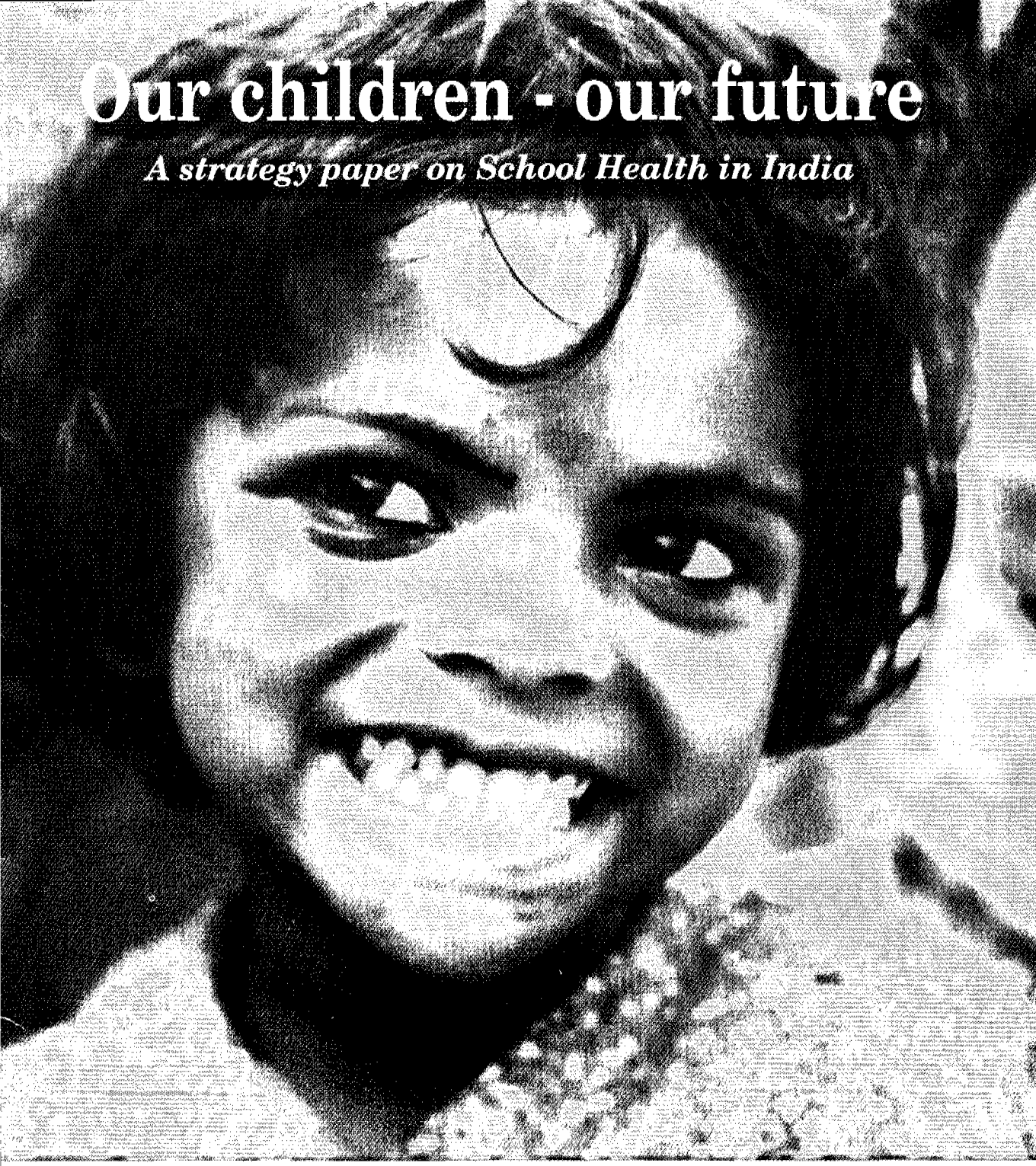
Our children - our future

A strategy paper on School Health in India



British Council Division
British High Commission

Our children our future

A strategy paper on School Health in India

A report incorporating the findings of the
National Workshop on School Health
February 20-22nd 1995
New Delhi

British Council Division
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Contents

SUMMARY

Schools have a vital role to play in improving the health of the young people of India and laying the foundation for the health and economic well-being of the nation.

