Partnership Consultation Workshops for Zanzibar Arts for Children's Eyesight (ZANZI-ACE)

Arts to improve eye health-seeking behaviour, vision and well-being

Date 20th - 22nd April 2021

Organised by:

QUEEN'S UNIVERSITY BELFAST

ZANZIBAR ARTS FOR CHILDREN'S EYESIGHT
ZANZI-ACE

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SERIKALI YA ZANZIBAR MAPINDUZI

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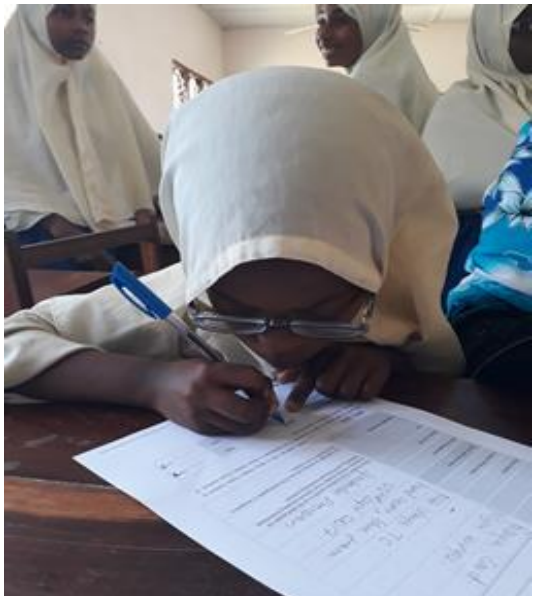
INTRODUCTION

The disability of vision impairment (VI) places a burden on children, communities, and public services and negatively affects the quality of life, including lower educational attainment and productivity later in life.[1] With an estimated 600,000 children in Zanzibar (defined as <16 years old), the burden of childhood blindness is approximately 0.1%, or 600 (Ministry of Health, unpublished). An evaluation conducted on a local school eye health programme[2] showed that the burden of other ocular morbidities among 11,134 school-going children aged 6 to 12 years was estimated at 3.8% (n=427), with uncorrected refractive error of 1.1% (n=122).



Delayed spectacle correction can have prolonged effects on children

Efforts to support inclusive education in Zanzibar have been in place since 1988 when the Inclusive Education Unit was established. Inclusive education was introduced in 2004 and officially included in all schools the following year. All teachers graduating from the Zanzibar Teacher's College receive inclusive education training, with teachers trained to diploma level further receiving education up to Degree and Master's levels. Furthermore, existing policies, such as the Social Inclusion Disability Policy, have been approved by the House of Representatives and implemented. Most of the irreversibly blind and visually impaired school children have had the opportunities to enrol in the schools, completed their schooling and are employed. However, many children in Zanzibar have preventable VI and treatable eye conditions not yet detected and managed. The World Health Organisation (WHO) estimates that the prevalence of refractive errors in low-income countries is 2.5%.[3] With this, we estimated that 10,000 Zanzibari children still have eye problems.

Despite sound policies and an existing comprehensive policy, and an established child eye health service delivery system, many children with eye morbidities are not managed. While there is no formal estimate of refractive errors in Zanzibari children, a case study from the School Health Integrated Programme (SHIP) reported that about 42% of the children in rural Zanzibar communities needed a pair of spectacles but did not have them.[4] We also observed that the current eye health education approaches in Zanzibar are ineffective due to a wide range of uptake factors such as:

- Rejection at the grassroots level was reflected in health posters being removed from schools by community members. Additionally, anecdotal insights include that children are being ostracised for wearing spectacles.

- There was, and that there is a lack of awareness of the benefits of spectacle correction. This may be due, in part, to underlying suspicions of western medicine and public health, which persist from the problematic practices of colonial legacies.

Attempt to remove poster from the school

However, an arts-based, peer-delivered health promotion strategy led by Chan et al. in rural Tanzania and subsequently replicated in Uganda and Kenya demonstrably improved the community's knowledge and

attitude towards eye health.[5] The project's successes drew the interest among key stakeholders in Zanzibar to develop a culturally relevant eye health education strategy to address the barriers to uptake of services for school children.

Community engagement is essential to co-curriculate culturally appropriate strategies which are responsive to such barriers. Drawing on the social science strengths of the PI's team, we extend the existing partnership with the Ministry of Health to the Ministry of Culture, community representatives, members of professional bodies and artistic groups. This interdisciplinary, inter-generational partnership, *Zanzibar Arts for Children's Eyesight* (ZANZI-ACE), aims to co-develop approaches to improve Zanzibari eye health-seeking behaviour, and thus their vision and well-being.

Aims and objectives of the partnership consultation workshop

Through a multi-sectoral partnership and consultation workshops, we aim to develop a Context-Mechanism-Outcome (CMO) configuration and a Theory of Change (ToC) map with our project partners, which include a wide range of key stakeholders in Zanzibar (both the main islands of Unguja and Pemba). This consultation workshop ensures that we understand the local barriers and needs, attitudes, and behaviours regarding the potential of utilising an arts-based approach to improving the uptake of child eye health services in Zanzibar.

In the longer term, the ZANZI-ACE strategy aims to increase the uptake of child eye health services and thus improve Zanzibari children's vision and well-being by using an arts-based eye health education strategy that is co-developed by local stakeholders through public engagement.

Our specific objectives for the partnership consultation workshop are to:

a. develop a CMO configuration that can explain the barriers to the uptake of child eye health services, discuss ways that can enhance health-seeking behaviours, and estimate the outcomes as a result of addressing those challenges
b. develop a ToC for the art-based eye health education strategy for Zanzibar
c. discuss the most effective forms of arts-based interventions in catalysing change in eye health-seeking behaviour
d. formulate the key messages in an arts-based eye health education intervention targeting Zanzibari children

METHODS

Approach

We conducted a partnership consultation workshop focusing on developing CMO configuration and ToC mapping using a structured conversation format. The guide to help facilitate the discussion was attached in Annex 1. The development of both has two key stages:

- Stage 1: Analyse the local barriers and context, and understand how the change in child eye care services happens.
- Stage 2: Develop the impact pathway(s) for the ZANZI-ACE strategy.

Key participants

The Steering Group brainstormed the key stakeholders who might be from an initial list of approximately 60 stakeholders. The group narrowed it to 25-30 key stakeholders drawn from Eye Health, Education, Culture, Civil Society and the Community.

The Steering Group worked backwards from the key questions to ensure that the key stakeholders are (1) representative of the groups involved and (2) willing and able to represent these groups.

To identify information-rich representatives from children, parents, and teacher groups, we consulted the school principals enrolled in the previous school eye health programme in Zanzibar (2017). The following table shows the key participants that have been invited.

Group discussion during the ZANZI-ACE workshop

No	NAMES	Sex	TITLE	ORGANISATION
1	Dr Omar D. Shajak	M	Principal Secretary	Ministry Of Health, Social Welfare, Elderly, Gender & Children (MoHSWEGC)
2	Abeida Rashid Abdalla	F	Deputy Principal Secretary	MoHSWEGC
3	Dr Fatma Omar		National Eye Coordinator Facilitator ZANZI- ACE	MoHSWEGC
4	Khamis A. Said	M	Deputy Principal Secretary	Ministry of Culture, Information and Communication
5	Issa A. Mussa	M	Ag. Manager Zanzibar Integrated HIV, Hepatitis, TB & Leprosy Program Facilitator ACE	MoHSWEGC
6	Edden R. Mashayo	M	Optometrist/ Facilitator	Tanzania Optometry Association
7	Arafa Howe	M	Optometrist/Facilitator	Tanzania Optometry Association
8	Halima Ali Khamis	F	Program Manager Health Promotion	MOHSWEGC
9	Maryam Hamdan	F	Chairperson	Council of Art, Film Censorship and Culture
10	Rajab Mohd Hilal	M	PEC Coordinator	Eye Unit
11	Hakika Haji Jecha	M	Optometrist	MMH
12	Yussuf M. Hamad	M	Ophthalmic Assistant	Eye Unit
13	Ali Suleiman Nuru	M	WASH/Feeding Programs	Ministry Of Education and Vocational Training
14	Halima Mohammed Khamis	F	Inclusive Education Officer - Pemba	Ministry Of Education and Vocational Training

