
- Annex 11 – Operational Vision and Hearing Screening Protocols
- Annex 12 – Pass / Refer / Priority / Urgent Referral Decision Matrix
- Annex 13 – Screening Equipment and Inventory Checklist
- Annex 14 – Practical Skills Checklists: Vision, Hearing and Referral
- Annex 15 – Teacher Classroom Observation and Initial Screening Tool
- Annex 16 – Common Screening Errors and Corrective Actions
- Annex 17 – Safe and Gender-Sensitive Screening Protocol
- Annex 18 – District Cascade QA and Trainer Readiness Checklist
- Annex 19 – Competency Assessment and Remediation Record

30. References and Online Resources

World Health Organization (2025). Vision and hearing screening for school-age children: implementation handbook. https://www.who.int/publications/i/item/9789240105201

World Health Organization (2024/2023 publication record). Vision and eye screening implementation handbook. https://www.who.int/publications/i/item/9789240082458

World Health Organization (2021). Hearing screening: considerations for implementation. https://www.who.int/publications/i/item/9789240032767

WHO. Vision and hearing screening for school-age children – digital publication. https://www.who.int/publications/b/75338

WHO Learning on TAP. https://www.who.int/teams/health-product-policy-and-standards/assistive-and-medical-technology/assistive-technology/learning-on-tap

WHOeyes. https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/eye-care/whoeyes

WHOears. https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/ear-and-hearing-care/whoears

United Nations Convention on the Rights of Persons with Disabilities. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

WHO. World Report on Hearing. https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/highlighting-priorities-for-ear-and-hearing-care

Ashraf F, Najam N. Pak J Med Sci. 2020;36(7):1659–1663. https://doi.org/10.12669/pjms.36.7.2486

Project source documents: Med Matrix Services Technical Proposal for RSPN/ECW FER-PMF/RFP/2026/005; Med Matrix Inception Report; Disability Inclusion Trainer's Manual supplied for the assignment; WHO sensory-screening resources listed above. Use the latest RSPN-approved project SOPs, referral directory, consent/assent forms and data-management procedures where they differ from generic guidance.

Final Trainer Readiness Check

- All trainers have reviewed the expanded operational protocols and the final RSPN-approved tools.
- All trainers can demonstrate vision, hearing, mobility and referral stations without critical errors.
- All trainers can explain Pass/Refer/Priority/Urgent decisions and the follow-up process.
- All trainers understand the whisper test is a contingency method when validated methods are unavailable.
- All trainers understand the 3-metre vision procedure and the project operational 6/12 threshold pending formal approval.

- All trainers know safe and gender-sensitive screening arrangements, PSEA/safeguarding and confidentiality requirements.
- All trainers have local-language job aids and know how to adapt communication without changing technical criteria.
- All equipment is checked, clean, functional and documented on the inventory checklist.
- All district cascade trainers have completed micro-teaching and practical competency verification before independent delivery.
- All referral facilities/contact points and urgent pathways are confirmed before field deployment.