A school health programme has three components: ***school-based health services*** including first aid, screening, immunization and simple preventive measures such as deworming and micro-nutrient supplementation; a health-promoting ***school environment*** including water supply and sanitation; and ***comprehensive school health education*** in the class room and school surroundings using action-based participatory learning involving children, teachers, parents and the wider community.

This document brings together the experiences of school health programmes in India and the rest of the world to critically assess the potential role of schools in the improvement of health in India. Available evidence shows that well-designed school based health activities ***can*** lead to improvements in health knowledge, health behaviour and health status. Success of school-based health activities depends on collaboration between health and education sectors, training of teachers, development of support materials, the use of activity-based health education methods and the involvement of parents and the community.

National policy documents on health and education in India have called for improvements in health promotion in schools. Despite the enormous potential of schools for health promotion and the existence of an adequate framework of legislation, the achievements have been disappointing. The reasons for this include low priority to school health promotion by education and health services, inappropriate teaching methods, lack of educational materials and the effect of poverty. A major problem is the lack of commitment to the mobilisation of schools for health promotion at all levels from the family, school, community, district, state and national level.

This strategy paper recommends the setting up of action groups at the community, district and state level. These should bring together interested groups including parents, teachers, health workers from both government and NGOs. These groups should review existing health promotion in schools and develop action plans that are effective, affordable, realistic and sustainable and that will increase the quantity and quality of school health promotion.

1. The challenge of health

INDIA - the facts

Literacy rate 52.19% in 1991

95 % of population provided access to primary schools within 1 km

Enrollment of children in elementary education	:	136 million in 1991.
Enrollment of girls in primary school	:	42% in 1991.
% of age group enrolled in	:	Primary education : 97 % (1990) Secondary education : 44% (1990)
Primary pupil/teacher ratio	:	61 (1990)
Drop-out rate Class I-V	:	47.9% Class VI-VIII 65.4%
Girls as a % of Class I-V	:	43% Class VI-VIII 39%
Adult literacy (female)	:	66 % (1990)
Adult literacy (total)	:	52 % (1990)
Primary schools without building	:	13.5% (1986)

Source: World Bank Development Report 1993

EDUCATION - the facts

Estimated population in 1993	:	896,567,000
% pop in urban areas	:	27%
Aver urban annual growth	:	3.7%
Annual population growth rate	:	2.0% (1980-93)
Under 15 year olds as % pop	:	35.8 % (1991)
Crude Birth Rate (per 1000 pop)	:	30 (1991)
Crude Death Rate (per 1000 pop)	:	10 (1991)
Total Fertility Rate	:	3.9
GNP per capita	:	$ 330
% population living below the poverty line	:	40% (approx.)
Under 5 mortality rate (per 1000 live births)	:	Female 125; Male 123 (1991)
Life expectancy at birth	:	Female 60 (yrs) Male 60 (1991)
Babies with low birth weight	:	30 %
nfant mortality rate per 1,000 live births	:	90 (1991)

74% of the population in rural India has access to potable water

11% of the rural and 62% of the urban population have access to latrine facilities

*Source:*World Bank Development Report 1993

2. National and international policies on school health

In India

The National Health Policy recommends that

> "Organised school health services integrally linked with general, preventive and curative services would require to be established."
>
> "The recommended efforts on various fronts would bear marginal results unless nation-wide health education programmes backed by an appropriate communication strategy are launched to provide health information in an easily understandable form to motivate the development of an attitude to healthy living."
>
> "Public health education programmes should be supplemented by health, nutrition and population education programmes in all educational institutions at various levels."
>
> "Simultaneous efforts to promote education, especially adult and family education without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal and child health cannot bear fruit, would be required. "

The National Policy on Education (1986)

- Emphasises the need to pay special attention to the overall development of the young child and placed a high priority on its Early Childhood Care and Education programme which is concerned with the "holistic nature of child development, viz, nutrition, health and social, mental, physical, moral and emotional development" of young children

- Calls for a strengthening of the School Health Programme as part of the overall policy to bring about "A full integration of child care and pre-primary education both as a feeder and a strengthening factor for primary education and for human resource development."