15	Siti Mohammed Hassan	F	Optometrist- Chakechake	MoHSWEGC – PBA
16	Suhuba D. Issa	M	Head of Division for Secondary Education	MOEVT - Zanzibar
17	Eshe H. Ali	F	Asst. Social Welfare Department	MOHSWEGC
18	Dr Fadhil A. Mohammed	M	Director preventive services & Health Education	MOHSWEGC
19	Dr.Ahmed Muumin	M	Ophthalmologist	Mnazi Mmoja Hospital
20	Ramla A. Ahmed	F	Mother of the Vision Impaired Child	Pemba
21	Aisha Said Ali	F	Vision Impaired Child	Pemba
22	Saleh Masoud	M	Journalist	Zanzibar Broad Casting (ZBC)
23	Fatma F. fadhil	F	Journalist	ZBC
24	Omar Abdalla Juma	M	Journalist	Zenj TV
25	Saade Khamis Ali	F	Secretary	MOHSWEGC
26	Ali Juma Ali	M	Asst .Accountant	MOHSWEGC
27	Mmanga Hamad Mmanga	M	Division of Secondary Education Officer – Pemba	Ministry Of Education and Vocational Training - Pemba
28	Fatma K. khamis	F	News Department Officer	MOHSWEGC
29	Asya Issa Ali	F	Director of Secondary School	MOEVT- Zanzibar
30	Shaheen Fauz Mohammed	F	Chief Accountant	MOHSWEGC
31	Juma mwadini Abdalla	M	Deputy Director Education	Central District
32	Mwatima S. Haji	F	Support staff	MOHSWEGC
33	Sharifa S.Majid	F	Acaedemic Manager	Agakhan Foundation
34	Dr.Omar A.abdalla	M	E.Secretary	Art Society- Zanzibar
35	Journey A.Ramadhan	M	Project Manager	Busara Promotion
36	Shaib A.Mohamed	M	Director of UWZ(Disability)	UWZ
37	Shemsa Nassor Msellem	F	Health Coordinator	Milele Foundation

38	Moh'd Idarous Moh'd	M	Assesment officer	Ministry Of Education and Vocational Training - Zanzibar
39	Kassim Ali Khatib	M	Father of Children with VI	
40	Luthi Kassim Ali	M	Children with VI	
41	Hassan Makame Mcha	M	Social Welfare/ON	Mnazi Mmoja Hospital

Workshop preparation

We conducted two facilitated half-day workshops in Unguja and Pemba to allow full and rich discussion for Stages 1 and 2. We provided participants with background documents in advance to accelerate the process. There were short breaks between the workshops to allow time for the write-up and further reflection. For Stage 2, we allocated another half-day to allow sufficient time to review the key sources of evidence.

Stage 1

1.1 To present the key elements of the ToC approach, discuss and achieve a broad shared overall vision for the change (1 hour 30 mins)

We first introduced the ToC to the audience. This initial activity set the scene for the audience, staff and partners who may not be familiar with ToC, addressing its purpose and why we use it. We introduced the audience to the ToC terminology and levels of change. We factored in a few minutes for a quick Q&A session. We started by introducing the Eye Health Education ToC developed by the International Agency for the Prevention of Blindness School Eye Health Group. Using this ToC as a guide, we engaged the audience in a visioning exercise so that partners can easily see the links between their vision and the ToC impact. The aim is to identify the ultimate impact of their programme, articulated at the community level.

1.2 To review the burden of ocular morbidities and uncorrected refractive errors, and low child eye health service uptake in Zanzibar (45 mins)

We started reviewing the burden of ocular morbidities and uncorrected refractive errors, and low child eye health service uptake. In small groups, we brainstorm the key features of the current situation.

1.3 To discuss and achieve a broad shared understanding of cultural barriers towards child eye services uptake in Zanzibar (1 hour 30 mins)

Each participant was requested to identify three key barriers that need to be overcome by writing them on a piece of paper. They were divided into smaller groups with various backgrounds from government bodies, local communities, arts groups and non-governmental organisations (NGOs). The identified barriers were combined in a wider group.

Stage 2

2.1 To select an art medium(s) for our product-driven project that can improve child eye health services through arts-based intervention(s) (5 hours)

Reporting back to the group

We first work towards a shared understanding and ethos for the intervention by agreeing on what we were trying to achieve and the key messages and our goals. The aim is to work towards a statement of commitment for all stakeholders. We discussed the possibilities and problematics of different community art forms, their different processes and how they can be used in different ways for knowledge transfer and exchange. This session was conducted with smaller mixed stakeholder groups, which involved note-taking, discussion, deliberation and solutions.

Feedback analysis and Theory of Change presentation

We took several steps to ensure rigorousness of the feedback following standard procedures to guarantee excellence for stakeholders' partnership workshops:

1) Credibility (equivalent to internal validity): We enhanced this through prolonged and varied engagement with participants throughout the ZANZI-ACE initiation period and reviewing existing literature and monitoring and evaluation documents; ensuring high-quality feedback by following a well-designed protocol for the workshops sub-study, training for the facilitators, having a qualitative research expert analyse field notes and analytic memos, and peer debriefing.

2**) Transferability** (equivalent to external validity or generalisability): We provided a rich description of methods, context and findings, and ensured representative stakeholders and analysis to saturation were completed transparently. This allowed others to decide if the methods and findings could be transferred to their setting or population (case-to-case generalisation) or added to the literature on the subject.

3) Dependability: We provided a rich description of study methods and documented audit trail (copy of all documents generated during the workshops).

4) Confirmability: We gained a deep understanding of the ZANIZI-ACE project initiators' positionality; done by maintaining reflexivity when project initiators keep notes and share their experiences at end-of-day team meetings; and the use of multiple methods and data sources throughout the ZANZI-ACE project.

5) Validity and fairness: We critically engaged in unequal power relations. It is important to acknowledge oppressive histories in health/artist/educational practice and find ways to work against this while encouraging creative expression.

The outputs from the workshop included:

A. A written report that showed the results from the community participatory consultation in identifying the art-based eye health education strategy preferred by the local stakeholders.

B. A ToC was developed for Zanzibar Arts for Children's Eyesight (ZANZI-ACE). In each session, feedback from the stakeholders was collected, analysed and presented using the logic model. The logic model allowed for more detail about how ZANZI-ACE was being delivered. We started with the ZANZI-ACE final goal and worked backwards to the intermediate outcomes. We broke these down into the changes ZANZI-ACE was trying to make according to the beneficiaries' knowledge and skills, attitudes and thinking, and behaviours, all of which should logically help them towards ZANZI-ACE's final goal. We agreed on ZANZI-ACE intermediate outcomes and described our inputs, activities, outputs and enablers.

Data (workshop notes) analysis

The workshop notes were recorded in English or Swahili, based on the language used in the discussions to ensure accuracy and then translated into English (if it is in Swahili). A bilingual facilitator (IM) produced an English-language version of each workshop note.

The analysts created a blank table for each topic from the question guide populated with relevant quotes from workshop notes (one quote per row). The tables consisted of four columns, one for the row number, another for the quote, then one for a summary of the quote's meaning and finally one for a code/sub-code developed from the meaning statements.

Starting with one workshop note, two analysts (ACY and DM) independently populated the tables and wrote a brief statement about each quote. They conferred and reached a consensus on this work and then independently assign labels (codes and sub-codes) based on the meaning statements. They conferred again, reaching a consensus on the codes and sub-codes. The aim is to reduce the number of labels used to 5-8 codes per topic.

Each time the analysts met to discuss their codes, they updated a document with the list of codes and sub-codes, each with a definition and exemplary quote. They also updated the document, noting the new version code, date and source transcripts.

Subsequently, all the data from the individual tables for a specific topic were combined into a single master table. The analysts then discussed codes that have a large number of entries, deciding if they should create new sub-codes or codes and split the data. Likewise, they discussed codes and sub-codes that were rarely used, either labelling them as unique or unanticipated findings or folding them into another code or sub-code.

The analysts examined the codes used for a particular topic and list them in rank order both for the number of times each code was used (salience) and the proportion of participants whose statements were represented by a code (relevance). The analysts presented the rank-ordered results in tabular form based on the number and proportion of mentions, noting the associated proportion of participants. Responses (codes) that are both highly salient (>80% of the mentions) and highly relevant (noted by >80% of the participants) were the focus of discussion about domains or topics. This process was repeated, identifying the most salient and relevant sub-codes for each code.

In cases where disagreement persists, PI was involved, and the opinions were taking into consideration. After that, using the guided framework, findings were inserted to develop the CMO configuration and the ToC mapping.

Ethics consideration

Ethical approval was sought from the Ethical Review Board and Queen's University Belfast. The permission to conduct the workshop was obtained from the Ministry of Health, Zanzibar.

