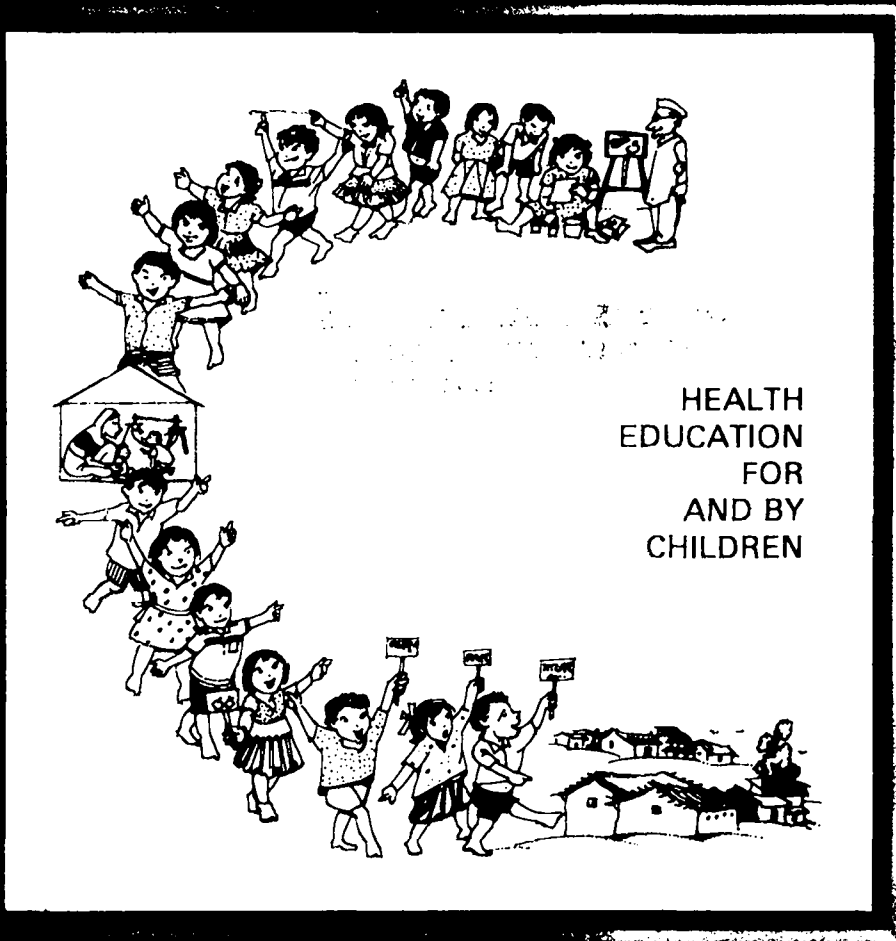


LEARNING

FOR LIFE



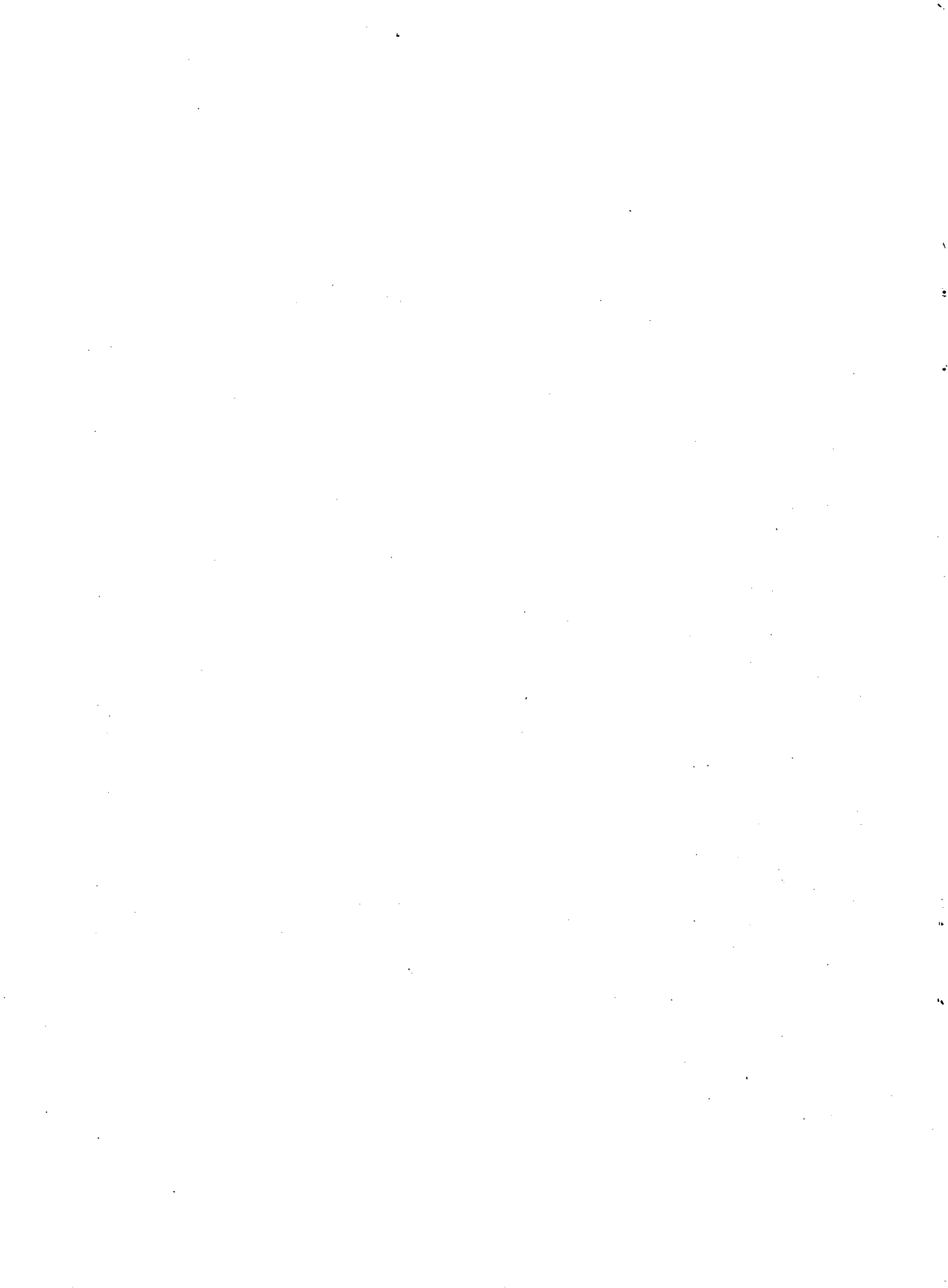
Report of Workshop organised by CHETNA
sponsored by Aga Khan Foundation New
Delhi, 24-26 April, 1990

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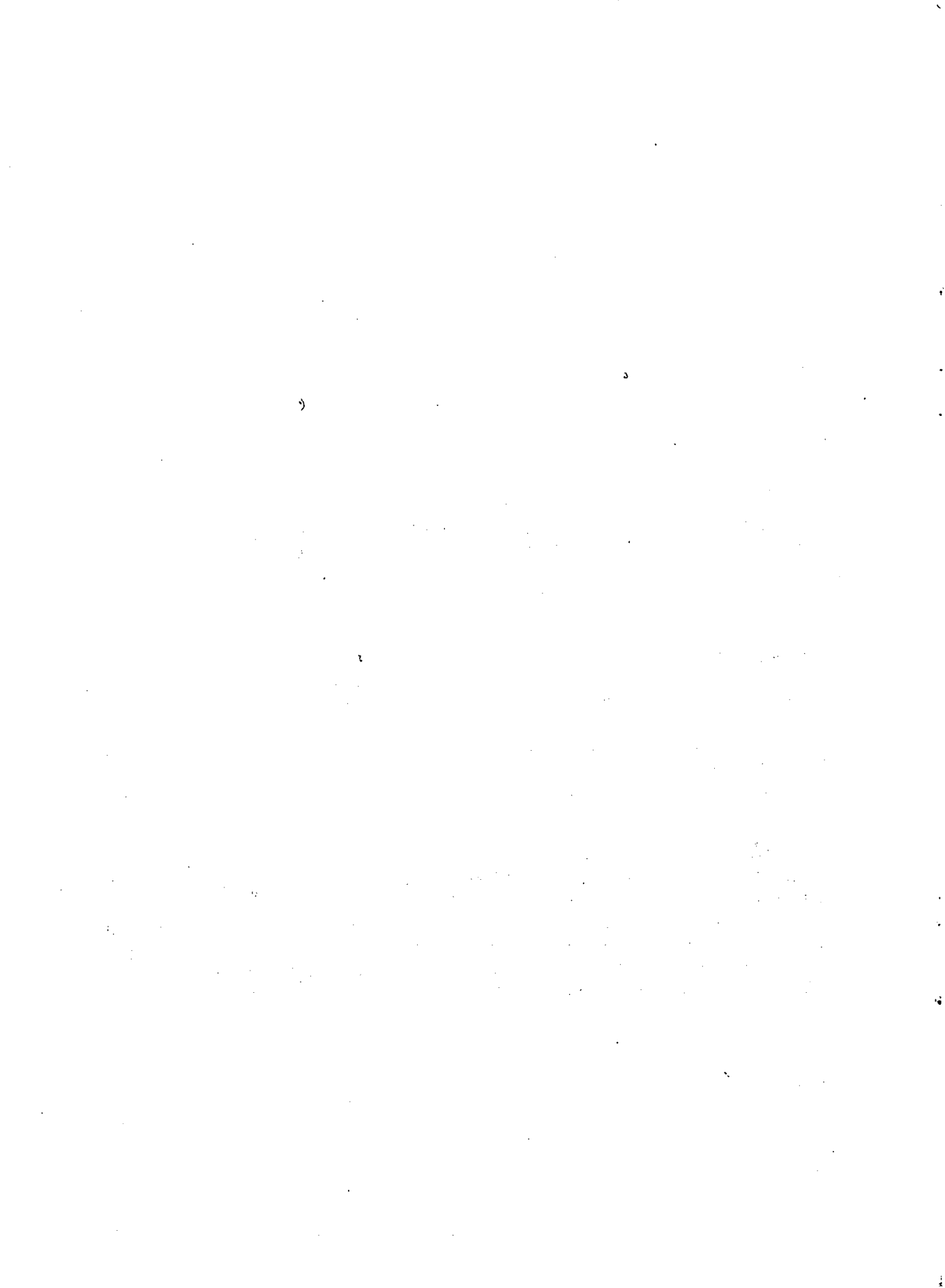
PREFACE

While child-centred health education in India is several decades old, health education efforts by children are relatively newer. Yet, both the governmental and non-governmental sectors have already gained considerable experience in health and education programmes. An exciting array of resources—human and material - is available to support and initiate efforts in health education for and by children.

The Aga Khan Foundation sponsored a three-day Workshop which was organised on the Foundation's behalf by CHETNA in New Delhi during April 24-26, 1990. Over one hundred participants from all over India and a small number of key resource persons from overseas participated. A display of health education materials was an added attraction.

This report is not just the traditional account of workshop "proceedings". Rather, it collates and analyses the presentations, collective thoughts and discussions of the participants over the three days. We hope this "state-of-the-art" document will stimulate further discussion and action in this important field.

We are grateful to the many individuals and organisations who contributed to the conceptualisation and planning of the Workshop. We are especially grateful to the Central Health Education Bureau (CHEB), National Council for Educational Research and Training (NCERT), Voluntary Health Association of India (VHAI), and the Vishwa Yuvak Kendra, New Delhi. Special thanks go to the resource persons and participants who generously gave their time and engaged freely in discussions that have enabled the preparation of this report by Dr. Meera Chatterjee with assistance from Ms. Minaxi Shukla and Dr. Deepa Grover.



INTRODUCTION

The Workshop began.....

with a welcome by Dr. N.A. Siddiqui of the Aga Khan Foundation, India. He explained how AKF initiated Child-to-child projects in India, and described the background of the Workshop (see box).

with an inaugural song by a group of children from a municipal school in Delhi.

And with Minaxi Shukla and Sonal Mehta of CHETNA charting out the objectives and logistics of the Workshop.

Objectives of the Workshop

- To share and review the experiences of innovative approaches to health education for and by children, including the Child-to-child approach.
- To identify and recommend strategies to integrate the lessons learned from governmental and non-governmental programmes.
- To identify and recommend strategies to incorporate newer health education approaches into the larger education and health systems.

The first day-and-a-half of the Workshop consisted of structured presentations of background information and issues, and of ten project experiences, with time for questions and discussion. From noon on the second day through the morning of the third day, there were informal exchanges, group discussions and presentations. The final afternoon was devoted to discussions with policy-makers, government officials and educationists from the Planning Commission, Ministry of Education, Ministry of Health and Family Welfare, the NCERT, and NGOs. The Workshop Programme is given in Appendix A

How AKF Got Involved in Child-to-Child Projects in India and How this Workshop Came About

Child health and development is a major area of programmatic interest at the Aga Khan Foundation (AKF). AKF initiated Child-to-Child programmes in India in 1986. The programmes, located at Bombay, Delhi and Gujarat, used different approaches to health and nutrition education. The programmes were conducted by a diverse range of agencies in equally diverse settings of urban formal schools, an urban slum, rural schools, and Mobile Creches for migrant groups. Programme delivery was through a Department of Community Medicine of an urban Medical College, Municipal Department and privately managed urban schools and NGOs. The basic premise of the programme was that children are natural communicators and, if equipped suitably, can be used to communicate health and nutrition messages to their peers, families and communities. The programmes had an in-built mechanism for training of teachers, supervisors and workers, as well as for on-going documentation, monitoring and evaluation. Concurrent evaluation of these projects was carried out by the Centre for Research and Development, Bombay, Lady Irwin College, New Delhi, and the M.S. University, Baroda.

The Child-to-child programme started with the organisation of a small workshop in 1985. A second workshop was sponsored by AKF in 1988 to review the experience gained thus far. It brought together implementors and those who were documenting and monitoring the projects. Both these workshops were organised by CHETNA. One of the recommendations of the second workshop was to hold a national workshop in 1989 to review the experiences accumulated over five to six years, see what lessons had been learned and where the programme should go.

This Workshop was in the making for a year, with AKF, NCERT, VHA1 and CHEB helping CHETNA to plan it. Although it was originally focussed on Child-to-child efforts, it was felt that broadening its scope to include other approaches to health and nutrition education would be beneficial. There was an enthusiastic response from invitees, and a mix of participants—representatives of implementing agencies in the government and NGO sectors, apex and funding agencies, public institutions, academics, researchers, government officials from the Education and Health Departments and from the Planning Commission (see Appendix B.) Participants were not compensated for their travel nor for attending the Workshop, an index of their keenness to attend. Although it started out as a National Workshop there were international participants as well - from Bangladesh, Pakistan, Tanzania, the Child-to-child Trust in London, and the Aga Khan Foundation, Geneva.