- Envisages that "Health education at the primary and middle levels will ensure the commitment of the individual to family and community health."

- "Health planning and health service management should optimally interlock with the education and training of appropriate categories of health manpower through health-related vocational courses."

3. The current status of school health in India

Each country must find ways to address the following questions, from national to local levels:

- ***Is comprehensive school health education being implemented as intended?***
- ***Is comprehensive school health education achieving the desired effect on children's health?***

Comprehensive School Health, a WHO document which provides recommendations and guidelines for implementing and strengthening Comprehensive School Health Education in the South-East Asia Region (1992).

A national workshop on school health promotion was held in New Delhi 20-22nd February 1995 which brought together persons from government and NGOs throughout India to share experiences on school health programmes. The overall picture that emerged was of some exciting programmes, but a lack of implementation and many missed opportunities. The following obstacles were identified for urgent attention.

The low priority given to health promotion within the school and community. The low commitment currently awarded by policy makers and educators to health in schools is a major contributing factor for poor implementation.

The adoption of a narrow medical view of health emphasising disease and cure and dominated by doctors rather than a broader section of people including teachers, social development and community level health workers.

The marginalisation of health within the curriculum. The National Curriculum for all levels of schooling, developed by the National Centre for Education, Research and Training lays down that fifty per cent of the time given to Health and Physical Education (which is allocated ten per cent of total school teaching time) should be spent exclusively on health education. However, in reality very little of this time is actually spent on health education.

The overemphasis on factual didactic learning methods. The health content taught at present mainly emphasises examination-oriented learning, formal lessons and learning of facts. At the end of this process the child may have health knowledge, but this is not translated into decision-making and action.

Lack of training and support for teachers. The quality of school health programmes is mainly dependent on the amount of time and effort that teachers are willing to put

into health education and their understandings and skills in health education. Teachers are often too busy, lacking in interest, feel uncomfortable dealing with health issues and lacking the skills to adequately teach the subject. Teacher training institutions do not give enough attention to health education.

The poor state of the school surroundings. The school surroundings are often inadequate with overcrowded classrooms and a lack of water and sanitation facilities. Children cannot be expected to learn about health if they are unable to put into practice what they have learnt.

Insufficient links with health care staff. Health is usually seen as a matter for health workers and not teachers. The lack of active interfaces between the education and health sectors for joint planning and action is a major drawback for development of school health in India today

The need to build links between the school and the community. The involvement of parents and the community is essential if the knowledge and skills acquired at school are to be translated into action at home. Links between school and the community are very weak. Where links do exist e.g. parent teachers association these are not involved in discussing school health issues.

Lack of materials. Educational materials such as books and teaching aids are scarce. When they are available they are often of poor quality and out of date. Distribution mechanisms for getting materials out to schools are not well developed.

EDUCATIONAL MATERIALS are required for teachers to enhance their ability to carry out health education in classrooms regarding topics which are curriculum specific using a methodology which is interesting to both the pupils and teachers. Participatory methods and materials such as flashcards, flipcharts and discussion posters have been found to be well received in the classroom environment.

The production of health education materials should undergo a thorough process of design, pre-testing and evaluation and be applicable to the requirements of those using the materials and those being exposed to the materials.

The situation of the girl child. Girls have poorer health than boys yet are less likely to benefit from existing health education activities. Millions of children in India, and significantly more girls, never attend school or drop out in the first five years after enrollment due to a variety of factors.