Recruitment strategy:

The list of invited stakeholders was prepared based on our stakeholder's analysis. An invitation letter and a participant information sheet were delivered to the stakeholders (the current local etiquette). A local coordinator followed up with them if they need clarifications and their availability to attend the workshops. In the case of inviting community stakeholders (parents and children) and those who were illiterate, the local coordinator met with them and explained the objectives of the workshop by reading out the participant information sheet informing participants that:

- their participation is voluntary
- they may withdraw from the workshop at any time without giving an explanation or experiencing any consequences
- their feedback will be treated with full confidentiality and that, if published, it will not be attributable to identified individuals

The Participant information sheet and consent form, parent information sheet, consent to allow participation of child in consultation workshop, and child assent form to participate in the consultation workshop were attached in Annex 2, 3 and 4, respectively.

Participants were oriented about the workshop, and their doubts were clarified as needed. The facilitator obtained their signatures in writing on the consent form if they agreed to participate after reading the workshop information sheet. A separate participant information sheet, parental consent form and assent form was prepared for the invited children.

Extra care was in place to ensure discussions with children were conducted in a conducive environment to feel safe to express freely. We referred to the *Save the Children. So you want to consult with children? A toolkit of good practice* for best practice. The following points were noted for the meeting:

Preparation:
We brief the children on the objectives and learning needs of the meeting before attending the meeting. They were being reminded of this at the beginning of the meeting.

On arriving at the meeting:
We brief the children on children's protection issues on arrival at the meeting and departure. A trained facilitator responsible for this during the meeting was introduced to the children.

The environment:

We provided a child-friendly venue where participants felt comfortable, safe and able to concentrate on the work at hand. We avoid conference-style rooms with fixed seating, with enough space and rooms to accommodate small discussion groups. In addition, they have easy access to safe outside areas for leisure/breaks and toilet facilities.

In the meeting environment:
We ensured all facilitators were trained to listen and respond to children's responses by planning six break-away sessions, enabling a less intimidating environment for children to participate. For children who were not actively taking part in the discussion, we politely ask them to encourage participation. However, for those not comfortable speaking about personal experiences, no pressures were put on them. We encouraged them to share experiences but will not have to provide solutions. They were reassured that solutions were part of a consultative process. We ensured children were included in all parts of the discussion, not just brief statements at the beginning of discussions. To ease understanding and encourage participation, we used local language and avoided colloquialism, jargon and too many technical terms. A facilitator was translating to those who needed translation.

Data (workshop notes) management:
All facilitators taking discussion notes were trained and required to follow the relevant security and data usage policies. Paper files (consent forms, flip charts and notes) were kept securely in locked filing cabinets in rooms requiring authenticated access to gain entry. Access to data was limited to the workshop leads, Dr Ving Fai Chan and Dr Fatma Omar. Notes taken from the discussions were verified by consulting the stakeholders.

Workshops were conducted in a venue with sufficient rooms for small group discussions. The workshop venue was booked in advance by the local workshop leader, Dr Fatma Omar. Workshop notes and notes jotted down on the flip charts were captured on a day-to-day basis.

To maintain confidentiality and anonymity, we minimised the need to collect and maintain identifiable information about the stakeholders. Responses were collected anonymously, or the identifiers were removed and destroyed as soon as possible. We linked individual stakeholders with their responses/data and assigned each participant an ID. On a separate document/file, type each stakeholder's name along with their unique study ID (e.g., MOH, MOEVT, CHD). We stored this document separately from data documents.

All workshop notes will be retained for ten years after the workshop ends. At the end of the data storage period, all data will be destroyed thoroughly and completely to ensure data cannot be extracted or re-constructed. The database files will be password encrypted. Only the workshop leaders have access to the workshop notes, database and face sheets.

All workshop notes were held according to QUB and Ministry of Health, Zanzibar's Research Governance Policy on managing physical research data and working with electronic data. Any data held on portable equipment such as laptops, memory sticks or portable hard drives were risk-assessed according to the relevant SLSP, taking into account the sensitivity of the information. All data were transferred to the main data repository, where they were stored on a secure server protected against unauthorised access by user authentication and a firewall. All identifiable data were stored in an encrypted format. Dr Fatma Omar, the local workshop lead, is the custodian of the workshop notes.

RESULTS

Context-Mechanism-Outcome Configuration to guide intervention to address low eye health services uptake among children in Zanzibar

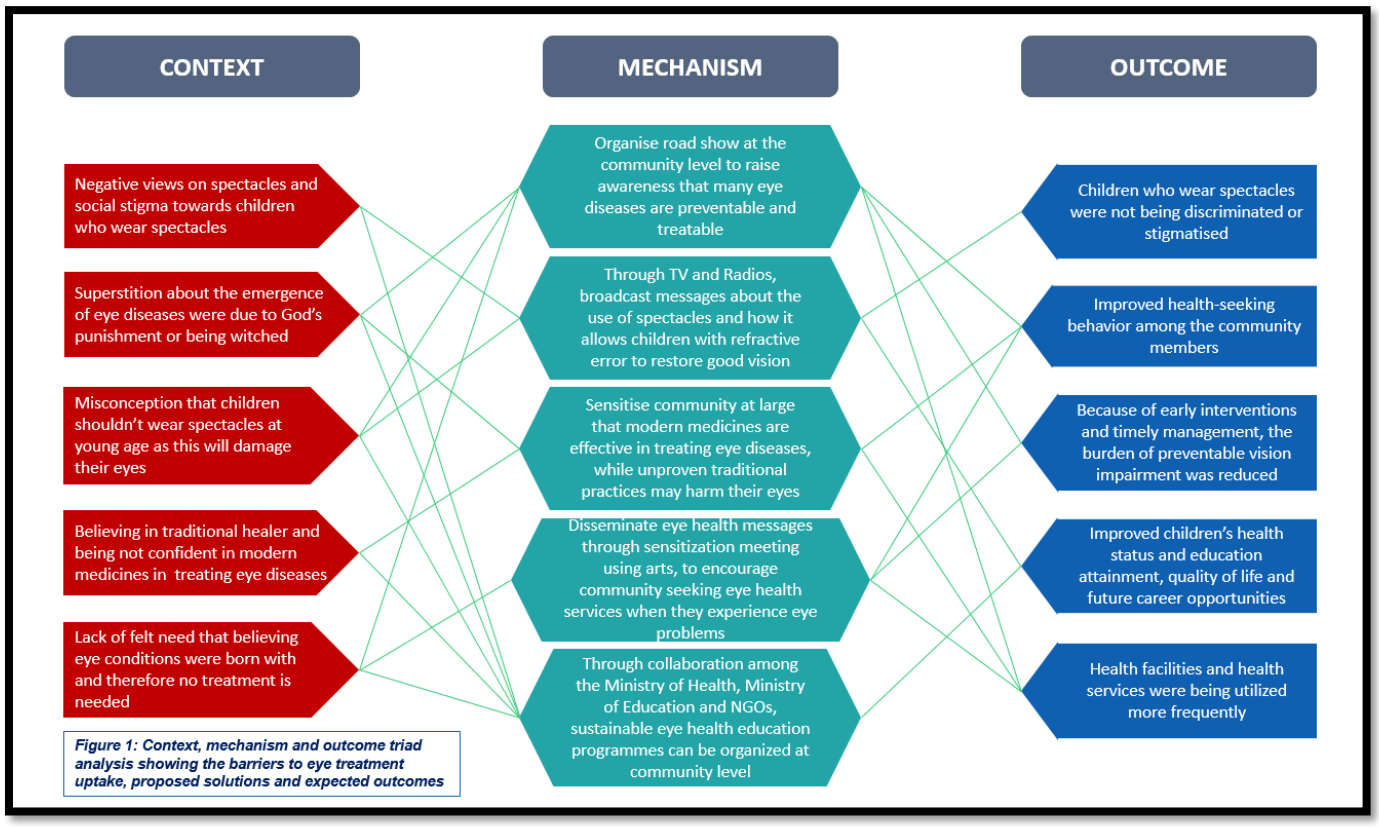


Figure 1. Context, mechanism, and outcome analysis showing barriers to eye treatment uptake, proposed solutions and expected outcomes

Context

Context/contextual factors in our model refer to the barriers towards child eye health services uptake in Zanzibar. Responses from the local stakeholders from various backgrounds were categorised into cultural barriers and social barriers. The two cultural barriers that were discussed repetitively were i) the belief in traditional healers and the reluctance to seek modern medicines even though they suffer from eye problems, and ii) the superstition that having certain eye conditions were due to curse or punishment from God or being cast witchcraft by someone.