Setting The Stage

As learning from experience was a priority concern of the Workshop, it began by taking stock of past and existing efforts - exploring the "why" "what", "when", "where" and "how" of health education and the school-age child. To set the stage for the detailed project presentations and Workshop discussions, Dr. Deepa Grover and Dr. Meera Chatterjee presented a detailed review of health education efforts for and by school-age children, and raised issues emerging from this experience. Some major questions were: How can health education for and by children be incorporated into the large health and education systems? In general, how can these systems absorb the experience of smaller efforts? In particular, how relevant is the approach to India today? In the context of poverty and deprivation, how can children help themselves, help other children and help their families and communities, as the CtoC approach intends? To answer these questions, it was necessary to consider the school environment, the economic and social environments, and the bureaucratic environment.

The School Environment. What is the physical and pedagogical "state-of-preparedness" of our schools? There are shortages of buildings, toilets, drinking water facilities, teachers, educational materials, and so on. However, there is the challenge of 700,000 schools and over 200,000 non-formal education (NFE) centers. For activity-based education, a change is clearly called for in the pedagogic environment. Is it necessary to introduce activity-based teaching across the curriculum? Can the education system handle this change with its current resources? In the short-run, CtoC efforts may be sustainable with intensive inputs as happens in pilot projects, but in the long-run, major systemic changes may be necessary.

Teacher training has been emphasized as a critical need by several pilot projects, as the role of the teacher expands with health education. Teachers find activity based education time-consuming and an "extra burden". They say it does not fit into the exam-oriented system. It is necessary to deal with these resistances in order to propagate activity-based learning. **Teachers** have first to be socialised into new behavior. Both pre-service and in-service training are important, and training materials, manuals, etc. need to be reviewed. There is also the question of **who** should train teachers. A variety of modalities have been utilised in pilot projects. Teachers' value systems, beliefs, motivation, rewards, etc. also need to be examined.

Another aspect of the pedagogic environment is the choice of health topics. How many topics should there be? Which ones? Who will select them? The most important criterion for their selection is probably relevance to the children's lives. They must be incorporated into learning materials such as text-books and activity sheets. Teaching must take into account learner capabilities, the cognitive abilities of children at different stages.

The Economic Environment. Family poverty keeps children out of school. The CtoC approach offers a partial solution to their health needs. Children in school reach out to their out-of-school peers with the message that they can be self-reliant in health, and help their families as well. Is this a meaningful message to children who are hungry, who do not have resources such as clothing or books, chalks and slates? The crux may be to utilise the materials they **do** have in their environment.

Health Education and School-Age Children — The Current Framework

The motivation to provide health education to school-age children arises from the belief that appropriate knowledge can prevent common diseases. Positive influences during the formative years can have far reaching benefits in adult life. If children are socialised into behaviour that is conducive to healthy living, they can influence those around them, thereby enhancing the health of their families and communities. Thus, children are viewed both as recipients and transmitters of health knowledge.

Children are open to a variety of influences of which the most important come from the home and the community. Health values, attitudes and behaviours are shaped from the early childhood years. However, few children actually absorb from their environment that health is a high priority asset and that they themselves can be instrumental in improving it. Concerted educational attention through schools and the mass media holds the potential of changing health behaviour. In India, schools contain the single largest captive audience, with almost 90 million children enrolled in a network of over half a million schools. School teaching offers the most direct opportunity to influence health behaviour, as syllabi in science or social studies can be modified to incorporate health messages. As teachers are a respected and authoritative socialising influence, the credibility and durability of health knowledge which they impart to children is enhanced.

Some health teaching has always been a feature of Indian education. In the last three decades, several pilot projects have been undertaken in the government sector to demonstrate suitable approaches and the feasibility of incorporating them into the regular education and health systems. Voluntary organisations have also experimented with innovative educational techniques in both the formal and non-formal streams to devise, test and refine packages which can be adopted on a larger scale and on a long-term basis.

Both the National Policy on Education (NPE) and the National Health Policy have emphasised the need for health education for school-age children. The NPE recognises the need for substantial improvement in education through the adoption of child-centered and activity-based learning. The National Curriculum for Elementary and Secondary Education, which was prepared in the wake of the NPE, recommended health and physical education as an important component at all levels of education. For effective health education, coordination between the health and education sectors is of paramount importance.

Even as a vast number of children are enrolled in school, large numbers do not attend school. By 1991, 90 million children aged 6-11 years and 54 million in the 11-14 year age-group will be outside the formal school system. Out-of-school children pose the greatest challenge to health educators. They are dispersed and their circumstances are diverse. Unlike school children they are unfamiliar with organised learning, and so require approaches which are innovative, flexible and captivating. The educational content of programmes for them must be especially meaningful to their lives. Recognising this, the voluntary sector has made some effort to provide innovative education to children out of school. Some out-of-school children are reached by non-formal primary education provided by the government. Infact, the non formal sector is the fastest growing in the state educational system. In 1986, there were almost 1.25 lakh NFE centres in the country with an enrolment of almost 3.75 million children. In a typical centre there are 20-25 learners, who are undifferentiated in terms of previous educational experience and age. NFE centres represent an important arena where health education can be imparted.

The mass media, radio and television, offer additional opportunities to influence health knowledge and behaviour. Health messages must be presented repeatedly and interestingly. If the messages corroborate what the child has learned elsewhere, the likelihood of internalising the information is enhanced.

"Child-to-Child" denotes an approach and methodology rather than a programme with a specific structure and predefined components. It introduces the possibility of health education for both school-going and out-of-school children. Its principal objective is to develop in children the knowledge, attitudes and behaviour necessary to manage their own health, as well as the skills to help others. The approach rests on three main assumptions : (1) that primary education is more effective if it is linked to things that matter to children and their families and communities; (2) that education in school and out of school should be linked so that learning becomes a part of life; and (3) that children have the will, the skill and the motivation to educate each other and can be trusted to do so. The distinguishing feature of the CtoC approach is its insistence that learning should be activity-based, that the child should be a participant in the learning process. In outreach projects, children engage in activities which benefit their younger siblings, their communities and their environments. In other "inquiry based" projects the object is to improve the quality of learning through the use of interactive child-centered educational activities such as games, stories, songs, dramas, etc. There are atleast 23 projects in India which incorporate the child-to-child approach. They emphasize activities, including **bal melas** (children's fairs) and **prabhat pheris** (street processions), and have developed activity sheets to make learning more interesting and fun.

The Social Environment has many dimensions. Health education itself is a process of socialisation into health-producing behaviour for life. The process is enhanced when children take health messages to their families and communities. However, there is a need to ensure that we are not "using" children as agents at the expense of their own needs. Gender concerns are another aspect of the social environment. While girls must receive a special focus because they are more deprived than boys in matters of nutrition and health and of educational opportunities, this focus must not result in a "for girls only" type of health education. Indeed, health education could be a way to break the cycle of female deprivation, but to do so we must address both boys and girls. This issue has implications for the design of materials, for teacher training, and for the content of activities.

Certain aspects of the bureaucratic context are very important for health education, particularly the need for the health and education systems to complement and reinforce each other. Several models of complementarity emerged from past experience. In the Community Contact Programme attached to the Nutrition, Health Education and Environmental Sanitation (NHEES) project, the school functioned as a community health outreach organisation. Another model was that of health education within school health services, where the health worker acts as an extra-curricular educator of children. A third model, Child-to-Child, calls for very close linkages between homes and schools: individual children take home what they learn in school, and groups of children undertake community health activities. Although this may be intended to bridge the gap between health services and communities, the health service system must provide back-up health services to enable children to utilise their learning. The health system must also reach and teach the community. The bureaucratic set-up is also responsible for strengthening school facilities - surroundings, sanitation, drinking water and nutrition, in addition to health care. Coordination between the health and education sectors requires synergism without duplication, as resources are limited. This starts with a common perception of goals. We have to bring together the skills of health workers and schools teachers, engendering mutual responsibility and responsiveness, and making them both accountable for health practices in the community. How are these changes to be brought about?

How can we build on the many useful lessons of past experience? Several projects have been evaluated, mid-course corrections made, and recommendations for the future tabled. Even though it is difficult to prove the success of health education (because many other factors intervene to deny a clear, causal relationship with changes in health knowledge, behaviour or status), success has been claimed more often than failure discussed. We felt that in the Workshop we should discuss both the positive features and difficulties encountered by each experience in order to understand what had worked and not worked. We felt that in this way errors could be avoided and strengths built on, resulting in the best use of limited resources, as we incorporate the lessons into subsequent efforts. We also felt the need to give thought to how the strategies of one situation could be transferred to other different situations, and how to sustain programmes with useful approaches. We expressed the need for continued documentation, greater sharing, and frank dialogue among all those involved. True sharing, we recognised, was predicated on our mutual commitment to increasing children's awareness and improving their health.

SHARED EXPERIENCES

The core of the Workshop was a series of presentations by individuals who have been involved in significant efforts to provide health education for and by children in both the governmental and non-governmental sectors. In the first session, three urban experiences were presented - that of the Municipal Corporation Schools in Delhi, the Malvani Slum Project run by G.S. Medical College and KEM Hospital in Bombay, and Mobile Creches in Bombay. These were followed by presentations on three projects in rural areas: the Intensive School Health Education Programme (ISHEP) being run in ten states in the country, CHETNA activities in Gujarat, and the Tamil Nadu Integrated Nutrition Project. The next session compared two projects within formal school settings - the NHEES Project run by NCERT and the School Health Education Project under the SHEB in Gujarat - with efforts in non-formal settings - the activities of Action Aid, and of the United Artists' Association in Ganjam district, Orissa.

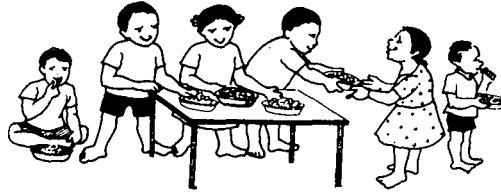
Children in Urban Slums

Before describing the experiences of the Child-to-Child Project in the Delhi Municipal Corporation Schools, Dr. R. Muralidharan explained how NCERT got involved in the project. This history showed the close link between early childhood education and primary schooling - the possibility of starting activity-based health education at the pre-school level, and the need to continue it during the primary years.

Discussing the CtoC programme in the schools, Dr. Muralidharan highlighted the need to bring about attitudinal change among teachers, who lack conviction in the "learning by doing" philosophy. Parents also feel that learning should not be mixed up with play. However, these resistances can be overcome by demonstrating what is possible. She stressed the need to work with the total system - teachers, supervisors, trainers and officials - in order to make an impact and she illustrated the important role of collaborating departments such as Health and Works & Engineering.

In the project, NCERT had the specific role of developing an approach which could be spread through the network of MCD schools. The project now covers 100-150 schools, particularly in slum and resettlement colonies. The experience shows how difficult it is to motivate an entire organisation, to penetrate the organisational behaviour and culture. But once it is done, people enjoy the new environment. There is always a fear that with a change of personnel or with time a programme may come to an end, but this has not happened in the MCD schools because of the support system behind the programme - NCERT, the trainers and supervisors. Once the importance of the programme was realised, a commitment and momentum developed within the organisation. With the expansion to over 100 schools, even if the leadership changes, the programme is likely to be sustained.

Having learned from this experience, NCERT is venturing to take the Child-to-Child approach to other states. Three master trainers from each of 11 states are learning about CtoC, how it is to be done, how to train for it, etc. The MCD schools are the laboratory where they can see how it is being done.



The current educational climate is right for CtoC programmes. The National Policy on Education was a turning point as it talks of child-centered education and the activity approach. The Policy also proposes setting apart 30 percent of time for work experience, art education, health education. Thus we can tell teachers that they have time for these activities. The subsequent mass orientation of teachers all over the country also concentrated on child-centredness and activity-based learning. These concepts are being propagated by the NCERT, the SCERTs, the DIETs, etc. Thus, teachers are also a little better prepared for the Child-to-Child approach.

Child-to-Child in Delhi Municipal Schools

In 1984, the MCD approached NCERT for help in the Early Childhood Education Project. NCERT took up ten ECE schools to conduct a demonstration experiment which the MCD could later expand more widely. NCERT worked with the ECE centres for a couple of years, but we found that when the children went on to primary school, there was little lasting impact. While in the nursery there were a lot of activities and play, these did not exist at the primary level. So we decided to take the preschool play-activity approach to primary schools. Around the same time, the child-to-child idea was being talked about, and we saw it as a good way to get into the primary school as a whole, working with all Classes between I and V.

In 1986 we held our first meeting with the Corporation, UNICEF and AKF to discuss how to go about the CtoC project. We started by training a few good Class IV and V teachers. But it was very difficult to make an impact. The MCD set-up had several advantages - fairly good buildings, trained teachers with proper pay scales, and so on, but there were also basic problems. The teachers didn't take pride in their work. They felt they were working with disadvantaged slum children who would not be able to do anything special. They asked why we were wasting our time. What was really required was an attitudinal change in these teachers. We wanted them to be proud of their children, to take pleasure in their work. For that, we put them through different kinds of training.

We first had to convince the primary school teachers that we were not asking them to do anything extra. We showed them that what we had in mind was already in their science books, and that we were only now telling them to do the same things a little differently. They were asked to identify the most important topics in their textbooks, which needed extra attention. They were assisted to develop activities for the topics. Then came the activity sheets. The project got going with training programmes, monitoring workshops, schools visits, and so on. After some time we found that the very same teachers who used to tell us that they couldn't do anything in their set up because the children came from such difficult home situations, turned around and started asking us why we thought their children were not as good as public school children! There was a complete change in their perception of what children are.

Another grave problem working with primary school teachers was the supervisory system. You cannot work in isolation with the teachers, you have to take the heads of

A Hospital Gets Involved

The next presentation by Dr. Vijaya Bhalerao of the Malvani project in Bombay provided some further insights into the processes of health education for and by slum children. Since 1978, the Department of Preventive and Social Medicine of the G.S. Medical College and KEM Hospital, Bombay, has been providing comprehensive health care to one lakh people in the slum of Malvani. While the programme started with mothers' involvement, it went on to involve children. Dr. Bhalerao described how the KEM staff came to realise that children were an important health education resource. This led to the development of their Child-to-Child project, one among several innovative approaches they have utilised. Children were effective in teaching mothers and in changing the practices related to ten aspects of health which the project took up sequentially - personal hygiene, diarrhoea and oral rehydration, immunisation, anemia, kitchen gardens, scabies, balanced diet, and so on.

In the next phase, the project leaders worked with school teachers. Dr. Bhalerao drew a comparison between Project 1 which was led by health staff and Project 2 which involved teachers. The knowledge of children and parents involved in Project 2 was found to be significantly better than in Project 1 on the three topics covered by the latter.

schools, the supervisors and inspectors, and the education officers into confidence and orient them. We convinced the teachers that it was important for them to work with activities. They got enthused because they found that with activities the children changed. Feedback is immediate, so teachers feel happy. But the supervisors were more difficult to convince. One enthusiastic teacher worked very hard to develop puppets for health messages, using all her activity time. One day, her supervisor told her she was wasting her time. All our work of six months was wasted. The teacher was angry. We first had to bring her around, then go to the supervisor. It is extremely important to bring in the total system, otherwise it cannot work.

The co-operation of different departments is also important. Fortunately, we had a dynamic Commissioner in the Corporation at the time, who was able to bring together the people from the Education, Works & Engineering, and Health Departments. That was a great advantage. In some schools there were no toilets, in others they were blocked; but the Commissioner was able to get the Engineering Department to come and repair them.