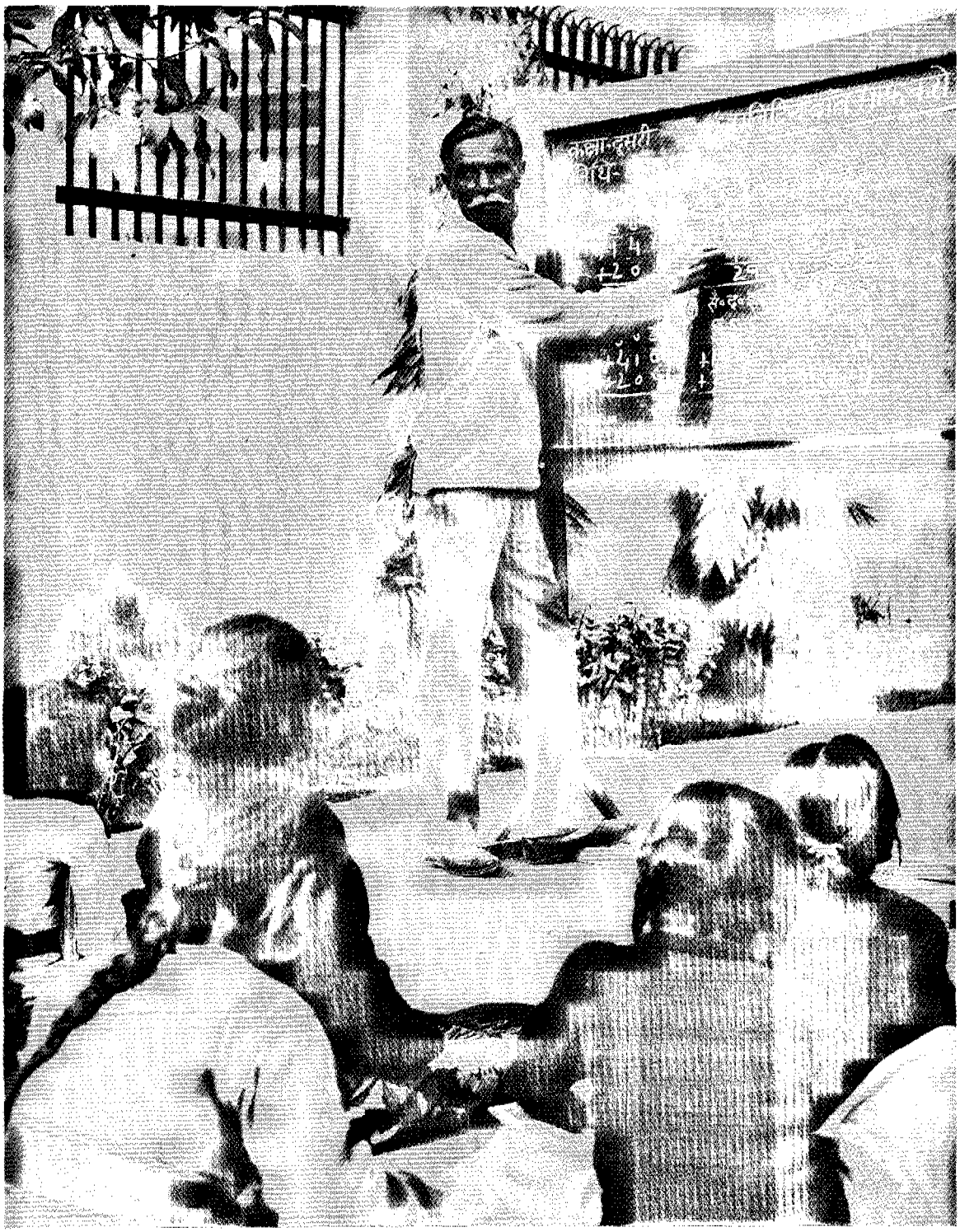
THE GIRL CHILD

Every year 12,000,000 girls are born and 25 per cent do not live to see their fifteenth birthday. Those who live are confronted with a world that denies them food, health care, education, employment, and even dignity and respect.