> *"The utilisation of breast milk from mothers to treat certain eye conditions."* (Group 1)

> *"There is a belief that the eye could not be treated with western medicine or be operated."* (Group 4)

"*Modern medicines are not as effective to treat eye problems compared to traditional medicines.*" (Group 5)

"Other people regard that having certain eye conditions emerged due to curse or punishment from God." (Group 5)

The social barriers were i) negative views on spectacles and stigma towards children who wear spectacles, ii) misconception that children should not wear spectacles at a younger age as this will damage their eyes, and iii) a lack of felt need, believing that eye conditions were born with and therefore no treatment is needed.

"Eye problem believed to be natural/ born with." (Group 3)

"Self-medication." (Group 4)

"Peer influence against wearing glasses (distort facial appearance)." (Group 4)

"Children at their young age are prohibited from wearing glasses, thinking that their eyes will be spoiled earlier." (Group 4)

Mechanism

Mechanisms in our model refer to proposed solutions to address the social and cultural barriers towards the uptake of child eye health services in Zanzibar. Proposed mechanisms to address both the barriers were surrounded by one common focus theme - the sensitisation of parents, teachers, children, and community members with proper eye health knowledge.

"Community sensitisation on health-seeking behaviour, especially eye care." (Group 3)

"Raised community awareness." (Group 4)

Various approaches to disseminate eye health knowledge were suggested, (i) organising eye health roadshows at the community level, (ii) broadcasting eye health messages on social media via television or radios, and (iii) sensitising the community through arts-based interventions such as songs, dramas, poems, and themes.

"Roadshow for providing messages." (Group 1)

"Artist, production of theatre at public media (TV/ Radio)." (Group 2)

"Sensitisation meeting, using of media houses, songs, drama, poem, themes." (Group 6)

Contents for sensitisation were (i) the function of spectacles and that it is a safe and effective device to correct refractive errors in children and allow clear vision, (ii) the effectiveness of modern medicines in treating eye problems, (iii) the potential harms of receiving unproven traditional medicines, (iv) most eye diseases are preventable and treatable, and (v) encourage seeking eye health services when they experience eye problems.

"Protect your eyes by wearing glasses." (Group 1)

"Application of different cosmetics to the eyes, both ancient and modern, some of which are harmful." (Group 3)

"Get proper advice and treatment as soon as you are diagnosed with an eye problem." (Group 5)

Outcomes

Outcomes in the model refer to the outputs as a result of the implementation of the proposed mechanisms. The outcomes were (i) children were not being stigmatised for wearing spectacles, (ii) enhanced health-seeking behaviour and health facilities were being utilised more frequently, (iii) preventable eye diseases were reduced, and (iv) improved eye health status that leads to higher school attainment, a better quality of life and future career opportunity.

"Reduction of eye problems and improving access to education." (Group 2)

"Sick children with eye problems are being sent to health facilities." (Group 3)

"Children enjoying a happy life, increased school's performance." (Group 4)

"Avoid dependence and discrimination." (Group 6)

Discussion

In Zanzibar, despite health facilities are available and located at a reachable distance from the community, many of the local population choose not to utilise the services. Our study explored the barriers to service uptake (Context) and the potential solutions (Mechanism) to address them. The local stakeholders frequently mentioned that community sensitisation plays a crucial role in addressing the identified cultural barriers and social barriers. The ultimate goal (Outcome) is to improve health-seeking behaviour and thus reduction of preventable vision impairment and blindness that may negatively impact children's lifetime. This Context-Mechanism-Outcome (CMO) configuration will be used to inform the initial programme theory.

Our study found that the primary reasons people not attending health facilities were cultural and social barriers, a finding similar to South Africa, where cultural myths were identified as common barriers for visually impaired old-aged people reluctant to seek cataract surgery.[6] They believed that blindness caused by cataracts was associated with witchcraft, and nothing can be done to restore their vision. Delayed treatment may cause unnecessary poor vision that may negatively impact one's daily routine and productivity.[7] The impact is even more significant for children because their cognitive development may be adversely affected and thus can cause lifetime difficulties.[8]

We found that Zanzibar's community has a strong belief in traditional practices. This finding was consistent with a systematic review on health-seeking behaviour for other health conditions, such as cancer, where traditional, complementary and alternative medicine was associated with prolonged medical health-seeking.[9] Due to the lack of exposure and awareness and distrust of the effectiveness of modern medicines, the local community confides in traditional healers for traditional medicine, when unsafely used (e.g. using plant-based extraction to cure infectious eye conditions [10]), could risk their health and made the conditions worse.

Contrary to a few studies that highlighted non-affordability as a reason people do not access health services, especially in resource-limited settings,[5][6] we found that the local stakeholders in Zanzibar did not report financial constraints as a barrier. We hypothesise that it is because the Zanzibari government provides free eye services to its population.[11] Nevertheless, Ntsoane et al. reported that although some communities were given free services, low service uptake was observed.[12] This contrary is partly due to the low health literacy within the communities. Education health campaigns to educate communities was suggested as an approach to overcome this shortcoming.

Our local stakeholders also commented that the community sees that spectacles are not for younger children, and the misconception that spectacles may damage children's eyes were documented. Stigma and resistance towards spectacles wear among children are common in both low- and middle-income countries[13] and high-income countries.[14] Saif et al. revealed that factors contributing to negative perceptions on spectacles wear included young respondents who felt that wearing spectacles made them less attractive and could reduce their marriage opportunities.[15] While in parents' perspective, they commented that spectacles symbolise disability. Enormous effort and effective interventions suitable for and conform to the local context are needed to address this challenge.

The Zanzibar stakeholders suggested that broadcasting eye health messages through Televisions and radios could be a workable strategy in attracting and reaching more people. Some commented that arts such as song, drama, and films could be used as media to deliver key messages. Community sensitisation has proven to be effective in increasing health literacy.[516] Various methods can be used to sensitise the population, and one which is more adaptive to the local context will be more effective and accepted by the locals. Njomo et al. found that disseminating health messages through posters was ineffective due to low literacy levels among the community members in rural Kenya.[17] In contrast, target populations could learn the key messages better with religious institutions and radios and lead to effective behavioural change.[17]

Our stakeholders believed that enhancing health-seeking behaviour and improving eye health will likely bring more significant benefits to children regarding their educational attainment, future work productivity, and career opportunities that lead to a better quality of life. In a randomised controlled trial conducted in China, the researchers found that students with poor vision corrected with spectacles scored higher than those without the corrections.[18] While in India, improved work productivity by 25% was observed when tea pickers were provided with a simple pair of reading spectacles.[19] "Children's health, the nation's wealth" is a book stressing the importance of having good health in children as they support the future workforce in society.[20]

Recommendations

Recognising context specific to the local population can guide the formulation of effective mechanisms that can potentially address the barriers, thus achieving desirable outcomes. Understanding factors influencing a community's health-seeking behaviour is necessary to intervene in behavioural change. The most challenging barrier in Zanzibar's context is the lack of awareness about eye health, in which community sensitisation was identified as a critical approach in addressing it. Secondly, traditional medicines that have been culturally rooted in the local practices may explain the low service uptake by the locals. Working alongside traditional healers in the programmes could be one of the mechanisms that can effectively increase the confidence and trust of community members towards modern medicines.

RESULT - Theory of Change for Zanzibar Arts for Children's Eyesight (ZANZI-ACE) project

The Theory of Change (ToC) was developed after a consultative workshop with more than 30 representatives from the Ministry of Health, Social Welfare, Elderly, Gender & Children; Ministry of Education & Vocational Training; Ministry of Information, Culture & Communication, Ministry of Tourism, and Heritage, Council of Art, Film Censorship and Culture, Optometric Association of Tanzania, Media houses, government hospitals, parents, teachers, children, religious leaders and NGOs. The representatives were grouped into five teams. A Chair and a note-taker led each team discussion.

The aim was to discuss how effectively arts, when incorporated into eye health strategy, can improve parents and children's eye health-seeking behaviour, leading to improved child eye health service uptake, vision and well-being in Zanzibar.

The team came up with the expected impact for an art-based eye health intervention. The team then was grouped into five groups and asked to list the inputs and activities required for the art-based eye health intervention to achieve that impact. The groups also listed the expected outputs and outcomes. The data was later coded and grouped to derive themes listed under each category as activities, input, output, outcomes, or impact. This ToC is based on the findings from the workshop discussions.