In the big slum schools, there were 45-50 children per class. It is difficult for teachers to personally supervise so many children. So we introduced the adoption scheme in the programme, in which a Class IV or V child adopted a Class I child. The older children help the teachers of the lower classes to do some simple tasks. They take responsibility to monitor the younger children's health and hygiene. Every morning they check nails and teeth for cleanliness. This is an important component of the CtoC approach. Health habits started to change because of this personal monitoring.

Some other areas in which we had success were in motivating children to maintain a clean school environment, and to bring a balanced lunch to school, which the children persuaded their mothers to give them. The families were not economically poor but their awareness, involvement and time were limited until we introduced the concept of a balanced diet to the children. Slowly their food habits started changing. Another example was the street food vendor. We suggested that some children could make snacks and sell them inside the school. When we first introduced this, there was utter chaos because the children didn't know that queuing up was required. They fell over each other—the entire school was on top of the five or six children who were selling snacks! We had to tell them to stand one behind the other so that everybody could get some. These were significant changes because the children had no clue that they had to do such things.



This suggested that teachers were more effective than health staff in communicating with school children. Community participation was also better in Project 2.

However, the KEM staff were dissatisfied with this approach as children did not come to the health centre, which suggested that the health education in school and use of health services were dissociated. Hence, they worked out an integrated approach during the

The Malvani Slum Project, Bombay

Involving Mothers. In 1979, the Municipal Commissioner of Bombay requested the KEM Hospital to run a nutritive meal programme for 4000 children in Malvani slum. We agreed, and involved mothers in the preparation and serving of food, and teachers to supervise the preparation of the meals. Soon we began educating the mothers to let them know that nutritive meals were within their purchasing power. However, within a month, there were no women in the class and we had to threaten them by saying we were not bound to continue the programme if they were not interested. Within an hour about 25 mothers came and said that their children had persuaded them to come back. This opened our eyes: while we as medical doctors and social workers had failed to get the mothers, the children could do it in a few minutes. From that moment we have moved from one phase to another, utilising the children.

Involving Children. We gave the children health and nutrition education through role plays, dances, puppet shows. We soon found the children volunteering to take group talks, which told us not only that we could make them health conscious but that they could become health educators. They brought their siblings for immunisation. We achieved 90% coverage with three doses through siblings in school, while coverage at health centres was 50% and 20% in the community. Thus, we started the first Child-to-Child project with 175 children who each adopted 6 families, covering a total population of 5025. We developed pictorial proformas for the children to keep a record of their families. The pictures were reminders of health messages. We took up several health topics using activities. We found that popular Marathi songs are powerful educational media. We have developed sixty-four games which have helped to sustain the children's interest as well as to evaluate how much they have grasped. Through games, children also gain confidence to express themselves.

We started with the topic of personal hygiene - Class V children adopted five children in Class I. They examined them every month, scored them according to fixed criteria, and looked for improvement. Fifty-one percent of children improved in personal hygiene. In Malvani, a low lying area, there was complete flooding during the monsoon, and diarrhoea broke out. Each child went from house to house teaching mothers about ORS



period when immunisation was being taught. This led to better immunisation coverage than had occurred in Project 1. Thus, teachers were found to be more competent in implementing the CtoC programme, and results were best when the schools and health centre worked together. This approach has been recommended by the KEM project leaders as feasible and replicable.

solution wherever there was a child with diarrhoea. They detected 253 cases, of which only four had to be admitted to hospital. The children thus showed the potential to teach mothers about ORT, get them to practise it, and bring about health improvements.

After diarrhoea, we turned to immunisation, starting with a *morcha* in which slogans were used. Children in urban slums see *morchas* everyday — we showed them that they can be used constructively. At the end of the procession, the children enacted a street play, which mothers watched with interest. Every child was then allotted five houses and asked to find the children under 5. They pasted the UNICEF immunisation poster on these houses and brought the mothers to the mobile immunisation centre. Initially, this was done mechanically, but soon they became persuasive motivators. A population of 28,000 was covered in two rounds. The children were able to answer mothers' questions because they heard the medical officers answering them! Then they were able to bring children in at the correct age for a particular immunisation. This change took place in three months. Although we stopped the immunisation teaching and went on to other topics, they did not forget as they have been bringing children continuously for immunisation to our centres.

Involving Teachers. Project 1 was criticised as being 'non-replicable' because it had been conducted by health centre staff, although all the staff involved were non-medical. It was suggested that we train the teachers and let them take the responsibility for health education. Thus, Project 2 involved the school teachers, and 834 children who adopted their own families, totalling 4170 people. Only anemia, diarrhoea and immunisation, which are priority problems, have been taught. The programme concentrated on each topic for three months using a multidisciplinary approach. All teachers - eg. drawing, crafts, singing and dance teachers - would run activities related to the topic. We are systematically recording activities being implemented by the teachers. The pictorial proformas are useful to maintain information about the families; for anemia detection, education and treatment; for diarrhoea - examination of the school and home environments, and recording cases of diarrhoea and treatment with ORS solution. If a child's own family does not have an infant, s/he takes a relative's or a neighbour's 0-1 year-old child to utilise the immunisation proforma.



Children on the Move

Dr. Indu Balgaopal presented the experience of Mobile Creches - Bombay through two video films which described on site activities and the worker training programme. She introduced Mobile Creches, a non-governmental organisation which provides services to migrant construction workers' families. As the children move with their families, they never go to school or avail of urban health services. Thus, Mobile Creches runs a comprehensive programme of curative and preventive health care, nutrition, recreation, vocational skills, and

Mobile Creches: Standing the Tests of Time

Mobile Creches runs day-care centres for children of migrant construction workers, reaching 8000 children per year. Children aged between 0 and 12 years receive health care and education, and engage in recreational activities, with different ages under one roof. This vertical grouping reflects the family set-up familiar to children, and encourages natural interaction, provides security, and creates bonding between siblings. The focus is on integrated development of children in a happy and congenial environment. We have implemented the Child-to-Child programme successfully through participatory, activity-based education. The implementation has been systematised to make it replicable in all situations. The systematic approach has resulted in a creative, dynamic organisation, that has stood the test of time.

The first step in the implementation process is to identify the children's problems, with the children themselves being involved in this "finding-out" activity. They are guided to collect information and take part in discussions to analyse and understand the problems. The next step involves detailed planning of activities on themes that emerge from the discussions, one at a time. Teachers and resource persons work together to evolve methods and strategies to get messages across to the children simply and clearly, to give them knowledge they can act upon. They engage in a process of collective thinking to identify applications of the theme to all areas of child development - psychomotor, socio-emotional and cognitive. They consider a number of approaches to teach the children and reinforce messages. This part is crucial and has to be carefully planned to suit the needs of children.

The next step in the process is translating the ideas into activities that the children can understand and implement. Multi-sensory media are used - songs, role plays, puppet shows, field activities. Songs and rhymes are the most effective means of communication - they are easily learned and remembered throughout life. After developing the methods and materials, these are shared with all involved in implementation. If there are a large number of field implementors, the trainers hold a workshop in which teachers make their materials from the prototypes provided. Implementation is in two stages—first, the children are given the message, and then they demonstrate and disseminate their practical knowledge until simple rules for good health become a habit. They communicate what they have learned to their friends, families and communities. They report their experiences to the teacher and together analyse the

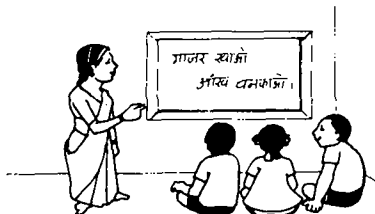


leadership training for the children. Health education is divided into five areas: safe and healthy environment, daily care for the child, nutritional needs, growth and mental stimulation. As the children move on quickly, Mobile Creches has had to develop strategies to give them maximum benefit in the shortest possible time. Dr. Balgopal stressed that children can be taught a great deal in a short time. The use of music in teaching is effective as songs and games are retained for a long time.

effectiveness or drawbacks of different strategies. Monitoring and follow-up of the programme are crucial. The activities need to be evaluated. The teachers meet to review the programme, identify successes and failures and problem areas.

In Mobile Creches, the major successes have been on the topics of a safe, healthy environment, provision of daily care, nutritional needs, and growth and development. Good personal habits, hygienic practices and prevention and treatment of common childhood illnesses are easily understood and dealt with by children. Superstitious beliefs about measles and chicken-pox have been overcome. Communities willingly accept the idea of immunisation, and teaching oral rehydration therapy has been one of the most successful efforts. Despite age-old traditions, intervention in cooking practices and proper food preservation have improved nutrition. But children feel helpless with environmental issues such as safe drinking water, disposal of waste, etc. Some other issues such as the ill-effects of alcohol and smoking have been included with a view to using children as change agents. Parents have had mixed reactions to these, but the children will hopefully store this knowledge away to be used when they are in control of a situation. Apart from information on health and nutrition, we impart value-based education through the CtoC programme, teaching respect for elders, sharing and caring.

The creative process is manifest in every aspect of the programme. It is our experience that if the material for children is distracting or gives only indirect messages, then the means become the end. The children go through fun-filled exercises without absorbing the lessons. Repeated messages through different modes and media help retain the interest and enthusiasm of children. Teachers remain interested through the development of different strategies and methods. Originality is necessary for a good teacher. The programme must be flexible to accommodate idiosyncracies. Apart from the routine workshops for content teaching we have special workshops for preparation of innovative teaching aids, project planning, art and craft development, developing story-telling and dramat skills for community education. Sensitivity is of the essence - the staff are sensitised to the ethos of migrant families and to the requirements of children. Almost every day brings a new situation, a new problem - so that the process of problem-solving is the most important aspect of the programme. The staff are trained in the art of listening, understanding and fearless decision-making. Regular exercises have resulted in the development of a strong group of committed workers who have learned to function in a democratic manner. The magic word is motivation, a positive attitude that provides satisfaction in the sense of achievement.



Going to Scale

The three projects presented in the session on rural/tribal efforts ranged from "mini" projects covering a few villages, to one in several districts of a single state, to a national programme being implemented in several states. Both government and non-governmental organisations were involved. This variation in size raised the issue of "going to scale" which requires a "system" to provide services widely, particularly in inaccessible areas and where socio-economic levels are low. The project experiences reveal that it is necessary to examine how the system works and how new efforts can be interjected in imperfect systems.

The Intensive School Health Education Project (ISHEP) for primary school children is the most recent governmental effort. Mrs. C.K. Mann of the CHEB described the plan for this programme and informed us of its current status. Before ISHEP, the Government of India had implemented a pilot scheme in 1982. This was later expanded and converted into a Centrally-sponsored programme which, following five years' implementation, was evaluated by the National Institute of Health and Family Welfare. The evaluation pointed to the shortage of manpower, and the inadequacy of three day training for teachers. There was also a paucity of teaching materials at all levels. Teachers felt that they were burdened with too many activities. Community participation was also poor. The evaluation report suggested that a comprehensive school health education programme should be launched which could be replicated later throughout the country.

The experience gained from these earlier schemes was thus incorporated into the present project, which was formulated to overcome these constraints. NSS volunteers are being mobilised to provide additional manpower. Mechanisms for active community participation have been designed — school health committees at the village level, and the involvement of "link mothers" — community women who have some education, interest in health education work, commitment and spare time. The duration of training has been increased. The project adopted a systematic approach to providing training and implementation materials. Existing materials were collected from government and voluntary organisations all over the country and scrutinised. Those which were found to be suitable were adopted, others adapted, and a workshop held to develop materials to fill the gaps.

The project seeks to address the problem of teachers' resistance through a number of incentives. They will receive honoraria for training, and a certificate at the end of their training programme. To sustain their interest, it has been suggested that they receive health check-ups themselves. Within a district, schools will be graded and a trophy awarded to the best, which is expected to generate healthy competition. The "best health education teacher" will receive a merit certificate. Monitoring and evaluation are integral parts of the projects and will involve a non-governmental organisation. Constant monitoring and feedback are envisioned so that the project implementation can be improved continuously from the start. There will also be a Central monitoring cell and state, district and block-level coordination committees involving representatives of all agencies involved.



The Intensive School Health Education Project

The Intensive School Health Education Project for primary school children involves the Department of Education, CHEB, NCERT, the Department of Youth Affairs and Sports, non-governmental organisations, and UNICEF in intersectoral collaboration. Its aim is to improve the health and nutrition status of primary school students in rural areas through intensive health education. The specific objectives are: to reduce the incidence of preventable diseases; to inculcate healthy practices for self-health care; to promote healthy life-styles in the community by utilising school children as channels of communication; to equip teachers and NSS volunteers to impart effective health education to primary school children. The project is being implemented in ten districts in ten states, covering 100 blocks for a period of three years. This will involve a total of 16 lakh primary school students, 43,000 teachers and 6,000 NSS volunteers in 13,000 schools. In areas where there are no NSS volunteers, rural youth leaders will be involved through Nehru Yuva Kendras. Each block-level PHC will relate to 100 schools, 200 teachers, 10,000 students and 50 NSS volunteers. One link mother will be selected for every 20 households, to watch the children's health and maintain a link with their parents and with the school teacher.

The planning phase of the project began in January 1989 with a workshop in which district and state implementors evolved a strategy jointly with Central staff. Following this, educational materials were developed before the project was operationalised, including guidelines for the implementation of the project, on the roles and responsibilities of the institutions and personnel involved, modules on Child-to-Child and youth-to-child approaches, and the training curriculum. Training is to be given at three levels—to key people involved at the Centre and in the states; to district and block-level functionaries; and to teachers, NSS volunteers and health workers. The first level training is completed, and the second is going on. The third level will be joint training so that the workers understand each others' roles, to complement rather than conflict with each other.

Initially, only eight "thrust areas" (topics) are envisaged - seven selected centrally and the eighth regionally. Teachers, NSS volunteers and school students will be involved in improving the school environment and in the health appraisal of students. PHCs, block hospitals and specialist camps will be utilised to provide needed health services on referral.



Training at the Core

CHETNA, the Centre for Health Education, Training and Nutrition Awareness, Ahmedabad, has been involved in health education for and by children since it organised the first CtoC workshop in 1985. The workshop generated a lot of interest among the participating organisations, and CHETNA has been helping them with training for the implementation of CtoC projects. Minaxi Shukla described CHETNA's experience to date and discussed some of the problems and constraints encountered. CHETNA's experience also highlights the links between pre-school and primary school, and the focus on the "whole child." Their approach to training teachers has been successful because it is participatory, and the involvement of children in community activities has helped to foster community interest, as well as strengthen learning among both students and teachers.

On the side of constraints, CHETNA found that working with formal schools was not easy as they had to liaise continuously with state and district authorities in order to involve teachers in training workshops, as the latter had to receive permission each time from their superiors. Thus, CHETNA felt that the programme must be incorporated into the regular school system. Another problem was the scepticism of parents and community members — they thought that children were only playing and not being taught; and they expected "incentives" whenever they were approached. However, Minaxi said, the children were always very encouraging: "They liked to be with us, play with us and learn with us."

Child-to-Child through a Nutrition System

The Tamil Nadu Integrated Nutrition Project (TINP) is one of the few projects that has not relied on teachers to foster child-to-child communication as it is primarily a **nutrition** and not an education programme. Jayshree Balachander presented the essential features of TINP and some special aspects of its CtoC efforts. She characterised TINP as a project with a good "system" - good training, monitoring and a highly-motivated and skilled grass-root level worker. This infrastructure has been largely responsible for the good results achieved by the project. The effectiveness of communications is due to the fact that they have been an integral part of the project from its inception.