As a young girl the cause of her malnutrition is not so much the lack of food as lack of access to food. She is given less food, eats last and often gets only the left-overs. The discrimination does not end there. A girl's health is of minor significance and mortality amongst girls is higher.

- Girls do not achieve their full height and weight potential.
- Their diet is inferior and more girls than boys in the same age group suffer from malnutrition.
- Girls are given less nutritious foods than boys.
- Fewer girls than boys receive timely medical attention.

Source: State of India's Health : VHAI 1992



The teacher - a crucial role in school health programmes

In *School Health - A Guide For Primary School Teachers*(1984), brought out by the Directorate General of Health Services, the teacher occupies a central position with regard to implementation of the school health education programme. The document identifies the following tasks:

- The teacher's main task is to provide health instruction to school children and promotion of healthful practices among them. The responsibilities associated with this are many and diverse. They relate to supervision of students hygiene-related habits and of the school environment including in-school food sanitation practices, planning relevant and need-based health educational activities, planning and organising in-school and in- community/home projects.

- The other tasks include detection of deviations from normal health, provision of first aid in accidents, and referral of children to health workers at the the nearest clinic.The teacher is also expected to assist in health check-ups and the immunisation of school children as well as in the maintenance of health records. The objective is not for teachers to replace health workers but to act as a first point of detection and referral.

- Thus, apart from imparting health education in the academic sense, teachers are expected to play a larger role in influencing the daily behaviour of their students , intervening directly and indirectly in minor and major health problems, and creating a bridge from school to home, school to community by creating linkages between students, parents and professional medical services.

- The list of expectations is long and challenging. It needs to be examined against the realities and experiences of teachers in India.

How can already overburdened teachers, already responsible for teaching regular curriculum subjects be helped to take on the additional responsibilities of health promotion?

4. Glimpses of hope from around the world

At the beginning of 1996 group of international experts were commissioned by the Andhra Pradesh School Health Programme to undertake a major literature review of experiences of school health programmes in India and the rest of the world. Their reports uncovered many examples of successful programmes. Although small-scale and from widely-differing contexts, the following case studies from their reports provide glimpses of what can be achieved in India

Nutrition

Malnutrition can affect a child's learning and cause permanent disability.

Iron deficiency affects 210 million school-aged children worldwide and results from insufficient dietary intake or parasite infections, mostly worms or malaria.

Intervention studies have shown that oral supplementation with iron can lead to improvement in haemoglobin status, growth and educational performance.

Iodine deficiency affects an estimated 60 million school-aged children worldwide and causes goitre, juvenile hypothyroidism, impaired mental function and retarded physical development in childhood and adolescence. Studies have shown that school-aged children who have been treated with iodised oil or iodised salt perform better on IQ, physical stamina and psychomotor tests.

One in ten school children from poor socio-economic groups in India show signs of vitamin A deficiency from low intake of vitamin A rich foods, which could be tacked either by single dose vitamin A supplements or school meals. The Nutritious Meal Programme in Tamil Nadu is the largest mass nutrition programme in the world and feeds 8.5 million children from 2-14 years of age. An assessment of the impact of this programme on 3,857 children showed that symptoms of vitamin A deficiency (Bitot spots) were reduced from 7 - 2 % over a one year period.

The Gujarat mid-day meal programme that began in 1994 combined mid-day meals, de-worming and vitamin A supplements. A comprehensive evaluation was carried out on 6000 school children. The prevalence of vitamin A deficiency decreased from 48 to 22% and intestinal parasite infections from 71 to 40%.

Eye health

Poor vision, caused by uncorrected refractive errors, vitamin A deficiency and poor hygiene is one of the most serious disabilities in India.