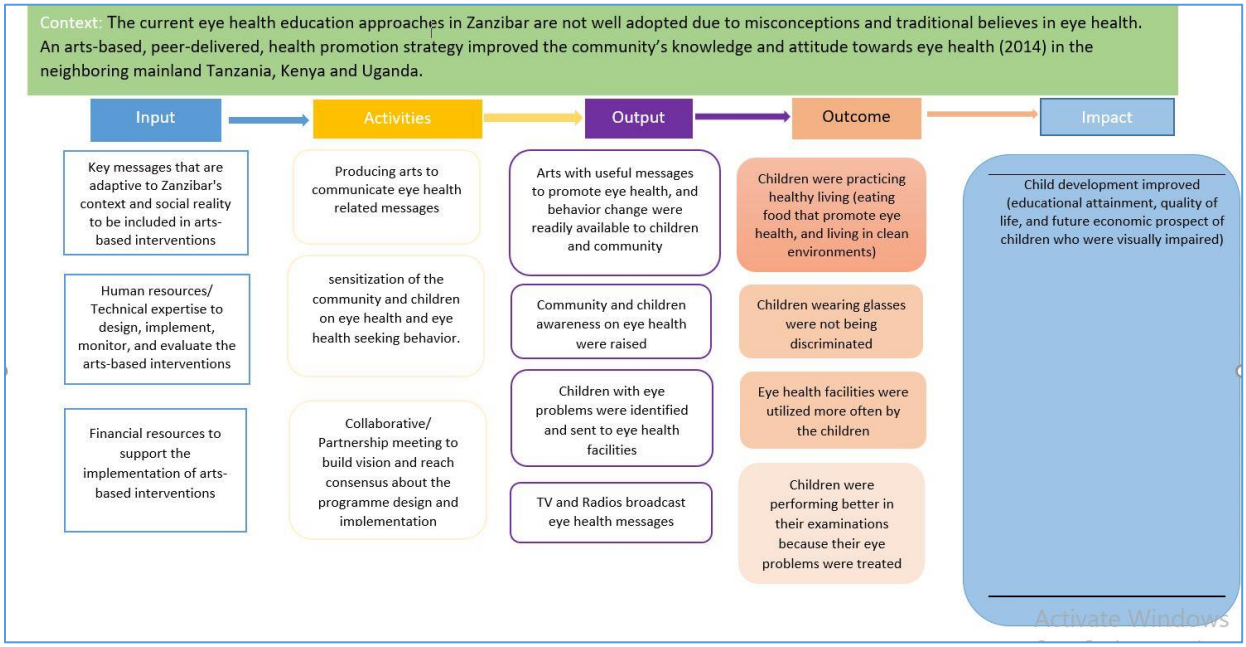


Figure 2. Theory of change to compare child eye health using arts-based intervention

Input

The inputs that listed for the arts-based intervention were:

a. Key messages to be incorporated into the art material.
b. Human resources and technical support for designing, implement, monitor and evaluate the programme, given this is the first arts-based eye health intervention in the African Region.

c. Financial resources to facilitate collaborative meetings among partners and stakeholders to agree on implementation design, implementation of the interventions, the co-creation and production of art material (drama, songs, and poems), and implementing the community sensitisation activities.

Activities

The three main activities proposed were:

a. Collaborative meetings aim to bring together all stakeholders to develop a vision and consensus on implementing the programme (design). Through the meetings, it was agreed that radio stations to broadcast the arts.
b. Co-creation and production of arts-based eye health education material that is acceptable and appropriate for the Zanzibari community.
c. Sensitisation activities implementation - how to distribute and avail the arts to children and the community would sensitise the community on eye health and thus enhance health-seeking behaviour that will promote voluntary service uptake at the eye care facilities among children identified with eye health problems.

Output

Outputs of the identified activities included arts interventions to deliver eye health messages. These arts included music, drama, poems, paintings, and storybooks. Raised awareness for children and community through the training and sensitisation by eye experts and through the arts that have eye health messages was the other output. Children with eye problems were identified and sent to eye health facilities as an output of sensitisation and media platforms, including broadcasting eye health messages via television and radio.

Outcome

Because of the availability of the arts that have eye health messages and sensitisation of the community and children on eye health, children were living a healthy life by eating healthy foods and living in clean environments. Children were also wearing spectacles without discrimination. Eye health facilities were utilised more regularly due to children with eye problems identified and sent to the facilities. The facilities were also more utilised because more people were reached through televisions and radios on eye health. Children were performing better in their examinations as a result of corrected eye problems.

Impact

Children who have eye problems live a healthy life that can lead to higher education attainment, better future career prospects, and good quality of life.

Assumptions

To achieve the activities, outputs, outcomes and impact, the assumptions made are that the local stakeholders and parents agree to support the programme, collaboration and cooperation between the Ministry of Health and Education and Development partners, and engagement and involvement of traditional healers in sensitising the community on eye health. It is also assumed that there are adequate eye health facilities reachable by children. The main challenge in eye care is access and demand, and the geographical distance between health facilities and residents (e.g., How many facilities are available per population?).[21]

Figure 3 shows the various art forms recommended by the local stakeholders to deliver eye health messages. Music or song ranked at the top among the other art forms, followed by drama and poetry, and cartoon being the fourth most preferred by the respondents. The use of painting, theme or slogan, storybook, and delivering messages in a concert setting was also suggested, with minimal favourable.

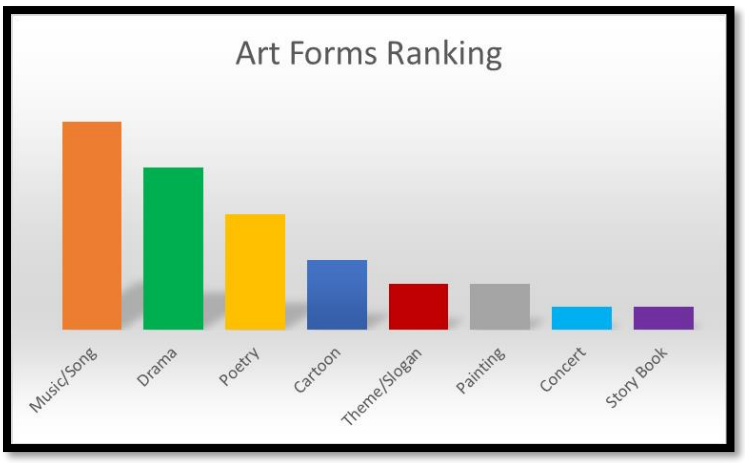


Figure 3. The preferred art forms for the eye health education strategy

Respondents reported that music or song is the most effective method in disseminating informative knowledge to the community because it has a large audience, and the messages can reach at a fast pace to all. (Figure 4) Forms in drama are also useful as the content can remain for a long time within the audience. Children are more likely to be attracted to cartoons, and therefore it could be a practical art form targeting the young population.

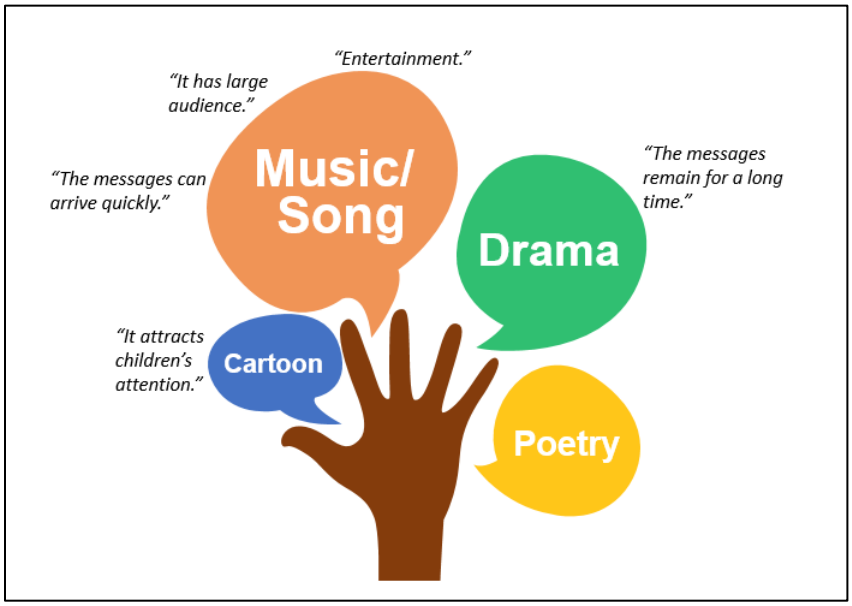


Figure 4. Reasons for preferred art forms

The highly ranked message was that eye health is a personal responsibility. Stakeholders gave examples of statements like *'healthy eye begins with you'* and *'reduce the use of electronic devices to protect your*

eyes'. The message of seeking eye health services for eye problems was ranked second, and good eye health leads to a better quality of life the third. The other messages including taking nutritious food to gain healthy eyesight, protect your eyes from diseases and harm, and that eye problems are not caused by curses or superstitions ranked at fourth, fifth, and sixth, respectively. (Figure 5)

Figure 5. Key messages for arts-based interventions

Discussion

Input

ZANZI-ACE arts-based intervention categorised input as financial resources, human resources/technical support and eye health messages. Human resource, finance, health information, consumables and service delivery are core requirements for any health intervention.[21] Both financial and human resources remain limited [22]; therefore, health interventions in most instances outsource the human resource and are either partially or fully funded by donors who are mostly non-governmental organisations. In this ZANZI-ACE arts-based intervention, financial resources were required to facilitate the implementation of the activities, including the collaborative meetings among partners and stakeholders to agree on implementation design, sensitisation of community and children, and the process of producing arts including drama, songs, and poems.