CHETNA and Child-to-Child

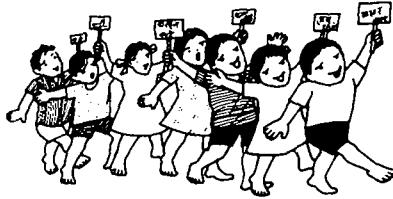
After organising the CtoC workshop in 1985, a six-month pilot programme was launched to implement the activity-oriented approach in an urban and a rural/tribal area. Those experiences fed into the three-year programme implemented in local government schools of rural and tribal areas, which will be completed in June 1990. CHETNA worked with local voluntary agencies rather than directly with the schools, as we wished the programme to continue after we withdrew in three to five years. The agencies were Sewa Mandal in Meghraj taluka of Sabarkantha district in Gujarat, the Aga Khan Education Service which runs day-care centres in Siddhpur, North Gujarat, and PEDO. People's Education and Development Organisation (an offshoot of the Social Work and Research Centre at Tilonia), in Mada, Durgapur district of Rajasthan.

PEDO worked through government primary schools and non-formal education centres, while Seva Mandal worked with CCF centres and other day care centres. In the AKES projects, although most of the children at the day care centres were younger than the age-group we originally envisaged, there were also older children. The primary schools were next door in all the seven villages selected.

As in other projects, initially the teachers were not willing to do anything extra. We therefore asked them to select topics from within the curriculum and textbooks in Classes IV to VI. Local health and nutrition problems were included as well as child development topics, because the whole child was considered important.

We selected two teachers from each school who were teaching science or environment subjects, not all the teachers. Most of the schools where we worked had more than one teacher. We held three-day teacher training workshops every month, discussing the content and an activity approach for two or three topics each time. After training and the development of educational materials - the activities to go with the activity sheets, we conducted monitoring and follow-up activities through field visits, going to the schools to talk to the teachers, asking them about their difficulties, requesting them to teach children in our presence using the activity-oriented approach. We observed them and discussed their problems. The visits preceded the training programme on new topics so that we could discuss the problems faced in the field, and work out solutions collectively.

Although we trained and followed up teachers in this intensive way, we still found something missing. There was not much interaction with children - and we found that the messages were not reaching them as they should. We also needed to mobilise the communities. So we thought of ways to work with the children directly through activities such as children's festivals and fairs in the villages. We also had the **gram yatra** programme, going village to village, staying with the children, going to their schools, and learning what their problems were and how we could help them. We could demonstrate to teachers, who were still not very comfortable with the activity-oriented approach, how to work effectively with children. During the **gram yatras** and **bal melas**, the village communities and teachers cooperated well, and so they were effective.



The Tamil Nadu Integrated Nutrition Project

The Child-to-Child approach in TINP has been part of its overall communication effort, which started well before the project itself. The community was told about the project ahead of its implementation in the villages. They were introduced to the workers, along with supervisors, health workers, and other leaders. The project continuously looked for ways to sustain communications. When we felt we had done what we could with women's groups, demonstration materials, village demonstrations, etc. we looked to children as an additional resource. The idea emerged as children were always a large part of the village audience for any activity. One of the first things that became obvious to the workers was that the children were a very encouraging medium because they responded readily and were good at communicating. They made communication easy.

In the CtoC programme in TINP, the worker went to the school teacher and asked for a group of children in the age-group 8-11 years who had leadership qualities and an interest in the programme, and who could take part in the cultural activities. The project was constantly doing things in the village such as organising folk programmes. The children were formed into a Children's Working Group and once a month the worker spoke to them on a particular theme, such as vitamin A. In addition to these information sessions, the district-level communications staff organised special workshops where they encouraged the children to participate in skits, competitions, kitchen garden contests, distributed prizes, and so on.

We prepared comic books which were circulated to the Children's Working Groups, and were very popular. Children carried placards, and announced the time and date of immunisation sessions to be conducted by ANMs. Games, stories, plays and skits have also been tried.

We have found it is easier to sustain a Children's Working Group than a Women's Working Group as the women are more demanding. However, the Women's Working Groups have been important in areas where there have been major resistances, such as in growth monitoring. But in other areas, such as immunisation, children have influenced mothers. Subsequently, all the "client capture" tasks are being entrusted to children, perhaps including growth monitoring in the future. In new project areas, we will form children's groups as well as women's groups from the beginning.



Community Contact is Critical

While health education was in the formal school curriculum before the 1960's, attempts were not made to systematise it to bring about changes in the attitudes, behaviour and habits of children, or to work through children to improve the quality of life of communities until 1975. At that time, in the Fifth Five-Year Plan, the Government of India launched the Minimum Needs Programme, which included elementary education, nutrition,

The Nutrition, Health Education and Environmental Sanitation Project

NHEES was in operation for more than a decade. Initially, very remote tribal or educationally-deprived blocks in each state were selected for the project. Before work started, an extensive socio-economic survey was conducted to find out the nutrition and health status of the people. The intervention programme was based on the existing situation. As health was viewed as a social problem, it was felt that it is not enough to teach it only at the primary level or in the formal school system. While the children carried messages home from their learning in school, they had to find fertile ground within their homes to bring about changes in health habits. Therefore, NHEES had a multi-pronged approach — an intervention programme in the school and in the community.

Community contact was considered one of the important aspects of the programme, and efforts were intensified in 1985. Many strategies were adopted. There was door-to-door contact by the school teachers, regular monthly meetings with community members, exhibitions, posters, role-plays, and so on. The efforts were monitored in order to see whether and how they worked. Project team members collected data on knowledge, attitudes and practices related to ten messages before and after a period of intervention. Data were collected on 16,000 households which participated in the Community Contact Programme. The achievements of 37,000 children involved were also investigated. The evaluation design included schools with no Community Contact Programme, others where there had been door-to-door contact with the community, and control areas with no programme at all. Currently, the two sets of data are being matched so that the achievements of children can be related to that of their households.

sanitation, and overall development of the educationally and socio-economically deprived sections of society. A number of innovative elementary education programmes were launched to improve quality, to bring about changes in the structure, and increase the coverage of primary school-age children. The Nutrition and Health Education and Environmental Sanitation (NHEES) project was one such innovative project. Some of the highlights, important strategies and implementation aspects of this seminal health education effort were presented by Mrs. Shukla Bhattacharya of the NCERT.

The major strength of the NHEES programme lay in its concerted effort to reach into the community through the "Community Contact Programme." This effort was systematically evaluated. Mrs. Bhattacharya identified some of the constraints as: the burden on primary school teachers who "have to do everything except teach"; the poor quality of schools; single—teacher schools; and teacher:pupil ratios as high as 1:60. She felt that child-centered health education strategies have to be worked out for these situations.

1989 was the last year of the Master Plan of Operations for the NHEES project. After the 1986 National Policy on Education, in which health and physical education have been given an important place from the primary to the "plus-two" level, the NHEES experience was sought to be integrated into the formal system. Health has been integrated into the environmental studies curriculum developed by NCERT and the CHEB. The publication, "Health Education for School-Age Children — A Framework," describes the objectives of health education, its modalities, how to integrate it, and transaction strategies for all levels of the formal school system.

Working with the Most Deprived

The efforts of Action Aid—India, an "apex" organisation which assists non-governmental organisations (NGOs) in different parts of the country, and the United Artists' Association, an NGO based in Orissa, focus on very deprived populations. While the approach of AAI is based on the premise that a good health education programme must relate to the socio-economic levels of the people served and amenities available within the community in order to sustain impact, the experience of UAA demonstrates what can be done with limited community resources.

The experience of Action Aid, which has worked with over 200 NGOs in India since 1973, is particularly interesting because it involves a "parallel" system. Rather than work within the school system, AAI runs non-formal education classes for **school-going** children outside of school hours. What is the justification for this, and what are its benefits? Mr. Satyabalan of Action Aid explained.



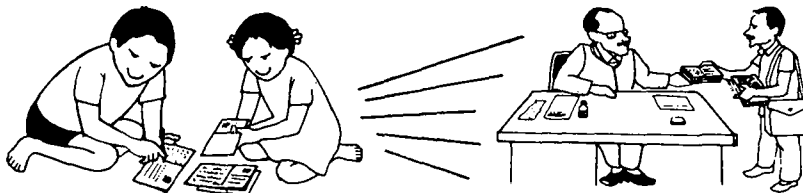
Non-Formal Education for School-Going Children

Action Aid fosters a multisectoral, integrated approach to development. Every project includes community organisation, including the formulation of village committees which strive to improve village amenities, such as wells, transport and street lighting, by interacting with the appropriate government agencies; agriculture programmes to improve for marginal farmers, and income-generating schemes for the landless; health, particularly immunisation, growth monitoring, community and school health services, and community health education; and education.

The need to provide better education to children in rural areas is considered paramount because of the poor quality of formal schools. While health education which emphasises good habits and attitudes among pupils is possible through the activity-based approach, we feel the conditions in formal schools do not permit activity-based learning. Teachers do not have enough experience and training. Thus, to enhance academic achievements, build concepts and give skills, Action Aid started a supplementary education programme in villages which are covered by the comprehensive development programme.

The supplementary education is for two hours daily, morning or evening, with one or two teachers taking one or two classes at a time. The curriculum includes 40 topics relevant to the children's lives, covering all aspects of village life, and includes topics related to science, environmental studies, health and hygiene. We found that teaching health as a separate subject or in the science curriculum is not effective.

The supplementary education schools recruit teachers from local areas, or from nearby towns if there are no local Class VIII-level candidates. The most important criteria for recruitment are motivation, interest, and willingness to live and work in remote villages. They are trained by Action Aid's educational staff. The training is on the job, activity-based, and practice-oriented rather than theory-oriented, so the teachers are equipped with teaching skills. General guidelines to teachers are not adequate—to ensure meaningful teaching it must be programmed minute-by-minute, and backed up by close monitoring. Our educational coordinators visit the supplementary schools regularly. Training and teaching methods have been improved through them. This programme has been going on for two-and-a-half years in Andhra Pradesh and Tamil Nadu. Action Aid is now planning to produce workbooks and materials, and to contact other agencies for help with teacher training in order to expand this programme to other parts of the country.



Empowering Children

The United Artists' Association works in ten blocks in remote areas of Ganjam

Child Power Unleashed by the United Artists' Association

The school health programme was started when UAA found that children could be effective communicators for community health education. We started giving children in 12 primary and middle schools information and skills to communicate health messages. When we found that children who were present at **mahila mandal** meetings appeared interested, we also introduced the teaching of health education in the non-formal schools run by UAA.

A systematic approach is being followed. First, a survey is carried out of the health situation of the school and a three-day meeting is held with the headmaster and teachers of the school at which programme concepts are explained. They are encouraged to draw up a plan for their schools. The next step is the formation of the school health committee. They select a "Teacher Health Guide" in the school who is in charge of the health education programme. A few interested students and community representatives and government health workers in the area, are also included in the committee. The last group helps to draw assistance from government authorities.

The programme functions at three levels — the school, family and community. At the school level, children receive health education from Teacher and Student Health Guides. There is one Student Health Guide for every ten students. Children in Classes IV and V take care of those in the lower classes. The student guides form a health brigade. The brigade selects a captain and vice-captain who receive seven days of intensive residential training from UAA staff along with the teachers.

Health education classes are held during a special period allotted as well as in SUPW, debate classes, and so on. The teachers have developed a syllabus based on the contents of different subjects, with a few additional topics incorporated. The activity-based approach is used. Health records are kept by the student health guides, who check the children's hair, nails, dress, etc. "Clean boy" and "Clean girl" awards are given once a year to the students with the best record.

The syllabus developed by teachers is in three parts, one focussing on the knowledge they want to impart, the second on the media that are used, and the third on the specific activities devised for each topic. For example, on nutrition for Classes VIII and IX, they decided on plays and songs as the media. Different approaches are devised for different levels. At the family level, they may teach about washing vegetables; at the village or community level, they may talk about planting seeds or trees.

The school teachers have developed education materials which have been produced and distributed to other schools. When the teachers realised that one-time training was insufficient, they developed several guidebooks, which are being field-tested before printing later this year. They have wall newspapers, hold health competitions, and give scholarships.

A lot of importance is given to the teacher. Teacher representatives for each zone attend monthly meetings at which they review progress and plan for the next month. Monitoring is important. Teachers report progress at the meeting. A representative then

district, Orissa, primarily with Scheduled Castes and Tribes and fisherfolk, with an integrated approach to rural development. The school health programme was started in 1985 and now covers 235 formal schools and 22 non-formal schools, involving 35,000 children in 187 villages. Sarat Das of the UAA gave interesting details of how school children have mobilised and acted to improve their own health conditions. The programme includes innovations such as "bal brigades," school health funds, and postcards to health officials. This experience also highlights the importance of interaction between NGOs and the government health and education departments to utilise existing resources, and with communities to generate action for health. It shows that if health education is made exciting to children they can carry out its messages effectively, even raising funds for infrastructural improvements from the community.

reports to the UAA, so that the teachers don't feel that they are reporting to UAA. There is a central committee on school health which includes the teacher zonal representatives, UAA personnel and government representatives from the education and health departments. They sit together bi-monthly or quarterly to review the programme and make creative changes.

When children do village cleanliness programmes, the communities encourage and support them. This has happened because UAA has trained village leaders in addition to training teachers and students. They are on the school health committee. They give money, organise melas, etc. The involvement and acceptance of government officials is also important. The Department of Education has issued instructions to the district-level to allow teachers to attend training, monthly meetings, etc.

We feel that it is no use teaching children about sanitation if there are no facilities in the school, so UAA contributes Rs. 1000 to schools which will construct latrines and urinals, if they will raise the rest of the funds from the community. About 130 schools have received this incentive thus far. Others have been given a contribution to dig a tubewell for drinking water.

Every school has a health fund with contributions from children and teachers, and money raised through different activities. Children pay 10 paise per week, or older children pay 25 paise and younger ones 5 paise. Teachers have been motivated to contribute 50 paise or one rupee per week. The bal brigade monitors the fund. Schools also raise nurseries, trees and kitchen gardens and collect money by selling the produce. One school earned Rs. 1500 from their nursery with which they purchased a water filter and a first-aid kit. Another is planning to buy a slide projector and show health slides to the community. In some schools, the children hold lotteries to raise money for the health fund. They stage dramas, focussing on different health messages. Mythological presentations are especially attractive to the community. One school raised enough funds to construct a latrine in the school.

Children go door-to-door to make lists of younger children needing immunisation, they take the lists to the PHC and organise immunisation camps, to which they call the mothers. In one school, children forced the ANM to sterilise her equipment for 20 minutes rather than follow her usual bad practice. They went with the teacher and complained to the PHC Medical Officer.

UAA believes in utilising existing resources. The Medical Officers at PHCs have been motivated by UAA staff to carry out their school health responsibilities. If a PHC MO does not come to the school, the children send postcards to him to remind him to visit their school. A special postcard has been printed for this purpose. The MO usually responds when he receives 50 postcards. If he does not, the students write to the Collector or to the Chief District Medical Officer to ask for help. This has been effective in getting the assistance of the health authorities. A school health card is maintained for every child. This helps if a child is referred for a serious illness — s/he receives proper attention at the dispensary or medical college hospital.