In Ethiopia a programme of health education for eye infections targeted to primary schools was implemented in the rural town of Metahara. The health education programme consisted of a multiple choice test followed by discussions, story writing and activities including drawing pictures. The evaluation showed improved knowledge scores on eye disease. Before the programme 88 of the 239 schoolchildren examined had dirty faces, defined as presence of dirt or discharge in the area surrounding the eyes. After 6 months only 4 out of 228 children had dirty faces. The prevalence of moderate and severe trachoma decreased from 12.1% to 3.3% ($p < 0.001$) in one year, and the prevalence of conjunctivitis from 7.5% to 0.4% ($p < 0.001$). *De Sole and Martel (1988)*

In India the Danida programme for the control of blindness has trained teachers to screen children for refractive errors. The evaluation carried out showed that teachers were able to detect cases of poor vision and their performance was comparable to that of achieved by trained staff such as paramedical ophthalmic assistants. The number of children provided with spectacles as a result of this screening has increased dramatically. In the target schools many children now know what refractive errors are and where to seek corrective services. *Limburg et al. (1995)*

Worms and parasites

Infection by worms such as hookworm and roundworms can stunt growth, cause anaemia, reduce growth and development and affect school performance.

In the Republic of Korea, a national control programme including chemotherapy, health education and a sanitation programme targeted at school children has successfully reduced worm infection prevalence from 60% to 1 % since 1969 and the incidence of surgical complications has decreased proportionally.

A two year pilot programme in Kenya involving mass chemotherapy, community-based activities like health education in schools and provision of safe water supply have shown a reduction in overall worm prevalence and intensity. School teachers actively participated in the programme.

In Thailand a community a community-based programme to prevent liver fluke disease involved treatment and health education in both the community and schools in two villages in Khon Kaen Province. Following training of teachers, a 'health education corner' was set up in the schools with displays of the snails and fish intermediate hosts collected around the villages and the parasites that had been purged from the patients. The health education corners were also used to educate the community. The activities included stool examination for all students and treatments for the positive. Within 1-2 years, all students were free from the liver fluke infection and the schools were finally declared to be 'liver fluke free'. *Sornmani (1988).*

Dental health

School-based activities can have a big impact on dental health.

In Indonesia the Indonesian Dental Health Foundation runs a schools programme involving a team of dentists, dental nurses and teachers. The educational activities involve simple lessons, production of booklets with pupil class/homework activities. Preventive activities done in class included brushing with fluoride toothpaste in front of mirrors, use of disclosing solution and fluoride rinses. Simple treatment is linked to annual screening and children with dental health problems are treated during school time at a central clinic. The effectiveness of the programme has been demonstrated by significantly lower plaque scores among participating children compared with controls. *Nio (1995).*

In India the *Muskata Dant* (Oral Health Self Care Project) started in 16 schools in Delhi used schools as an entry point for health education and self-care activities to prevent dental disease. A short-term evaluation showed significant clinical improvements, increases in knowledge levels, positive teacher perceptions of utility and design of the programme and parent and pupil recall of key dental health messages.

Sanitation and water supply

The state of water supply and sanitation in schools is very poor, affecting the health of children and providing a poor example to the community.

In ***Nepal*** a pilot health education and sanitation project was carried out to give secondary school students the knowledge and skills necessary for building domestic pit latrines in their villages. At the end of the 4 weeks campaign period there were 150 completed domestic pit latrines and 45 pits or partially complete latrines. *Hope et al. (1988).*

Child-to-Child programme

The Child-to-Child started in 1979 and has now become a global movement for the development of activity-based school health education. The movement is coordinated by the Child-to-Child Trust in the United Kingdom programme which has produced a series of activity sheets, books and resource guides providing guidelines on activity-based health education on a wide range of health topics.

In 1993 there were 36 organisations, mostly NGOs, conducting small scale Child-to-Child programmes in 11 States in India.