ZANZI-ACE appreciates the need for human resources and technical support for training on eye health and developing the messages into arts. It is important to plan human resources for eye health based on local needs.[23] For the ZANZI-ACE arts-based intervention, it is crucial to have experts who can effectively deliver eye health messages based on misconceptions and belief in traditional alternatives. These experts are key during both the sensitisation and integrating eye health messages using selected art forms.

Health messages

Examples of the messages agreed by the ZANZI-ACE stakeholders are, '*take nutritious food to gain healthy eyesight', Seek health services for eye problems', and 'eye problems are not caused by curses and superstitions'*. The messages promote prevention, risk or awareness about eye health and are used in the education and avoidance of ill health. Content selection, user input, review and refining of messages, and pre-testing of messages is the most appropriate process of the eye health message development process. A collaborative approach with a multidisciplinary team is essential to developing comprehensive, culturally pertinent and appropriate messages.[24]

Activities

Sensitisation campaigns

In the ZANZI-ACE, sensitisation of the community on eye health promotes health-seeking behaviour and further promotes children's identification with eye health problems. Behaviour change communication among rural masses sensitising eye health improves utilisation of existing eye health services in rural areas.[25] Creating awareness among various stakeholders in the community, especially the parents, is perhaps the most important outcome of the project; since they are more perceptive to their children's medical needs, being direct caregivers. Even greater success is achieved in sensitising women on the importance of eye care and where to access eye care services for their children, should the need arise. [26]

Collaborative meetings

The collaborative meetings bring together all ZANZI-ACE stakeholders to build the vision and consensus on the art-based intervention implementation design. Several stakeholders emphasised that multi-sectoral collaboration for facilitating adoption, implementation and continuation of the project. Specifically, networks and collaborations between health care facilities, village health cadres, government, local authorities, and schools are essential for the success of the project and its future sustainability.[27]

Producing arts with eye health messages

ZANZI-ACE has identified arts like music, drama, poetry and cartoons to communicate eye health messages to children and the community. Communication has an essential role in any action that aims to improve health. It is difficult to imagine how a message could be delivered to promote healthy choices if we could not communicate. The communication process is a multi-dimensional transaction influenced by a variety of factors.[28] ZANZI-ACE relates the identified arts to their ability to entertain as they educate the community and children.

Outputs

Arts

ZANZI-ACE identifies music, drama, poems, paintings, and storybooks as the arts most suitable for delivering eye health messages among the community and children. Reasons behind the selected art forms include their acceptability, entertaining quality, and ability to allow participation by the community. Most societies value arts for a variety of reasons. From a health perspective, they have been valued

primarily for therapeutic purposes. Subsequently, the benefit of the arts in health interventions is increasingly evident.[29] In ZANZI-ACE, arts that communicate eye health messages to promote eye health-seeking behaviours and reduce misconceptions around eye problems are developed and available to the community and children. These arts are developed in collaboration with stakeholders to ensure they are culturally sensitive and acceptable.

Raised awareness
Raised awareness for children and the community resulted from the training and sensitisation by eye experts and through the arts that have eye health messages. To effectively achieve this output, the assumption made is that the traditional eye health healers will participate in the sensitisation of the community. Their involvement enhances acceptance of the eye health messages by the community who closely interact with the healers when consulting and or seeking treatments for the eye problems. It also assumed that all stakeholders would support and collaborate, including the community itself, government, and other partners.

Media broadcasts
Media platforms including TV and radio broadcasting eye health messages ensure a larger reach to the community. 'Community' communication includes mediums used in community settings, such as local radio and newspapers.[28] Communication in health occurs on many levels, including individual, group, organisation, community or mass media. The main difference in communicating health is that the focus is not a general one but one specific to health information [28], and in the case of ZANZI-ACE, it will be the eye health information.

Children with eye health identified
Children with eye health problems were identified and sent to eye health facilities for examination as an output of sensitisation and broadcasts of eye health messages. Parents often do not realise the necessity of such examinations unless they are sensitised to eye problems, causes, and risks. Early detection of paediatric eye problems can prevent future vision loss.[30]

Outcomes

Healthy living
Because of the availability of the arts that have eye health messages and sensitisation of the community and children on eye health, children were living a healthy life through eating healthy foods and living in clean environments. Children were also wearing spectacles without discrimination. Eye health facilities were utilised more regularly due to children with eye problems identified and sent to the facilities. The facilities were also more utilised because more people were reached through televisions and radios on eye health. Children were performing better in their examinations as a result of corrected eye problems.

Healthy living related to eye health is a combination of diet and environment. The suggested quotes concerning diet and environments were '*put your environment clean to protect your eyes', and 'use fruits and vegetables to enhance your eye* health'. Nutritionists encourage eating different classes of foods [31] to promote healthy eyes. A report on 'status and way forward' for child eye health in Africa recommends keeping the face of a child clean to protect from eye diseases.[32] The quoted messages on healthy environment and nutrition to be included in the production of music, drama, poems, cartoons, paintings and storybooks for the arts-based intervention are anticipated to promote eating healthy diets and promote behaviour change among children in Zanzibar.

Improved academic performance

Studies show an association between academic performance and both visual acuity and refractive error in children. Children with poorer visual acuity and refractive errors are less likely to perform well in their education.[33] In the ZANZI-ACE intervention, sensitising the community on eye health promoted the identification of children with eye problems, leading to increased referrals to eye health centres. This output was linked to the children with the corrected eye problems performing better in their education.

The utilisation of eye health facilities

A study on factors influencing the utilisation of eye health facilities described visual impairment (low vision and blindness) due to the low utilisation of the facilities. The study further recommended educational campaigns for better understanding and promotion of greater utilisation of eye care services.[12] In Zanzibar, low utilisation of health facilities was linked to the belief that eye problems did not require medical attention. It was also a result of alternative measures, including traditional healers and natural ointments to treat eye problems. Eye health facilities were being utilised more often by the children identified with eye problems and referred to the health facilities. This outcome was also a result of the educational arts broadcasts through television and radio on eye health and health-seeking behaviour.

Children Wearing spectacles

In the ZANZI-ACE arts-based intervention, children wear glasses without discrimination due to the sensitisations on eye health through forums and social media, specifically radio and TVs. Compliance with spectacle wear is very low among school-aged children, even when spectacles are provided free of charge.[34] One of the reasons children in Zanzibar do not wear their spectacles all the time is a misconception by other children that those wearing the spectacles are bragging.

Impact

In the arts-based eye health project, four outcomes that can be used to measure the improved child development were brought out: children practising healthy living, children wearing spectacles without discrimination, eye health facilities being utilised more by the children, and children performing better in their education.

Improved child development results from a combination of factors, including good health, education and social interactions.[35] Good vision itself facilitates many activities of daily life and improves education and employment opportunities.[36] Effective eye health promotion involves a combination of three components: health education directed at behaviour change to increase adoption of preventive behaviours and uptake of services; improvements in health services such as the strengthening of patient education and increased accessibility and acceptability; and advocacy for improved political support for blindness prevention policies.[37]

Preferred art forms

In our interview with the local stakeholders, songs and drama were favourable and ranked as the top two art forms. This finding was consistent with a scoping review of arts-based interventions in promoting various health issues in Sub-Saharan Africa, where theatres and music were ranked at the top.[38] Bunn et al. commented that art forms that were widely accepted by the local population play a crucial role in disseminating key health messages more effectively. According to an analysis relating to the socio-cultural implication of music and dance in Africa, it was claimed that music is an important element that has been

deeply rooted in all facets of lives among the African communities.[39] Therefore, an in-depth understanding of the local habits and favours is an essential initial step when designing a health programme. With the observed consistencies between our study and other evidence-based studies conducted in African countries, we can conclude that our findings were relatively valid and likely applicable in Zanzibar. The finding is useful for our future programme implementation and ultimately to achieving significant programme impact.