The programme is extremely low cost—all inputs cost Rs. 1.83 per child per annum, an investment that can be made by government or NGOs.



A State-Level Effort

The final presentation was made by Dr. Suraksha Maharaja of the Commissionerate of Health Services in Gujarat. She described the health education programme in the state School System, tracing its origins to the efforts of the CHEB and DGHS to establish health education bureaus in the states beginning in 1965. At that time, a great deal of importance was given to health education for the masses, for school-going children, for workers and labourers, and so on. The Health Department wanted to introduce health as an independent subject, but some state Education Departments did not accept this because they thought it was a burden. The NCERT and CHEB worked closely at the national level, and in some states they collaborated to orient the Secretaries, Directors, and other staff of the Education and Health Departments, and to develop health education syllabi. The State HEBs were to involve both the Health and Education Departments to strengthen school health education. In Gujarat, the SHEB was strengthened with assistance from the WHO, and they undertook a comprehensive health programme in the schools.

Health Education in the Formal School System in Gujarat

The health education programme is aimed at the 6-11, 11-14 and 14-17 year age-groups. The Health and Education Departments collaborate in teacher training. During 1970-75 the Teacher Training Institutes also incorporated health education. A major question was: who should teach the teachers the "scientific" aspects? Workshops are held for all levels. A three-day training programme is held for Medical Officers of PHCs for the Comprehensive School Health Programme. Currently, nurses are also being trained. Other cadres of health staff, such as ophthalmic assistants, are also involved in the programme.

Four colleges give diplomas in Health Education, whose recipients go into the family planning cadre of Health Educators. A secondary school teacher training unit was set up in the state under the school health education division, with a staff including a Medical Officer, a Public Health Nurse, an Epidemiologist, a Sanitary Inspector, Health Educator and statistical personnel. They conduct training at the district level for the school health programme, covering the school health syllabus. It took 4 years to cover 19 districts in the state, orienting 900 Assistant Education Officers, Supervisors, and other personnel. In the VI, VII and VIII Plan periods it was proposed to train 26,000 headmasters of schools using a health curriculum based on the science textbook. However, only 3000 have been trained so far.

The programme has numerous good materials. A cumulative health booklet is given to every child. The programme involves NGOs and medical college departments. The Gujarat Vidyapeeth which runs 10,000 Adult Education centres and covers 26,000 primary school children utilises the same school health education materials. The ISHEP programme runs side by side with the school health programme and the midday meals scheme.



INFORMAL EXCHANGES

As there were many participants in the Workshop who were involved in health education efforts which had not presented reports in the structured sessions, we spent some time learning about their experiences in an informal session. Nandita Kapadia Kundu described the experimental programme being run at Pachod in Maharashtra, in which children are influencing their village communities to change defecation and hand-washing habits for the better. A tale of success and of learning from failure, this experience offers hope for the difficult area of environmental sanitation and hygiene.

Changing Sanitary Habits at Pachod

The Institute of Health Management at Pachod, Maharashtra, runs an experimental "community contact programme" in ten villages in which children are educating adults about hygiene. In an earlier effort in 54 villages, we had found little change in health knowledge or behaviour. The smaller number of villages enables us to work out the details of the approach. School teachers have volunteered and planned the programme. Teaching is limited to one topic — a new topic will be taken up only when change is evident. The teachers chose the topic of defecation as this is an area where change is necessary but difficult to bring about. Defecation occurs in open fields as there are no latrines. The teachers do not interact with the community constantly as they do not reside in the project villages. Balsevaks work in pairs, one wearing placards back and front and the other conveying health messages verbally. Three messages were developed: that people should defecate outside the village; that feces should be covered with mud; and that hands should be washed with soap after defecation.

None of the children had these habits at the start of the programme. We involved them in a situation analysis of defecation sites. They identified sites, measured the distances from water sources, listed households with and without soap, etc. Although 80 percent of households had soap to wash clothes, it was difficult to get them to use it for washing hands. We interviewed 121 women before and after the programme, and found changes in knowledge levels but much less change in practice. For example, while 50% had accepted the use of soap as a desirable practice only 5% covered feces with mud. In this way, the children realised that giving a message was not enough, that they needed to do more to bring about change. They volunteered to make mud heaps at the defecation sites, and even to clean the sites. Unfortunately, as the community did not respond well, this did not work. Although children were disappointed they have persisted through four rounds of information giving. They will interact with the community again after the fifth round, to decide what is to be done.

There is little information about how long it takes for knowledge on any topic to be retained by mothers, children, etc, and what it takes to reinforce the knowledge. At Pachod, we are trying to document all this, and examine the process involved. The children are enthusiastic and want community latrines but we feel that until this demand emanates from the community it won't make a difference.



Arvind Ojha of the Urmul Trust in Bikaner, Rajasthan, described children's involvement in improving the green environment of this desert area. A unique feature of this project is that brothers teach sisters who are not sent to school. D. Rayanna of Osmania University, Hyderabad, discussed the school health education efforts of the Government of Andhra Pradesh, in which non-governmental organisations are involved. The Educational Multi-Media Association in Madras runs a Child-to-child programme for 1500 village children, in which media play a very important role, as Emmanuel Mariampillai described.

Greening the Desert Environment

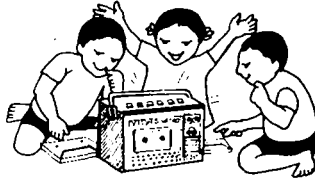
The villages in which the Urmul Trust works in the desert district of Bikaner, Rajasthan, are small and distant from each other. The project utilises an integrated approach to health, education, employment, irrigation, etc. We have started a new programme with children, establishing democratic **bal mandals**, involving all the children in each village. The children decided to plant trees, for which the project gives them Rs. 5 per tree. Thus, if they plant ten trees, they earn Rs. 50 to begin with. For additional requirements, such as the purchase of water pipes etc. they plant more trees. They are also starting small nurseries for vegetables.

The children also decided that they would teach people in their villages, where women's literacy is especially low. While boys go to school, very few of their sisters are doing so. Thus, they decided to teach their sisters at home. This includes health education, such as oral rehydration. The ORT message has spread widely in our villages, as have messages about immunisation and about the health facilities available.

Government and Non-Government Collaboration in Andhra Pradesh

A major government school health programme was started in Andhra Pradesh with Rs. 3 crores. It was planned in detail from the start. A school health card was prepared, and a programme worked out for health check-ups by medical teams. Health education was provided in the schools. On reviewing the programme, various problems were identified. For example, the nutrition of children, their follow-up, sanitation facilities, the school environment, etc. are inadequate. Health education cannot do anything about these. To deal with them, the government has planned the Andhra Pradesh Primary Schools project, which will construct school buildings and other facilities. It is a five-year programme with Government of India and ODA assistance.

One year later, the school health project is beginning. The **mandal** primary health centres (1:30,000 people) have been assigned the tasks of regular health check-ups, monitoring and training. These efforts are being supplemented with sanitation and water supply improvements provided by the **panchayats** and UNICEF. There are not enough resources in the state to take up a comprehensive school health project. Thus, resources have to be supplemented by outside agencies, and in Andhra non-government organisations such as the School Health Association are helping the programme.



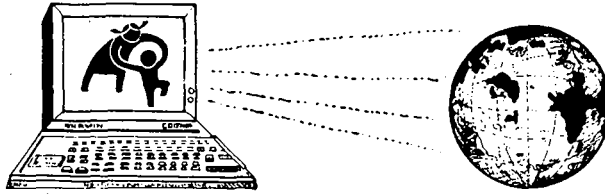
Children of Tea Plantation workers

The Educational Multi-Media Association in Madras is implementing a **Child-to-Child** programme for 1500 children in 29 villages. The children of tea plantation workers are given tuition in the evenings, during which fifteen minutes are spent on health education messages, checking nails and other aspects of personal hygiene. This is done by health workers who are 7th-8th Standard level and have received 40 days to two months training. Every week the workers get together to discuss the programme, and to prepare the topic for the following week. They have been given audio-cassettes which help with adults who have low literacy. EMMA has 50-60 cassettes of songs, drama, **villupattu** prepared by professional artists on health related subjects in Tamil. The children love the songs, remember them, and remember the messages.

On holidays, the children participate in cleaning campaigns in the villages. They have built soak pits. The older ones teach five younger ones. They carry placards in the villages and take out processions to make adults aware of health subjects. If the PHC medical staff don't come to provide health care, the children go as a group to the PHC and demand that the worker come and give immunisations, etc. The project has achieved 90-100% coverage with immunisation in most of the villages because of the efforts of the children.

Brief introductions to their organisations or work were also provided by others. Dr. Kshama Metre told us that the Chinmaya Tapovan Trust in Himachal Pradesh runs an integrated development programme which includes school health, **bal melas**, and a **balsevak** scheme. It provides a vibrant mix of services, awareness and training for various community groups, which are interlinked through the programme. While teachers are usually responsible for health education, in this programme health workers impart health education in schools as well as to mothers who are important health educators of children under five. The MPWs training programme is comprehensive, and the workers have the time as well as the ability to integrate education with health services. They have been very successful. Other health workers such as Health Guides and Traditional birth Attendants are also responsible for health education. These workers could be used more effectively for health education in other areas also. Teachers are also "integrated", but their training concentrates on other educational content. While the efforts are coordinated by the health centre, workers from other Departments, such as Irrigation and Forests are also involved in the programme.

The Tibetan Children's village in Dharamsala, Himachal Pradesh, runs an under-fives clinic, where R.Y. Kyipa is the Staff Nurse. They conduct six-monthly health check-ups, and refer serious health problems to the Kangra Civil Hospital or to the Tibetan hospital. Immunisation is provided. Health records are kept on school children and reports given to the Civil Hospital. Sushma Sharma of the National Institute for the Visually Handicapped at Dehradun pointed out that the handicapped require special health education and that blind children need particular attention.



The efforts of Sulabh International on the sanitation front were described by M. Narasingh Rao. Sulabh works to increase awareness and to provide facilities, usually combining both. The provision of sanitary latrines is important as there are 52 diseases identified which are caused by exposure to human excreta. Latrines are accessible to 5% of people in rural areas and 30-35% in urban areas. In Bombay slums, health motivators pointed out that while they teach people about sanitary latrines, they themselves defecate in open areas! If we want to give health education to children in schools, they must be provided with sanitary latrines. The skills to construct the two-pit sanitary latrines which are being recommended by the WHO and UNICEF can be imparted to children. Thus far, Sulabh has taught women or young adults only, who can earn Rs. 60-70 per day. Other areas of Sulabh's work are: waste-water disposal and community bathing platforms.

The experience of the Voluntary Health Association of India in the area of school health is broad, according to Padam Khanna. In the early 1980s, VHAI held orientation workshops to get people involved, although the concept of children supporting health workers took a long time to be realised. Since then, VHAI has been spreading the idea, helping organisations to develop materials and to run programmes. VHAI acts as a resource centre, collecting materials and sharing them with others to generate more action. They have held poster competitions in schools which have projects, including a joint effort with ARHTAG. Essay competitions have also been held on health topics. A quarterly magazine **Swastya Ke Naye Charan**, was started last year to generate more knowledge. There is a game in every issue. The state VHAs have the "School Health Mirror," a wall chart, to support school programmes.

Rachel Carnegie reflected briefly on the role of the Child-to-Child Trust in London. Ten years ago when CtoC started, the ideas were generated in London, but over the past three to four years there has been a reverse flow. Now the Trust's main role is to collect these ideas and information on the variety of experiences around the world, feed them into the CtoC information base, and send them out again. India has the richest diversity of experiences. Rachel appealed to the Workshop participants to keep the CtoC Trust informed about their work, the materials developed, etc. If people keep in touch, the Trust can expand its role as an information centre as a computer data base in London is used to put people in touch with each other.

In this session, we also heard briefly from our international invitees - Messrs. Ali Talib Kassim, Mohammed Ali Salim, and Abdulrazak Ali Salim from the Ministry of Education, Department of Educational Research and Curriculum Development in Zanzibar, Tanzania. The Department's main task is to cater to the development of the education system which is centralised. Zanzibar intends to introduce the Child-to-Child programme to help reduce the high infant mortality rate in their population. A lack of knowledge among parents and children is an underlying cause, along with a lack of practise of what is known. The Tanzanian participants felt they could learn from India's wide experience, and that their meetings and study tour will help them design their country's CtoC programme.

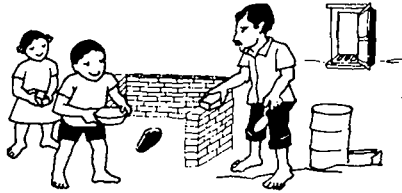
In addition, Sonal Zaveri of the Centre for Research and Development, Bombay, discussed some lessons learned from CRD's evaluation of the Bombay Child-to-Child Project. Professor Devgan of the National Institute of Health and Family Welfare, New Delhi, reflected on his organisation's role in the evaluation of the National School Health Pilot Project, and Dr. M.N. Siddiqui, Principal of a District Institute of Education and Training (DIET) in Delhi, discussed the role of DIETs.

How Children Communicate

In the Bombay Child-to-Child project, we learned something of how children take health education messages into the community. If a child has learnt the message well, s/he is more likely to pass on its contents, and do so correctly. Teaching must be interesting and retention must be complete. The process of activity-oriented inquiry-based learning is important for effective communication. For many children, the opportunity to communicate even in the classroom with peers and teachers is in itself a novel experience. Similarly, in health centre activities if children are able to talk, discuss, demonstrate, they acquire a confidence in dealing with others. This is the beginning of the process of communication for outreach. Children have different abilities. We have to tap individual talents to effectively use them for communication. Some children are more comfortable in drama, some in singing songs, some do not mind meeting face-to-face with mothers. Accordingly, they can participate in different activities. Otherwise, only a few children are able to perform well. Communication therefore depends on how effectively we teach children through an enjoyable experience.

When a child is expected to talk to elders, neighbours, etc. s/he needs to be taught how to communicate respectfully, how to introduce the topic, what to speak about. These aspects were examined at the Malvani project as well. The presence of the nurse, MPW or health centre staff initially helped the children direct these efforts. The credibility of the health message is very important. We are dealing with something normally done by an authority figure — doctor, teacher, etc. The community must be aware that there is a knowledgeable person supporting the child for them to believe the message. In a formal school, we found that while parents were not involved in the programme, children voluntarily talked to parents and neighbours. TV reinforced their messages and helped overcome families' scepticism. Parents in one school came forward and asked for more teaching. This teaches us that we must look at all communication channels through which information is conveyed.

Sometimes communication is incidental. For example, at Mobile Creches, because of the migrant population, they were clear in the beginning that they would not be able to undertake outreach activities. But an evaluation found that children were singing songs and the messages were being registered in the minds of neighbours. Thus, the children were communicating with others unknowingly.



Knowledge and Practice

A survey of schools by the National Institute of Health and Family Welfare revealed that while school health education is being imparted in most schools there is a wide gap between teaching and practice. Children are being prepared to change behaviour but our approaches do not address thought and action equally. The socio-economic and cultural milieu does not permit adoption of new practices. Thought was given to devising innovative approaches to encourage adoption of healthy practices. When we formed a force of school health monitors, school teachers felt they had a guiding role to play. School children built community latrines with the help of voluntary organisations. This aroused community interest. We must examine what is feasible, what and works.