The Kanghaza School Health Project in Kerala was set up to serve 30 schools in the catchment area of the MGDM Hospital. One teacher was selected from each school to be a health education coordinator responsible for development of the school health programme in their school, coordination of health education activities and supporting the health education activities of other teachers. The teachers were trained on: simple treatment and prevention of local diseases; first aid; as a range of health education activities including project-based health education approaches. On return to their schools they set up school health committees, attended sick children, started screening activities and set up a variety of Child-toChild school health education activities in the school and community. They were able to treat basic problems, refer children to the health centre and liaise with health services for screening and immunisation programmes. An evaluation of the four year period from the start of the project in 1975/6 to 1979/80 saw a decline among children in the project schools for the following diseases: Vitamin A deficiency (3% _ 1.2%), Trachoma (9.1% _ 5.5%) and Scabies 7.6%_1%). There was an estimated saving of several thousand school days.at a cost of less than 1 Indian rupee per student per year. *Joseph (1980).*

Mass media and school health education

Mass media offers exciting potentials for scaling up and reaching large numbers of schools.

In ***Bolivia*** a radio health curriculum on diarrhoea disease field-tested among fourth- and fifth-grade students in Cochabamba. The module consists of 10 interactive radio lessons in which the students respond orally to drill and practice, sing songs, or write key concepts in their notebooks. Following the 25-minute radio broadcast, the teacher conducts a 20-minute session that focuses on application and practice of the new behaviours. The module includes lessons on personal hygiene, water and oral rehydration, home sanitation and nutrition.

Students responded enthusiastically and achieved significant knowledge gains as a result of the program. Observations by parents and teachers also suggested that the programme had an impact on children's attitudes and behaviours. *Fryer (1991).*

In ***Swaziland*** the Expanded Program on Immunisation used radio among 5th- and 6th- grade students in a series of 8 radio spots. Radio was chosen because a large number of youths could be reached at minimal cost with a standard message at a uniform time. 16 schools received the accompanying materials and participated in the pilot program. The evaluation showed that children from the experimental schools increased their knowledge more than those in controls who had not received the broadcasts. *De Fossard (1993).*

Lessons from the global literature review

The above extracts from the global literature review show ***that well planned school-based programmes can be effective*** in improving the knowledge, behaviour and health of school children. Crucial factors to achieving success are:

An assessment of the current situation in the school and community and need for school health activities.

Collaboration between education and health workers.

Balance between medical, environmental and educational inputs.

Training and support for teachers.

Development of appropriate educational materials.

Involvement of pupils, parents and the community.

There is already considerable experience about school health promotion. The challenge is to put the lessons into practice....to scale up these school health activities into comprehensive school health programmes that are fully integrated into existing services and can be sustained within available resources.

Health education is defined as

"education concerning protection, preservation and promotion of health (physical, mental, social and emotional) through self care behaviour using available resources and seeking help from others wherever needed. It is a process of helping people to identify their health problems, formulate their own objectives in the context of available resources and constraints, and achieve these objectives with their own efforts."

"Health Education for School-Age Children: A Framework", developed jointly in 1988 by the Central Health Education Bureau and the National Council For Educational Research and Training.

Recent approaches in school health education

Many people have been critical of traditional teaching approaches in schools that over-emphasise learning facts and passing exams. Effective school health education must go beyond just giving children facts. It should equip them to make decisions, explore attitudes and values and adopt healthy practices both now and in their future lives. The approaches that are increasingly being emphasised in international initiatives by WHO, UNICEF and the Child-to-Child programme are summarised as:

- ***Child-centred approach*** - placing the emphasis on meeting the needs of the children, starting with the child's perception of a healthy lifestyle and recognising that children learn at different rates. The ideas introduced at each level of primary and secondary schooling should reflect the social/emotional, physical and intellectual development of the child.
- ***Active learning methods*** that encourage exploration and discovery and relate the information presented to everyday life, bridging the gap between home and community.
- ***Problem-solving or 'issue-based'*** learning which organises the learning around issues or problems rather than traditional subject disciplines. In this approach, students usually take a health topic and carry out a range of activities in the classroom, at home and in the community. Their finished project might include: songs, drawing, arithmetic, science experiments and story writing.
- ***Decision-making methods*** - role plays and exercises where children learn to take decisions. This might include role play where a young person has opportunities to try out different responses to another person's attempt to persuade them to smoke a cigarette, take alcohol or have sex.
- ***Peer teaching methods*** - which encourage the use of older respected children as 'peer models'.