Using educational arts can be an engaging and effective way to convey selected health messages within economically disadvantaged populations.[40] The community's input into the development of the arts-based intervention is essential for this initiative.[40] The intention is to ensure that the audiences have a take-home message after the song, drama, story, or poem. The key messages for the Zanzibar arts-based intervention were suggested by the stakeholders who were representatives of the community, children, government and partners. The key messages bring out the context necessary to have an impact on the target community. Key messages can be translated into local languages to promote ease of adoption.

Recommendations

Cultural bias to visit traditional healers for eye problems treatment is one of the barriers to achieving optimal eye health in Zanzibar. There is a need to schedule forums with traditional healers to capacitate them to identify eye health problems and refer them to the eye care facilities for further investigations to achieve sustainable uptake of eye care services. The healers can link the children and the eye health facilities for parents who prefer to take their children to the healers.

The project can consider a comparative analysis of the education indicators of selected children before and after the project life span to measure changes in educational outcomes due to corrected eye problems. This analysis can be extended to other indicators, including knowledge, attitudes and practices for children and the community concerning eye health.

Using a participatory approach to translate the messages into music, drama, poetry or painting is recommended. Experts in different fields can work with children and parents/communities to develop some art materials. This process will promote relevance and ownership of the messages by the children and community, which will contribute to sustainable eye health practices.

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ANNEX

Annex 1: Guide for multi-stakeholder discussion

Ground rules:
We would like to emphasise that the discussion in this workshop will be kept confidential. Anything discussed in the workshop would not be discussed outside of the workshop and that full names should not be used, where it can be avoided.

Furthermore, everyone's input is equally valued. Only one conversation will go on at once unless subgroups are working on a topic. Please don't take part in side conversations; listen and ask clarifying questions.

All members are expected to participate in all phases of the process (if you leave the room, you are responsible for getting filled in and agree to support any group decision). No idea is bad. Discussions and criticisms will focus on interests, not people. Respect differences. Don't discount the ideas of others. Share your experiences.

Be timely. We will start and end the session on time, take brief breaks, and be ready to start when breaks are over. No phone calls are allowed during the session. Keep phones on silent or vibrate mode during the session.

The following discussion guide is designed to help us understand the cultural barriers and selecting an art medium for our product-driven project. In the spirit of the community-driven processes, we will examine these questions with the various communities (from the community arts, health, education, laypersons) we are working with to refine before we meet.

A. Barriers to uptake of child eye health services

- What set values do you have in terms of child eye health services uptake?
- What beliefs do you have or exist within your community and society in general regarding child eye health services uptake?
- What patterns of behaviours do you have or observed in the larger community/society regarding child eye health services uptake?

B. Coming to a shared understanding and ethos [45 mins - 1 hour]

- What are we trying to achieve? What is our message? and what are our goals?
    - How do these relate to each group's intention/ interest? [take from consolidated points of groups]
    - How do we balance artistic expression and dialogue, with engagement with accurate information about health education?
- What are the challenges that the project attempts to address?
- How might we apply the principles of community engagement, anti-oppression, sustainability, community arts and health education to this project?
- Work towards a statement of commitment for all stakeholders, such as 'A commitment to addressing the social and structural issues related to eye health in Zanzibar' or 'A commitment to changing the eye health practice of our communities for the better'

C. Different art forms carry different messages and have different processes (e.g. individual, group, celebratory, provocative etc.)

- How does the art medium you are working with/considering add to the message of this project and/or our specific goals?
- What are the advantages and challenges to using each art form (e.g. ethical issues, literacy levels, cultural sensitivity, cost, sustainability etc.)?

D. Art forms can be used in different ways for knowledge transfer and exchange.

- How will the created works be shared, exhibited or displayed?
- Are there any ethical concerns to exhibiting the works?
- How will you ensure the target audiences can access the work, and are comfortable with viewing and sharing?
- How will you ensure people are comfortable with sharing their work in different ways/venues?

E. From the artistic community of practice:

- In what ways would you wish to be involved, and acknowledged during the project and once the product is made?
- What expertise can you contribute, in terms of your artistic practice?
- Which networks/ platforms/events can be call upon to further the project?
- What benefits do you foresee for the arts and heritage of Zanzibar through such a project?
- What are the concerns you have about such a project, and lessons learnt from others related to health education and the arts?

F. From the health community of practice:

- What are the lessons learnt from other health education projects that included the arts in Zanzibar?
    - Positives
    - Negatives
    - Challenges to be overcome
- What are the concerns you have about the arts-based possibilities discussed? and How may they be addressed?

Annex 2: Participant information sheet and informed consent

Invitation
You are invited to take part in the Zanzibar Arts for Children's Eyesight (ZANZI-ACE) consultation workshop. Before you decide whether or not to take part, it is important for you to understand why the workshop is being held and what it will involve. Please take time to read this document carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you want to take part.

Purpose
There are many children who have problems seeing clearly and this can affect their lives now and in the future. Unfortunately, most children who have a problem do not go and get treatment from the clinics. If their near vision gets worse, then there is a good chance that they will struggle to study as well as they want. We want to understand how we can use the arts to improve the number of children to get treatment from the clinics. This study is paid for by ESRC Impact Acceleration Account. The workshop is led by researchers in Zanzibar and the UK.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to join the workshop, you will need to sign this consent form. You will be given a copy of the form for your records. This workshop protocol has been reviewed by the Faculty of Medicine, Health and Life Sciences Research Ethics Committee of The Queen's University of Belfast and received permission to conduct the workshop from the Ministry of Health, Zanzibar.

What will happen if I take part?
We're inviting you to take part in this workshop because you can contribute to the planning of ZANZI-ACE. If you decide to take part in this workshop, you will be joining another 25 -30 people to give your views on what is stopping children from getting treatment from the clinics and how we can use arts to solve these problems. Everyone taking part in the study will receive reimbursement for transport. Meals are provided during the workshops. If you decide to take part in this study, we will ask you to attend the workshops for 2 full days. We'll keep track of our discussion using flipcharts and notebooks.

How long will the workshop last and how many people are involved?
25 to 30 people will take part in this workshop and it will last for 2 full days.

If I want to, how would I withdraw from the workshop?
You can decide to withdraw from the workshop at any time. Leaving this workshop will have no effect on your healthcare. However, if you decide to leave the workshop, your views up to the point of withdrawal will be retained. If you have questions about your rights or if you want to withdraw from the workshop, please contact Dr Fatma Omar *at 0777288834*.

Are there any risks?
No major risks. If you do not feel comfortable to speak during any sessions, just let our workshop facilitators know, and you can re-join the workshop at any time you want. All complaints will be formally directed to the National Eyecare Coordinator, Dr Fatma Omar within 24 hours. We also included Dr Rajab Hilal from Ministry of Health as the complaint handler. To ensure complaints are handled fairly and consistently, Dr Ving Fai Chan will also be informed. Dr Rajab Hilal will ensure that the complaints be resolved and report back to Dr Fatma Omar and Dr Ving Fai Chan. All complaints and resolutions will be logged and presented to the Ministry of Health. You can also contact Dr Fatma Omar *at 0777288834 or Dr Rajab Hilal at 0777481666.*

What are the benefits of taking part?
You will not be paid for taking part in this workshop but any transport costs associated with taking part in this workshop will be reimbursed. Meals will also be provided during the workshop.

Will my taking part in this project be kept confidential?
Any information you provide that identifies you will be kept confidential. The records in which your name appears will only be accessible to Dr Fatma Omar in order to contact you, if needed.

What will happen to the information collected?
The notes collected during this workshop will be studied by scientists in Zanzibar and the UK. The goal is to take the results of this workshop to plan for ZANZI-ACE research and possibly publish them in a scientific journal. We will also write reports about the workshop and discuss them at scientific meetings. It is possible that the meeting notes we get from this workshop will help researchers in the future. If so, we'll share the meeting notes with them, but it won't contain anything that can be used to identify you. Ten years after the end of the study we will remove any record of your name from the meeting notes.

What if I have a question?
If you want to know more about this workshop, please contact the workshop leader, Dr Fatma Omar *at 0777288834*.

Workshop INFORMED CONSENT FORM

Please read each statement below. Put your initials below the 'YES' or 'NO' box for each item. If you answer 'Yes' to Items 1-8, then answer items 9.