The Potential Role of DIETS

The District Institutes of Education and Training were established under the National Policy on Education. Each of the three DIETs in Delhi has seven departments, all of which are doing something about health education. In the Pre-service Teacher Education Department there are 100 trainees at each DIET. They do practice teaching in schools for about 30 days, and community service for 30 days. They can provide health education in the formal or non-formal sector. A project can be planned for the forthcoming year to engage pre-service trainees in health education. This may involve the three Teacher Training Colleges in Delhi, the Central Institute of Education, Lady Irwin College, and the Teacher's College at Jamia. Other NGOs can also work together with DIETs.

In the Work Experience Department there is also community service. In the in-service training programme, every year about 3000 primary school teachers are trained. During the three-week training programme, three days are devoted to the Child-to-Child concept. Two years ago, after the programme, there was a cholera outbreak. The teachers were able to get the message to children and a pamphlet was distributed through children to families. There was not a single case of cholera among 7 lakh children in Delhi's primary schools. The Curriculum and Evaluation Department has been involved in making activity sheets and slide-tape programmes, using educational technology. There are District Resource Units for Adult Education and Non-Formal Education. The DIETs also train principals and headmasters in planning and management.



A Bouquet of Resources

In another brief informal session we had a chance to describe individual and organisational interests and expertise, and to mention any specific needs. As one participant put it later, "Everyone offered help, but few said they needed it." Although we recognised this as a problem, we felt that a good beginning was made toward identifying the resources that could be shared amongst us in the future.

CHETNA offers training support and educational materials, and help in project development. It has been involved in training teachers, trainers, supervisors and programme heads in formal and non-formal settings. Materials are available in Hindi, Gujarati and English. CHETNA has also been involved in developing curriculum. It conducts workshops and seminars. It can network organisations through its quarterly newsletter. It would like to receive reports and documentation from other organisations. (Indu Capoor)

The Educational Multi-Media Association in Madras has carried out a survey of training centres, resource persons and teaching materials for primary health care which is available in Tamil Nadu and has brought out a catalogue of these. They are helping to set up a resource centre in the state for materials to train village-level workers and people with low—literacy. They have cassettes of songs and dramas recorded by professional artists on health themes. (Emmanuel Mariampillai)

The District Institute of Education and Training at Rajinder Nagar, Delhi, has a Department of Education Technology with computer facilities. They are involved in curriculum and materials development and evaluation, and make low-cost teaching materials and toys. The Planning and Management Department trains principals and head-masters in the management of integrated programmes. The Pre-Service Teacher Education Department trains teachers, incorporating health aspects, and the Work Experience Department offers facilities for field placement and exposure to community service. (Dr. M.N.Siddiqui)

Khel Khiloney develops and produces traditional toys and materials based on folk traditions. They hold material development workshops. (Brij Kul Deepak)

The KEM Hospital, Bombay can undertake training for Child-to-Child and other child-oriented programmes at no cost. They have considerable experience with implementation and evaluation of such programmes, especially in municipal settings and with slum dwellers. They can conduct workshops, but cannot offer accomodation! (Dr. Vijaya Bhalerao)

In the Department of Education, Delhi University there are students doing M.Eds., M.Phils and Ph.Ds. with backgrounds in Health Education, who can help to study, evaluate and

research on-going efforts. The Department could use the help of others in their pre-service training programmes and projects. (Dr. Najma Siddiqui)

The Centre for Research and Development, Bombay has been conducting evaluations of Child-to-Child projects since 1976. It offers help with evaluation, monitoring, planning and documentation. (Sonal Zaveri)

The Centre for Learning Resources, Pune conducts research and evaluation. With the help of faculty and students in Teacher's Training Colleges it can do quick surveys. It can help with in-service training, which it suggests should be broken into 5-8 days courses during programme implementation. (Dr. John Kurrien)

The National Society for the Prevention of Blindness at Delhi is a media resource centre for the prevention of blindness. They have worked with children in slums. Mr. Parthasarathy also mentioned that the **South East Asian Regional Bureau of Health Education of the International Union of Adult Education** can disseminate information through its journal and can assist in conducting small studies and in in-service training.

Mobile Creches, Bombay runs a one-year training course for grassroots workers in child care and preschool education. Its training extension unit can help with in-service training for organisations working in slums, or with migrants. It has experience of training trainers and workers. A range of materials are available, including games and a game book, songs, trainees and workers' manuals. (Dr. Indu Balgopal)

The Voluntary Health Association of India at Delhi has an information and documentation centre, and disseminates materials. It has had considerable experience with school health among many subjects. In addition to the health magazine it brings out a newsletter for village health workers in Hindi, and plans Bengali, Gujarati and Tamil versions. Another newsletter is intended to sensitise development groups who are not involved in health. The national and 19 state VHAs are involved in training programmes. (Taposh Roy, Padam Khanna)

The Child-to-Child Trust, London has a newsletter with information from 70 countries around the world aimed at networking CtoC efforts. It also produces CtoC activity sheets and readers for primary schools. (Rachel Carnegie)

The Institute for Rural Health Management Pachod, Maharashtra can help other organisations initiate child-centred education programmes based on their experience with a **balsevak** programme. It runs short-term training for workers involved in health, nutrition, water and biogas programmes. There are facilities to board up to 30 workers. It also undertakes research and evaluation. Their newsletter gives details of their programmes. (Nandita Kapadia-Kundu)

The Commissionerate of Health Services Gujarat proposes a regional clearinghouse for health education material in Gujarati, especially for school health programmes. (Dr. Suraksha Maharaja)

The Department of Human Development and Family Studies at M.S. University, Baroda does training, research and field testing and has been involved in curriculum development in the areas of infant stimulation, early childhood education, child and family welfare and human development. They can help with research and programme formulation (Indira Mallya)

Dr. Meera Chatterjee, a health and nutrition scientist and planner working as an independent researcher and consultant, offered to assist with documentation, research, data analysis, and programme planning, analysis and evaluation. Her ongoing research also benefits from interactions with field programmes!

The Central Health Education Bureau, Delhi is a national level resource centre which develops and disseminates training and education materials, and has a newsletter which could network agencies. (Mrs. C.K. Mann)

The National Council for Education Research and Training, Delhi is engaged in developing curricula and integrating health education into existing curricula and textbooks. They have had first-hand experience of implementing Child-to-Child projects in the municipal schools of Delhi. (Dr. R. Murlidharan, Mrs. Shukla Bhattacharya)

The National Institute of Health and Family Welfare, New Delhi offers expertise in research and evaluation. (Prof. A.K. Devgan)

Mr. Rayanna, a freelance consultant, can assist in developing health-centred curricula for schools and in planning and initiating health education programmes, based on his experience with the government education department.

The Chinmaya Rural Primary Care and Training Centre in Himachal Pradesh offers the opportunity to learn first-hand about integrated rural development and can help with training and research inputs. (Dr. Kshama Metre)

The Aga Khan Foundation, New Delhi and Geneva provides financial assistance for innovative projects and experimentation in the area of health education, among several others. They can also help to disseminate education materials developed by the government or by NGOs. (Dr. N.A. Siddiqui, Rajni Khanna, Dr. Judith Evans (Geneva))

The World Health Organisation, New Delhi can provide information about on-going health education efforts and new developments at the global level. (Dr. Saroj Jha)

UNICEF, New Delhi can provide financial and technical assistance for innovative approaches to health education. It disseminates education materials developed in house, by government agencies and NGOs. (Dr. Sheila Vir)



An Exhibition of Child-Centred Health Education Materials

A special feature of the Workshop was an exhibition of child-centred health education materials. Participants had been requested to bring along with them any education materials they had developed and used in their programmes/ projects. Fifteen organisations responded with enthusiasm, including the Chinmaya Rural Primary Health Care and Training Centre, CHEB, CHETNA, the Child-to-Child Trust London, KEM Hospital Bombay, Mobile Creches, the Municipal Corporation of Delhi, NCERT, People's Education and Development Organisation Rajasthan, UNICEF, VHAI, VHSS Bangladesh, and WHO. The result was an interesting and varied display of colourful posters, attractively illustrated pamphlets, games, puzzles, puppets, and the like. There were exhibits made of simple materials such as beads of cereals and pulses. Activity sheets, books, readers, newsletters, magazines, journals and photographs were also exhibited.

CHETNA designed a special exhibit of eight picture posters depicting its three-year experience of implementing child-to-child projects through rural and tribal schools and non-formal centres. Other special educational aids which had been developed and used by CHETNA such as a bioscope and a fortune-telling parrot, were also exhibited.

Setting up the exhibition was a cooperative endeavour between CHETNA and VHAI, with material support from the CHEB. As the exhibits were mounted at the venue of the Workshop, participants and invitees could view them leisurely, and appreciated them greatly. Hearing of the exhibition some Delhi schools requested the organisers to allow their teachers and students to tour it. Thus, this aspect of the Workshop reached out to many others as well.



OUR COLLECTIVE THOUGHTS

Our discussions of the issues raised by the review presentation and the project experiences were rich and rewarding. The participants recognised that, though varied, the projects had many aspects in common. Many of the problems faced by projects were similar, but their solutions differed. For example, several projects found it difficult to involve teachers in activity-based health education, but while some utilised painstaking approaches to get teachers to participate by demonstrating the benefits to them, in other projects material incentives were utilised. The participants felt that the projects had demonstrated how teachers can overcome resistance to additional activities or to teaching another subject. The view was expressed that incentives should not be provided to teachers and medical officers, etc. for their regular work, of which health education is a part. Several projects have also demonstrated how health education topics can be integrated across the curriculum. Rachel Carnegie of the Child-to-Child Trust in London referred to similar trends in CtoC projects in Africa, for which a series of books entitled **Health into Maths, Health into Science, Health into Language**, is being developed.

When teachers complain they are overworked we must ask: How can we help them teach what they have to? We can help wherever health-related topics appear in the curriculum. Health education does not need a "health course" but can be done through reading, in mathematics or science. Teachers can demonstrate quarters by cutting a papaya - and can —add that a quarter of a papaya has enough vitamin A for a person for a day. This is more meaningful than the concept of International Units and saying to children that they need 5000 I.U. of Vitamin A a day! A whole set of activities can be designed with health and nutrition messages integrated for teachers to teach what is necessary. "We should help teachers teach and not expect them to do the health department's job"!

Another problem is that teachers have too many non-teaching tasks, such as conducting surveys for the issue of ration cards, motivating cases for family planning, and so on. He or she **has** to do these or face the censure of their supervisors. The Workshop participants felt strongly that teachers should not be given these other jobs, so that they can devote their time to teaching, including health education.

On Training. Although health teaching is expected to be integrated, teachers are sent for separate training programmes for each new "thrust area". They are expected to teach them all without being taught how to integrate the topics into their teaching-learning strategies. This approach must change.

"Cascade" or top-down training is being rethought because of the problem of knowledge being garbled or lost by the time it reaches from the 'top' to the 'bottom'. Although changes are being made in this approach, challenging old ways is difficult.

On the use of Technology. Although technology could be used to shift dependence from the teacher (which may be desirable because of their resistance and low motivation to adopt new ideas and methods), this is not possible everywhere in a poor country like India. So, the only alternative is to organise and structure the curriculum so that atleast minimum health/nutrition/environmental education takes place in schools.

On Curriculum. In the wake of the NPE, most of the "survival skills" important for children have been included in the curriculum—health, environmental sanitation and environmental protection topics.

On Training Materials. There are well-written books on health education which give activities, but they are not accompanied by teachers' guides. Consequently, while the "what" of health education is given, the "how" is missing. When teachers' guides exist they may not be available to teachers. Thus, in addition to training and able trainers, appropriate instructional material is required.

Focus on the Child... While health education involves teachers and health workers and efforts focus on how to motivate them and how they pass on the information, health education **for and by children** must not lose its focus on the child as the main beneficiary of the programme. It is the child who must enjoy learning and be able to use the learning to gain mastery over his/her own health and immediate needs. We must encourage him/her to develop a better understanding of the world s/he lives in. If the child remains the focus of what we are trying to do, then we will be able to plan our programmes and think about the results in that manner.

....the Whole Child..... Another crucial point emerging from the presentations was the need to look at the "whole child." Besides physical health and nutrition, health education should include social, emotional, psychological and mental health. Environmental and cognitive education are also important. Infant stimulation activities are as important as health, hygiene and nutrition, and must be done simultaneously. The NCERT is weaving this message into the training of State Coordinators for the Child-to-Child programme — but it may be easier for **them** to accept (because they are all educators) than it would be for others (eg. health workers). There is a need to work out how the CtoC approach can address the developmental needs of the young child. Older children can help to stimulate the development of their younger brothers and sisters, but they too have developmental needs. Through the CtoC approach both groups of children could be stimulated.

...but don't overload the child. Children are health messengers because they look after their young siblings at home from as early as the age of six. The Child-to-Child approach is based on the premise that we can help them do this more systematically, to be more knowledgeable and more skilled at it. But we must not overload the child. Children have a large volume of formal school learning, with the syllabi getting larger and more complicated. Many children do nothing else other than go to school, do homework, eat and sleep — there's hardly any time left for being a child at all. Recreation, play and self-time are important for a child's growth. Unless we provide this time the child will not be able to do anything for anyone else. Thus, in the messages they should be doing something for themselves also — improving their own lives, their horizons, their knowledge. The needs of the child and the "use" of children as change agents are not incompatible if education is really integrated.

Children learn by example. Children like to identify with teachers — if the teacher has good health and food habits, the child will adopt those habits also. Thus, teachers should be taught good habits. Furthermore, schools (and ICDS *anganwadis*) need basic amenities like clean water and toilets which help teachers teach and children learn.

Minimum Levels of Learning. Over the next two decades, most children will receive atleast five years of education. In this context there is a need to identify the basic knowledge and attitudes that can be provided for health and nutrition. This must be done for different levels, as is done for languages and mathematics, etc. It is not possible to put everything into health education. It is possible to train teachers to impart "minimum levels of learning" in primary schools and non-formal education. We should also then be able to hold teachers accountable for imparting this information.

Knowledge Must be Up-to-date... Over the years there has been a very limited amount of health, nutrition and environment education in the school system. Some is incorrect or obsolete as knowledge keeps on changing and improving. Children learn what the teacher says, so it is important to make sure that messages are meaningful, down to earth and up-to-date.

.....and Messages Credible. There is a need to make health education topics simple and appropriate for children — we cannot simply use the messages which were devised for mothers. There must be an authoritative figure backing the message, and the opportunity must exist for it to be communicated and practised.

One Topic at a Time. A key 'message' to us was that teaching should focus on one topic at a time, preferably moving on to another only when change is seen.

For the out-of-school child the most important message from children who go to school should be to come to school. Although giving health messages is important, it should not be a substitute for going to school. Although Child-to-Child is a good way of learning, children must be brought into the school environment.

On Non-Formal Centres. The fact that NFE centres are run for only two hours a day is a constraint to introducing health education in their activities. This time, it is felt, is for formal learning. In addition NFE workers are poorly paid at about Rs. 105 per month, so it is difficult to ask them to do anything "extra". Thus, the challenge is to motivate them to adopt the Child-to-Child approach and conduct activity-based education in this context.

The "How to?" It's not only the messages, but **how** they are going to be delivered that is important. Which are the agencies that will deliver them? What inputs are required ? The strategies differ in school and out of school; informal and non-formal settings, in the home or outside.

The Participatory Approach. Many projects highlighted the participatory approach. Child-to-Child brings about active participation in the classroom, but the participation of teachers and families at the grassroots is vital. So also of policy-makers at the top. However, participation is not adequately documented.

On Mothers. Although mothers are the most important child health workers, we don't give them responsibility, nor adequate education to take on this responsibility.

The Role of Demand. Demand plays an important role in the success of health education. Several projects stressed that they only do things when people demand them. Even demand from children contributes to the success of efforts.

"School Health" or "School Health Education?" The confusion between them may be one of the biggest impediments to a successful school health education programme because school health involves "Pills and bandages" the teacher "becoming" a doctor, and so forth. The School Health Programme includes school health education, health services, a healthy environment, and nutrition. To strengthen health education in the school health programme. It must be made conceptually clear to everyone. Health education is the development of healthy habits from childhood, and so it should not be approached piecemeal but introduced systematically in the formal and non-formal education systems. Although health education is a discipline on which all public health programmes have been developed, it has been neglected, so many programmes have failed in the process, even the malaria and leprosy programmes, for example.

On Integrating Health and Education Services. There were some key examples of actions which helped to integrate health and education services better, such as the postcards and referral system employed by the UAA. An attitudinal change is required among teachers for them to take responsibility, talk with parents, and undertake liaison with health professionals to provide health services. However, the issue of whether teachers should distribute medicines or not is an on-going debate. While this can extend the reach of health services, teachers have limitations. It is difficult to get doctors to come to schools for health check-ups for which a new approach is needed. But what is good the health check-up? There is never enough time to examine children properly to identify abnormal weight, behaviour, posture, hearing etc. Is the school meal programme a health programme or a political programme? Does it contribute to health or to the learning of good health behaviour ?

The KAP Gap. There are gaps between knowledge and practice, due largely to the socio-economic milieu. Providing infrastructure can help to close the gap partially. This may be particularly important in the area of sanitation, where motivation "software" should be accompanied by the provision of hardware (i.e. latrines). Another way of stating this is the need to integrate services and awareness creation.

On Health and Development. All health issues ultimately boil down to social and economic issues and are closely related to the country's development. Although economic conditions may not be conducive to health, nutrition and sanitation, if we are able to give sufficient knowledge and skills so that people select the right kind of food within their purchasing power, and organise their lives in a way that they can remain healthy within their means, then we are doing well. As educationists, and health workers we cannot change the social and economic environments, but we must deliver health messages as best as we can.

On Extending the Reach and Effectiveness of Projects. When we have a good community project and once we have done a lot for one community perhaps we can use

"child health visitors" to visit other communities, such as rag-pickers who need health and activity-based education.

Although there are a lot of Child-to-Child projects, teachers in the system are not reached adequately. If a project is associated with a teachers' training college, an attitudinal change could be brought about during the pre-service training. If teachers can be made to take pride in and feel responsible for health education when they are young and enthusiastic, they will do it on their own when they go into service.

The Child-to-Child approach is also being implemented within the ICDS programme in Goa, and in TINP, where programmes are aimed at the pre-school child. Interaction with them, offers an additional way of extending the reach of school-age programmes. The lessons learned within other health education efforts in ICDS may be useful to the school health education efforts. The ICDS scheme proposes to introduce adolescent girls as helpers of **Anganwadi** workers, in 14 blocks on an experimental basis—another form of "Child-to-Child".

Youth-to-child is another interesting possibility. The NCERT has tried this with talented university students during their summer vacation. Some who were interested or had experience working with children were involved in developing play and enrichment programmes for primary school children. The younger children enjoyed the presence of the older youth and related well to them.

The Role of Mass Media. Mass Media can play an important role in conveying widely the message that children learn by doing, as well as in reinforcing the messages that children are taking to their families and communities. There is a great deal of unused potential here.

On Duplication. There is some duplication of effort in the health education arena. For example, some Central government-sponsored pilot projects run side by side with states' school health programmes. The Gujarat health department has evolved their own health education, which differs from CHEB's ISHEP, for example, in training duration, incentives, etc. and both programmes run side by side.

On Expansion of Health Education Efforts. Although the programmes discussed were seen as "islands of hope in a continent of despair", participants agreed that health education is spreading.

Cost considerations are important to replication and expansion, but we have little information on programme costs. The UAA experience suggests that effective measures can be implemented at an affordable cost, but there is the question of whether low-cost investment in the large public systems will produce the same results as in the non-governmental sector.

On Funding Agencies. One educationist felt that "even the best of funders do not think that education is as important as health and nutrition. It is easier to get funding for projects focussed on health and nutrition but we have to beg for funds for education projects, although everyone says that education is the only thing that pays dividends in the long run. Clearly, this deserves rectification.

Evaluation. Within Child-to-Child we tend to emphasize the child's role as communicator within the school setting. But what happens when the child goes into a non-formal setting and gives a message to parents or siblings? What is the concomittant behavioural change? Although some projects have monitored this, we need to gauge this more broadly.

On Project Development. The experience of failure is an important tool in teaching.



THE WORKSHOP'S RECOMMENDATIONS

On the afternoon of the second day of the Workshop, we broke up into groups of 12-15 to discuss some specific topics in detail, and evolve recommendations. These were presented and finalised the following morning at a plenary session. They also formed the basis for our interaction with policy-makers and government officials on the final afternoon of the Workshop.

Group 1: Worker Selection and Training

Identification of Workers. The group identified the different types of workers in the "Formal" and "Non-formal" systems. Workers at the highest level in the formal sector are those in the nodal Departments of Health and Education (at the Central, state and other levels), and in peripheral agencies such as Public Works, Forests, Social Welfare and Human Resource Development. In the non-formal sector, this group includes project holders, managers, and coordinators. Government policy-makers, civic authorities and funding agencies are also involved. At the middle-level are health personnel—doctors and paramedics, Education Officers, BDOs, CDPOs and teachers. Finally at the grassroots (or "concrete") level are workers such as **dais**, NSS volunteers, **balwadi** teachers, and communities in the formal sector; and in the informal sector, "anyone who is willing to work".

Worker's Qualifications. In the formal system, although qualifications are specified in detail, aspects such as the candidate's motivation, dedication, sense of involvement, creativity, innovativeness, communication and listening skills deserve greater attention in the selection process. In the non-formal system, willingness to work and "staying power" were considered very important.

Selection. In the formal sector, the basic educational qualifications cannot be circumvented. In the non-formal sector, the minimal requirement was considered to be "someone who could read and write", beyond which a "KAP" examination, evaluation of expectations through an interview, and perseverance act in a process of "natural selection". In the non-formal sector, the rewards are self-esteem, acceptance by peer group, etc. In the non-governmental sector, it is believed that "anyone who comes can be trained".

Training. Higher-level training is virtually impossible in both sectors because in the formal sector it is highly structured, while in the non-formal sector everyone should be trained. Middle-level people require orientation and refresher courses. Training of trainers and of implementors should also be done. Content training can be given through literature, mass media, workshops, symposia, etc. More important is attitudinal training—for competence, communication skills, creativity, support of subordinates, field orientation, social acceptance, sensitivity and motivation.

Seventy-five percent of training should be on the job, which is difficult in the formal sector, in part because resources are limited. Field training has to be in a well-structured well-run programme, an "ideal situation". In the non-formal sector, training should be 4-5 days in the initial period, reinforced at frequent intervals. It is necessary to monitor and alter the training on a continuous basis. In the formal sector, training is 3-4 days plus one-day quarterly at the school-level and centralised for one day a year later. Because of the scale of programmes it is not possible to do it more frequently. Instead the use of media and literature can help once personnel are exposed to training. In participatory training an optimal number of trainees is 30. In the formal sector as many as 50 may need to be accommodated, but they should have repeated refresher courses.

Group 2: Media, Materials, Messages, Methods, Communication

1. All children in the formal and non-formal systems should achieve certain minimal levels of learning in health and nutrition. There should be testable knowledge and behavioural components. This will also help teachers to be more aware of what should be learnt and also make them more accountable.
2. Methods should be activity-based and interactive, eg. theatre, puppets, flipcharts, audio-visual slide shows, etc.
3. Teachers should be provided with appropriate materials for health and nutrition education. There should be scientific pretesting of materials and media before they are reproduced and disseminated in bulk. Teachers should also be provided with the skills to develop the materials, at national, state and local training workshops.
4. Pre and in-service training should give the requisite content and skills.
5. There should be national and state-level committees which review the existing training programmes and materials, including textbooks, and suggest whether new materials should be developed and how materials can be incorporated into the system. The committees should have representatives from government, NGOs and experts in the field of health and nutrition.
6. Resource centres should function at the national and state levels (eg. CHEB or NCERT) for easy access to materials. They can link up with the DIETs at district level, and collaborate with other agencies. Different tasks should be assigned to the different levels. The current system requires rationalisation, and existing agencies should play their roles more effectively.

Group 3 : Coordination and Networking

The main issue discussed by the group was how to maximise use of available resources of manpower, materials and money. The group recommended that:

1. The newsletter of CHEB which should include information on published materials should be disseminated widely.
2. The papers presented at this Workshop should also be disseminated.
3. A directory of available resources (human, training centres, materials, etc) should be published by some agency.
4. Key people involved in government and NGOs should be identified to mobilise human resources.
5. Self-reliance should be encouraged at the local level, ie. the use of local resources. Government and international assistance should help this process. Government funding should be more flexible.
6. State-level meetings of government and NGOs should be held once a year, and district-level meetings more often.
7. Media such as radio and TV should be used for networking, and feedback from listeners should be emphasised. Networking is also required at the national and international levels.

Group 4: Monitoring and Evaluation

Evaluation should be an on-going process, with both quantitative and qualitative components. However, large-scale projects may not be able to implement a qualitative component.

M&E should occur from the inception of projects, beginning with a baseline, through the planning and implementation phases. There should be joint participation of implementors, evaluators and funders. Methods must be developed to facilitate this process. The success of M&E depends on the motivation of functionaries who should be part of the system.

The tools for the collection of information should be simple. Existing staff or children may be involved in collection of data. Training should be adequate for consistent and reliable data, and findings should be utilised.

All action projects need to have a research component as the experience of project needs to be understood in greater depth. Process documentation is especially important. This will help to identify effective methods, materials and tools. Findings should be

disseminated. Academic research and training centres should be involved in the evaluation of projects because they have access to information which can be useful. A nodal agency should be identified to set up a data-clearing house, to collect existing tools, eg. schedules, checklists, etc. experiences through observation, and information about projects. Information can be edited and classified to enable ease of dissemination to other projects. Such information could guide projects to improve.

Group 5: Parent Education and Community Participation

The group defined "parents" as those of school children, "community" as all families at large, and "participation" as the process by which the community can prioritise problems, evolve solutions and assume responsibility, measured ultimately by the amount of change in practice and the demand generated.

The topics for parent education were considered to be community-specific, dependent on the epidemiological profile of the community, major morbidities and mortality. They should include infant stimulation, ie. what parents can do for the emotional development of infants. It was felt that the community and parents should be informed about the potential of the child as a communicator. Education must remove gender bias.

Implementation includes the selection of children and assessment of their talents at the beginning. Follow-up of messages given by children should be the key criteria for the assessment of such programmes, and should be included from the beginning.

In short:

1. The credibility of children as educators must be formulated from the start, systematically established, and the community prepared for it.
2. Messages to parents and community must be monitored and evaluated beyond delivery.
3. Demand must be created for the programme, and teachers and children must be linked with the formal health system so that services are provided when demanded.
4. The Child-to-Child approach must be incorporated into electronic and folk media to reinforce the message to parents.



A SESSION WITH POLICY-MAKERS

The final afternoon of our three-day Workshop was spent interacting with government officials and policy-makers. The purpose was to apprise them of the proceedings of the Workshop and its recommendations in order to encourage and facilitate further action in the area of health education for and by children. Dr. Siddiqui of AKF welcomed the participants, explaining the inception of Child-to-Child projects in India and of the Workshop. He posed the question, "Where do we go from here, and how?" Indu Capoor of CHETNA gave a brief overview of the Workshop's structure and participation over the first two-and-a-half days and then requested some of the participants who had been present to share their views on the Workshop. After this exchange, Dr. Meera Chatterjee presented the Workshops' Recommendations to the group.

Participants Say Something About the Workshop

"The Workshop was interesting because of its wide representation, including many people whom we were meeting for the first time, who have been doing good work. There was a good mix of government and NGOs, some miniscule projects and also very large programmes. The Workshop focussed on the point that health education is an integral part of a child's learning. It was the first time a national workshop has discussed health education by children. It dwelt on the role of the child as a change agent in the community. The activity approach was strongly advocated. Most projects used activities as the key approach to convey health messages to children. We discussed training, monitoring and evaluation, parent education, coordination; and some major recommendations have emerged".

"Health education is a large area. We discussed minimum levels of learning, which have to be worked out for the area in which the programme is to be implemented. In health education we are dealing with the health and education sectors. While we may approach it from the health or education side, unless we are able to inter-link the workers at the level where they are teaching the children, they may not be able to convey the messages. We should have a philosophy of learning that makes children enjoy what they learn so that they retain it better and can communicate it to others. Not only did we talk of health and education, but of the child at the centre."

"I came to this Workshop quite ignorant of the Child-to-Child approach and of everything going on. But we have learnt what a great potential the concept has. At the same time we have also been concerned to come up with strategies which could be applied on a larger scale and not only in small pockets where we (NGOs) are working."

"For many organisations which are isolated from each other, this was an opportunity to interact with others, learn from them, share experiences — a good forum where everybody could meet and offer help. We have a long way to go to realise what the lacunae are and take help from each other. Interestingly, everybody offered help, nobody wanted help! That sums us up."

Some Key Recommendations

On Workers : Regardless of the formal qualifications that any system may require of its workers, the most important criteria for selection are motivation, dedication, willingness to work in difficult situations, involvement in the work, and interest. Workers should have communication, including listening skills. These characteristics can be looked for in interviews, which is done successfully in the Mahila Samakhya Programme.

On Training : Training of trainers is critical. They should have regular exposure to content in both pre- and in-service training, as well as in the form of literature, media and materials which they get regularly. More important is training to engender the correct attitudes in workers, which must be sustained over time. Training must be field-oriented. The smaller and more participatory the training group is the better. As NGOs have had success training trainers and in attitudinal training, government programmes should draw upon their experience. Training on-the-job is also extremely important, but the training situation must be a structured one for workers to fully understand approaches and get good habits.

Materials, Messages and Media: The messages should be decided locally, within the following four areas: personal hygiene, environmental sanitation, locally-important diseases, and nutrition. Learning should be aimed at the concept of minimum levels, activity-based and integrated into the curriculum. The interactions amongst children, and between them and all others are important, and can be engendered by dramas, street plays, puppetry, **balmelas**, street processions etc. Teachers should be provided the skills to develop materials themselves. For the large amount of material already available Resource Centres are needed at the national, state and district levels. Existing institutions playing this role should be strengthened following a rationalisation of the system within each state, and networking should include NGOs.