I have read and understood information given to me about the workshop, or as it has been read to me. All my questions have been answered to my satisfaction.	YES	NO
I understand that I can refuse to answer questions if I wish.	YES	NO
I understand I can withdraw from the workshop at any time, without having to give a reason, and there will be no consequence or action taken in that case.	YES	NO
I understand that the information I provide will be used for planning and research purposes only.	YES	NO
I understand that any personal information that can identify me – such as my name—that is needed to contact me will be kept confidential and not shared with anyone other than Dr Fatma Omar *at 0777288834*.	YES	NO
I understand that before the analyst examines the information I provide, any personal information that can identify me – such as my name—will be removed.	YES	NO
I give the researchers permission to keep my anonymised information in a long-term file so it may be used for future research or planning purposes.	YES	NO
I understand that what is discussed during the workshop is confidential with the exception that if I disclose information that indicates that I am at risk of harming myself or others, or in danger of being harmed by someone else, the researcher is legally obliged to pass on this information to relevant authorities.	YES	NO

If you have answered 'YES' to each question above, please answer the following question.

9. I consent voluntarily to join the workshop.	YES	NO

Please retain a copy of this consent form.

Participant name:

Signature: _____ Date _____

Workshop leader's name: Dr Fatma Omar

Signature: _____ Date _____

For information please contact: Dr Fatma Omar *at 0777288834*.

Annex 3: Parent information sheet and consent to allow participation of child in consultation workshop

Dear Parent,
Your child is invited to take part in the Zanzibar Arts for Children's Eyesight (ZANZI-ACE) consultation workshop. Before you decide whether to provide consent to take part, it is important for you to understand why the workshop is being held and what it will involve. Please take time to read this document carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you want your child to take part.

Purpose
There are many children who have problems seeing clearly and this can affect their lives now and in the future. Unfortunately, most children who have a problem do not go and get treatment from the clinics. If their near vision gets worse, then there is a good chance that they will struggle to study. We want to understand how we can use the arts to improve the number of children to get treatment from the clinics. This study is paid for by ESRC Impact Acceleration Account. The workshop is led by researchers in Zanzibar and the UK.

Does your child have to take part?
It is up to you to decide whether to give permission for your child to take part. If you decide to allow your child to join the workshop, you will need to sign this consent form. You will be given a copy of the form for your records.

What will happen if your child takes part in the workshop?
We are inviting your child to take part in this workshop because he/she can contribute to the planning of the ZANZI-ACE project. If your child takes part in this workshop, he/she will be joining another 25 -30 people, which include the programme team, government ministries, arts-groups, charity groups and teachers, parents and other children, to give their views on what is stopping children from getting treatment from the clinics and how we can use arts to solve these problems. Everyone taking part in the study will receive reimbursement for transport. Meals are provided during the workshops. If your child takes part in this workshop, we will ask him/her to attend the workshops for 2 full days. We will keep track of our discussion using flip charts and notebooks. Throughout the workshop, your child will be accompanied by a workshop facilitator during panel discussion, and group facilitators during group discussions.

How long will the study last and how many people are involved?
25 to 30 people, which include the programme team, government ministries, arts-groups, charity groups and teachers, parents and other children, will take part in this workshop and it will last for 2 full days.

If I want to, how would I withdraw my child from the workshop?
You can decide to withdraw your child from the workshop at any time. Leaving this workshop will have no effect on your healthcare or your child's. But if your child leaves the workshop, we will still keep their views in our records. If you have questions about your rights or if you want to withdraw your child from the workshop, please contact Dr Fatma Omar at 0777288834.

Are there any risks?
No major risks. If you do not feel comfortable to speak during any sessions, just let our workshop facilitators know, and you can re-join the workshop at any time you want. All complaints will be formally directed to the National Eyecare Coordinator, Dr Fatma Omar within 24 hours. We also included Dr Rajab Hilal from Ministry of Health as the complaint handler. If a child made a complaint, their teachers and parents will be informed. To ensure complaints are handled fairly and consistently, Dr Ving Fai Chan will also be informed. Dr Rajab Hilal will ensure that the complaints be resolved and report back to Dr Fatma Omar and Dr Ving Fai Chan. All complaints and resolutions will be logged and presented to the Ministry of Health. You can also contact Dr Fatma Omar *at 0777288834 or Dr Rajab Hilal at 0777481666.*

What are the direct benefits to your child for taking part in the workshop?
Your child will not be paid for taking part in this workshop but any transport costs associated with taking part in this workshop will be paid. Your child will be provided meals during the workshop.

Will my child taking part in this project be kept confidential?
Any information that your child provides that identifies him/her will be kept confidential. The records in which your name appears will only be accessible to Dr Fatma Omar to contact you, if needed.

What will happen to the information collected?
The notes collected during this workshop will be studied by scientists in Zanzibar and the UK. The goal is to take the results of this workshop to plan for the ZANZI-ACE project and possibly publish them in a scientific journal. We will also write reports about the workshop and discuss them at scientific meetings. It is possible that the meeting notes we get from this workshop will help researchers in the future. If so, we'll share the meeting notes with them, but it won't contain anything that can be used to identify your child. Ten years after the end of the study we will remove any record of your name from the meeting notes.

What if I have a question?
If you want to know more about this workshop, please contact the workshop leader, Dr Fatma Omar at 0777288834.

WORKSHOP INFORMED CONSENT

1. I have read and understood information given to me about the workshop, or as it has been read to me. All my questions have been answered to my satisfaction.	YES ☐	NO ☐
2. I understand that my child can refuse to answer questions if he/she wishes.	YES ☐	NO ☐
3. I understand my child can withdraw from the workshop at any time, without having to give a reason, and there will be no consequence or action taken in that case.	YES ☐	NO ☐
4. I understand that the information provided by my child will be used for planning and research purposes only.	YES ☐	NO ☐
5. I understand that any personal information that can identify my child or myself such as name—that is needed to contact us will be kept confidential and not shared with anyone other than the Dr Fatma Omar at 0777288834.	YES ☐	NO ☐
6. I understand that before the analyst examines the information provided by my child, any personal information that can identify myself or my child, such as our names—will be removed.	YES ☐	NO ☐
7. I give the researchers permission to keep my child's and my anonymised information in a long-term file so it may be used for future research or planning purposes.	YES ☐	NO ☐

If you have answered 'YES' to each question above, please answer the following question.

8. I consent voluntarily to my child joining the workshop.	YES ☐	NO ☐

Please retain a copy of this consent form.

Parent name: _____ Child's name: _____

Signature: _____ Date _____

Workshop leader's name: Dr Fatma Omar (Mobile number: 0777288834)

Annex 4: Child assent form to take part in consultation workshop

Hello. We would like to invite you to take part in the Zanzibar Arts for Children's Eyesight (ZANZI-ACE) consultation workshop

Vision is important. You use it a lot in studying and playing with your friends. Some children have problems seeing clearly and this can affect their lives now and in the future. Most children who have a problem do not go and get treatment from the clinics. If their near vision gets worse, then there is a good chance that they will struggle to study as well as they want. In this workshop, we want to understand how we can use the arts to improve the number of children going to get treatment from the clinics.

If you decide to take part, then you will be joining another 25 -30 people to give your views on what is stopping children from getting treatment from the clinics and how we can use arts to solve these problems. The workshop will take 2 full days and meals will be provided at this time. We will keep track of our discussions using flip charts and notebooks.

Nothing bad can happen to you when you take part in the workshop. If you do not feel comfortable to speak during any sessions, just let our Workshop leader, Dr Fatma Omar know, and you can re-join the workshop at any time you want.

Other people will not know that you took part in the workshop. We will not use your name or any of your details when we are telling other people about the workshop. Your parents must give permission for you to take part in the workshop. You also get to say whether you are ok to take part. If you don't want to take part in the workshop, it is ok and no one will be angry. If you are ok to take part in the workshop now and change your mind later, that is ok as well.

If you want to know more about this workshop, please contact the workshop leader, Dr Fatma Omar at 0777288834.

Assent:

I understand the reason for the workshop.	YES ☐	NO ☐
All of my questions about the workshop have been answered.	YES ☐	NO ☐
I understand that I can refuse to answer questions if I wish.	YES ☐	NO ☐
I understand that I can withdraw from the workshop at any time and it will not be a problem.	YES ☐	NO ☐
I understand that my personal information will not be shared with anyone.	YES ☐	NO ☐

I, (name), agree to take part in the workshop.

_____

_____ _____

Signature of Child Date