Monitoring and Evaluation : M&E should be conducted jointly by implementors and evaluators, be built into programmes, and should be from the perspective of the community. The process could be made simple by a data and/or survey-instrument bank so that the current duplication of effort is eliminated.

Coordination : Both government-non-government and health-education coordination are important. New modalities are needed, such as joint training of workers. Integration must also take place in the minds of workers who will be motivated to coordinate if they are convinced of its benefits, which is a function of training. There is scope for more exchange between government and NGOs through workshops, newsletters etc.

Parent Education and Community Participation: The use of mass media should be expanded for the purpose of preparing communities and families for health education for and by children. All workers also have a role in community preparation. The success of efforts lies in changes in practices, which should be monitored at the community level.

During the discussion that followed some points were stressed, and others added.

The need to change the **attitudes of teachers** through training programmes, and to make health an integral part of education, weaving in the messages, and based on the activity approach was stressed. Kiran Dhingra of the Department of Education added that a holistic view should be taken of changes needed in the classroom in teaching methods, practices and approaches to the child. Training should equip teachers with skills for interactive teaching. Child-oriented teacher—training must be continued in the VIII plan.

The **multiple tasks of the teacher** must be reduced or eliminated.

The relative effectiveness of changes in **pre-service and in-service training** were debated. It was recognised that as resources were limited, choices needed to be made on this score. The inability to continually withdraw teachers for in-service training was acknowledged, and so the need for integrated in-service training was signalled. Greater orientation of trainees in pre-service training institutions for activity-based teaching is also required, though the gaps between pre-service training and employment, and its contents and the real situation in school were pointed out. Ultimately, it was felt that we cannot work only on pre-service or in-service training because all teachers are part of the system and influence each other. However, the problems of doing both in the same institutions, such as the DIETs, were acknowledged.

The **selection of trainers** needs to be examined—they should be people with experience of teaching.

The need to identify **essential learning outcomes** and the specific inputs necessary to achieve, them is paramount.

Convergence of services at the field level requires considerable strengthening. Dr. K. G. Krishnamurthy of the Planning Commission said that the Commission is working on how to integrate the activities and workers of 16 schemes concerned with women and children, including health and education. Interdepartmental coordination certainly deserves more attention.

There is need to address the specific **constraints of girls**, to devise strategies to collect and address **children who are out-of-school**, and to enhance the capability of **non-formal education centres** for health education. The strengthening of NGO involvement in the non-formal system was considered desirable.

There is scope for introducing **teams of children** and sending them to target households to give health messages.

The use of **mass media** such as television to publicise "model" experiments was mooted. TV could also have a serial about health during prime time or a regular "feature" programme, though it may not always reach those on whom we need to focus.

The need to dovetail the **experience of small NGOs** with that of the government system, i.e., involve them in the larger effort, and enhance government support to them, continues. The areas of collaboration that have been identified are: NGO support to government for

training of trainers; sharing of information which is collected by government and NGOs; and government support to NGOs for innovative programmes. It was suggested that state governments should network NGOs working in pre-school education, Child-to-Child, etc.

The expansion of Child-to-Child approaches in the ICDS system should be encouraged, as it was recognised that the earlier activity-based approaches are introduced to children, the better. There is experience to show that this is feasible. It could be done through a few Anganwadi Training Centres which are known to be more innovative. Replication on a large scale may be a problem but training supervisors makes it possible to reach more Anganwadi workers, than by training them directly, even though supervisors may not be as "close to the grassroots" as is desirable.

Some Messages We Carried Away

"We are all fellow travellers trying to reach the same goal."

"We cannot have health without education, awareness creation."

"Everybody—the poor and rich, young and old — agrees that education makes a difference as far as health is concerned. However, while messages have gone to the remotest parts of the country, it is difficult to change practices.

"The complexity of issues related to health education efforts is greater than immediately meets the eye".

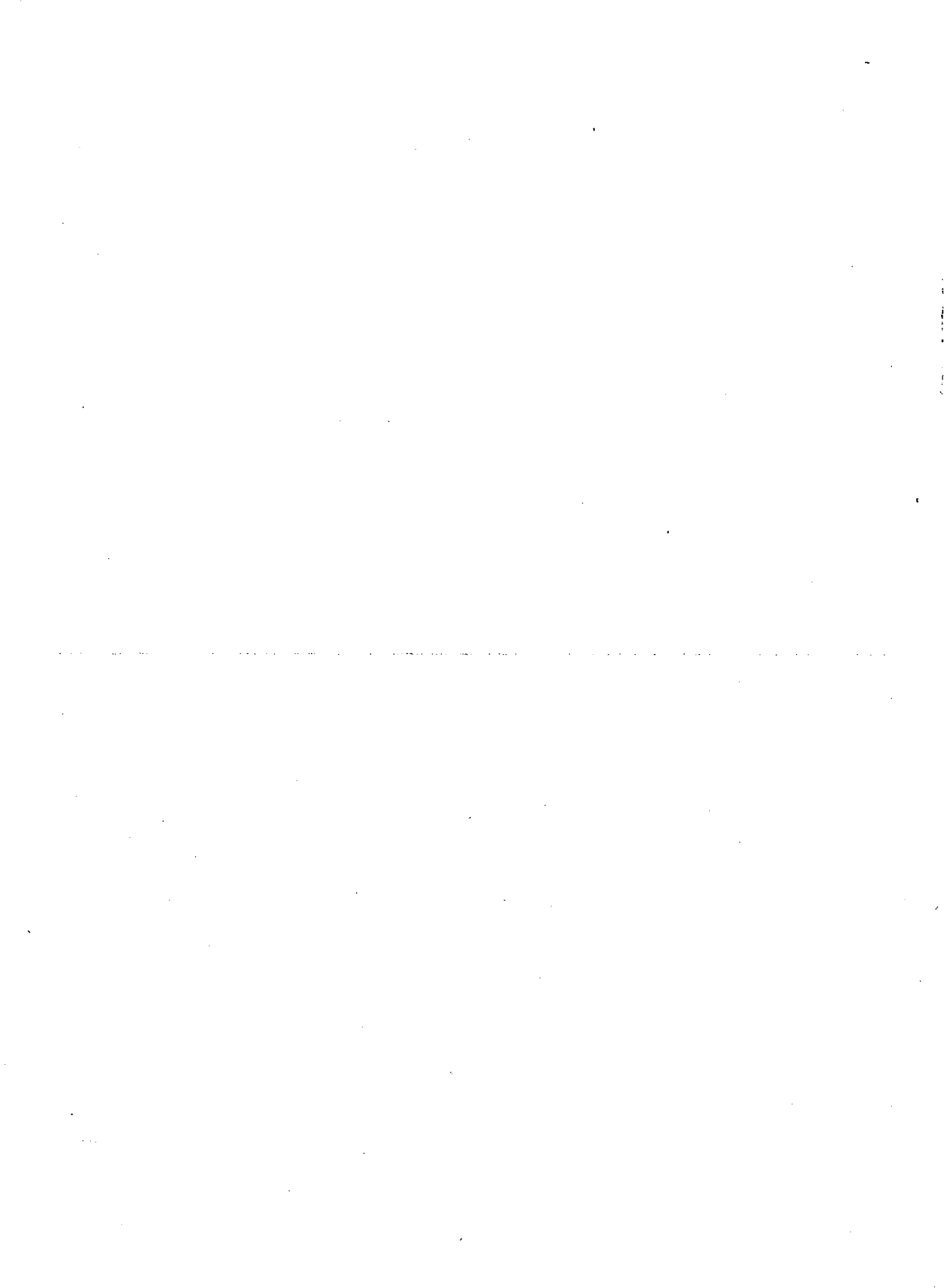
"Every time we hear about these projects we learn something new."

"We must provide everything which we think every child has a right to have."

"Children are here to stay as communicators, and projects will have to continue to use them without exploiting them in any sense. They are a resource that should be used constructively."

"Be positive about the possible."





APPENDIX A

The Workshop Programme

First Day: 24 April 1990

Registration

Welcome by Dr. N.A. Siddiqui of AKF(I)

Inauguration by Children from MCD Schools

Rationale and Objectives of the Workshop by Minaxi Shukla, CHETNA

Introduction by Participants

Background Paper Presentation by Drs. Meera Chatterjee and Deepa Grover

Experiences of Child-Centred Health Education Programmes in Urban Areas:

MCD Schools Project - Dr. R. Murlidharan, NCERT

Malvani Slum Project - Dr. V. Bhalerao, KEM Hospital, Bombay

Mobile Creches Bombay - Dr Indu Balgopal

Experiences of Child-Centred Health Education Programmes in Rural/Tribal Areas:

ISHEP - Mrs. C.K. Mann, CHEB

CHETNA Projects in Gujarat and Rajasthan - Minaxi Shukla, CHETNA

Tamil Nadu Integrated Nutrition Project - Jayshree Balachander, TINP

After Dinner Session on Health Communication Strategies - PEDO/CHETNA Team

Second Day: 25 April 1990

Health Education in Formal and Non-Formal Settings

NHEES Project - Mrs. Shukla Bhattacharya, NCERT

Gujarat School Health Education Programme - Dr Suraksha Maharaja

Action Aid Experience-Mr. Satyabalan

United Artists' Association - Mr. Sarat Das

Free Communication Session

Simultaneous Small-Group Discussions

Group 1: Worker Selection and Training

Group 2: Media, Materials, Messages, Methods and Communication

Group 3: Coordination and Networking

Group 4: Monitoring and Evaluation

Group 5: Parent Education and Community Participation

Presentation of Working Group Reports and Recommendations

Third Day: 26 April 1990

Resource-Sharing Session

Comments on the Workshop

Field Trip to Delhi Municipal Corporation Schools

Session with Policy Makers

Participants Talk about the Workshop

Presentation of Workshop Recommendations

Discussion of Follow-up Action by Agencies Represented.

APPENDIX B : Workshop Participants

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APPENDIX C
AKF(I) SUPPORTED CHILD-TO-CHILD PROJECTS IN INDIA

S.No. Name of Project	Location	Principal Implementors	Type of Centre	Principal Instructors	Number	Target Group	Number	Health Topics	Other Activities	Evaluators
1. Meghraj Project	GUJARAT Sabarkantha Dist. (Rural)	CHETNA Sewa Mandal	12 Non-Formal Education Centres	CCF Teachers (+Balwadi and Govt. School Teachers)	12 24 12	School age children	600	PCM. Vit. A Defy. Anemia. Balanced Diet, Malaria, Diarrhoea, Clean Water, Worms, Immunization	Songs Drama, Puppets, Health related slogans Gram Yatras, Bal Melas. Audio visuals, Roleplays	Faculty of Home Science, M.S. University, BARODA
2. Mada Project	RAJASTHAN Dungarpur Dist. (Tribal)	CHETNA PEDO	22 Shikshan Kendras 10 Schools	PEDO Teachers Govt. School teachers	50 30	Stds -3 Primary/ Secondary School Children	600 1500	a.a.	a.a.	a.a.
3. Siddhpur Project	GUJARAT Mehsana Dist. (Semi-Rural)	CHETNA DCC of AKES(I)	7 Day Care Centres 7 Schools	DCC Teachers Govt. Teachers Mahila Mandals Members Anganwadi Workers	14 14 10	Preschool Children Primary School Children		a.a.	a.a.	a.a.
4. MCD Schools Project	DELHI (Urban and Rural)	Municipal Corporation of Delhi + NCERT	108 MCD Schools	Teachers	452	ClassIV-V Children	1,880	Diarrhoea, Skin Diseases, Accidents, Care of Sick, Care of Teeth/Eyes, Disease Prevention, Envir. Hygiene, Balanced Diet	Songs, Rhymes, Role Plays, Puppetshows, Games, Prabhat Pheris, Balmelas	Department of Food & Nutrition Lady Irwin College, NEW DELHI
5. Malvani Programme	BOMBAY (Slums)	Preventive & Social Medicine Dept. Seth G.S Med. College	Schools serving Slums	Teachers Health Personnel		ClassV Children	350	Diarrhoea. Hygiene, Immunization, Scabies, Anemia, Malnutrition, T.B., Malaria, Growth Monitoring	Games, Demonstrations, Home Visits, 'Morchas' Dance, Dramas, Cleanliness Drives	Centre for Research & Development, BOMBAY
6. Mobile Creches Programme	BOMBAY (Slums and Migrant settlements)	Mobile Creches	Day Care Centres	Balpalikas		0-12yr. Olds	Varying	Diarrhoea Measles, Balanced Diet Polio, Chicken Pox, T.B., Accidents First Aid., Jaundice	Games. Songs Street Plays Discussions. Story Telling. Charts Pictures.	a.a.
7. Diamond Jubilee Schools Programme	BOMBAY (Urban)	Diamond Jubilee Schools	Schools	Teachers		Class V Children	50+ 50	Hygiene. Diarrhoea, Accidents, Burns, Scabies, Measles	Cleanliness Drives Games, Dressing Contests, Drama, Films, Songs. Crossword puzzles, Demonstrations,	a.a.

a.a. = as above

From : D. Grover and M. Chatterjee (1990) "Innovators and Influencers : School Age Children and Health Education". Paper presented at the National Workshop on Approaches to Health Education For/By Children, New Delhi, April 1990.

Glossary

APPENDIX D

AAI	Action Aid India
AKES	Aga Khan Education Service
AKF	Aga Khan Foundation India, New Delhi
anganwadi	Pre-school child centre
bal mandals	children's groups
bal melas	children's fairs
balsevak	child health worker
balwadi	Pre-school children's centre
BDO	Block Development Officer
CDPO	Child Development Project Officer
CCP	Community Contact Programme
CHEB	Central Health Education Bureau, New Delhi
CHETNA	Centre for Health Education, Training and Nutrition Awareness, Ahmedabad
CRD	Centre for Research and Development, Bombay
CtoC	Child-to-Child
DAI	Traditional Birth Attendant
DGHS	Director General of Health Services, Government of India, New Delhi
DIET	District Institute for Education and Training
ECE	Early Childhood Education
EMMA	Educational Multi-Media Association, Madras
gram yatras	village tours
ICDS	Integrated Child Development Services
ISHEP	Intensive School Health Education Programme
KEM	King Edward Memorial Hospital, Bombay
MCD	Municipal Corporation of Delhi
MPW	Multipurpose Worker
NCERT	National Council of Educational Research and Training, New Delhi
NFE	Non-Formal Education
NGO	Non-Governmental Organisation
NHEES	Nutrition, Health Education and Environmental Sanitation Project
NIHFW	National Institute of Health and Family Welfare, New Delhi
NPE	National Policy on Education
NSS	National Service Scheme
ODA	Overseas Development Agency, U.K.
ORT	Oral Rehydration Therapy
PEDO	Peoples' Education and Development Organisation, Mada, Rajasthan
PHC	Primary Health Centre
prabhat pheris	street processions
SCERT	State Council of Educational Research and Training
SUPW	Socially-Useful Productive Work
TINP	Tamil Nadu Integrated Nutrition Project Tamil Nadu
UAA	United Artists' Association, Ganjam District, Orissa
UNICEF	United Nations' Children's Fund
VHAI	Voluntary Health Association of India, New Delhi
villupattu	a Tamilian folk theatrical form
WHO	World Health Organisation