5. Current initiatives in India

There are two large scale initiatives which are exploring ways of introducing a comprehensive school health programmes in rural and urban settings and applying the global lessons described in the previous section.

SEHAT -School Health Action And Training Project

SEHAT, a New Delhi-based project, aims at implementing a child-centred approach to health promotion through schools by focusing on changing attitudes and behaviour.

The SEHAT experience is also an example of an NGO working and cooperating effectively and positively with the government. Following an initial pilot phase in 30 Delhi schools the project expanded to 250 Delhi Administration schools and 500 Municipal Corporation schools. The Indian Dental Association is the official project holder and receives and distributes project funds.

Key features of the programme are:

- Local participation by teachers and the community in the planning of health education activities in their schools.
- Training of key functionaries including headmasters and teachers in health education methods especially participatory learning in the classroom.
- The development of appropriate materials which include a Teacher's Guide on health based concepts for promoting health oriented knowledge and behaviour among school children.
- This Guide is supplemented with an activity-based workbook for children.
- Continuous contact is maintained with the schools after the teachers have been trained to provide support through materials and advice.

SEHAT seeks to incorporate sustainability into its programme by involving the Government of Delhi at all stages of planning and development and recruiting its field staff from teachers on secondment from government service so that a trained cadre is built up to carry out activities in the long-term.

SEHAT works in close cooperation with other programmes such as the Education For All project which aims at reducing the number of drop-outs, improving the quality of education and enhancing the environment of the schools. Linkages with other organisations and agencies including the Government of Delhi, the Delhi Municipal Corporation, the Indian Dental Association and the National Council for Education Research and Training were also established both to obtain technical/advisory support for activities and to develop mechanisms by which its experiences can feed into policy making process.

Going to scale in Andhra Pradesh

Most effective school health promotion programmes to date have been on a small scale and have involved NGOs rather than government systems. A major challenge is to 'scale up' these small scale programmes and introduce school health programmes within national education and health systems.

It was in response to these challenges that the Andhra Pradesh School Health Project was set up in 1992. This ambitious and innovative project will run for 7 years and eventually reach over 5 million children in 49,000 state primary schools of all the 23 districts of Andhra Pradesh.

The main project activities are: training of teachers and health workers, improving school health services; enhancing the ability of field staff to carry out health education activities and research. This is involving:

- Training 140,000 teachers and 22,000 multi-purpose health workers to identify, treat and refer common ailments in children. Each primary school will be provided with a health kit which includes simple medicines and first aid materials. The teachers will be trained use the kits to treat pupils with minor ailments, carry out screening for vision and hearing and refer pupils to health services where necessary.
- Introducing activity based and child-to-child health education methods and developing educational materials. Children will be encouraged to educate each other and take simple messages home to their families.
- Strengthening the capacity of local hospitals to treat school children. This has involved the provision of dental instruments and ear, nose and throat equipment.
- Improving water and sanitation in schools.

The first three years of the project have raised many critical issues which include: the need to develop interfaces between health and education systems at every level from the state to the village, the problems of curriculum innovation and reform, the role of teachers as health care providers and the need to develop working links between teachers, health workers, parents and community. The project has also had to consider the influences of the wider development context, especially poverty and gender, on the health of the school child. These important issues are being explored through a programme of operational research which will provide an information base on which the lessons learned can be applied in the rest of India and other developing countries

SEHAT and the Andhra Pradesh School Health Project are providing valuable lessons

on specific components of school health programmes. Operations research activities in these projects will provide further information on the benefits of specific inputs. However, enough is known already to justify a massive scaling up of school health activities throughout India.

There are 8.7 million children enrolled in primary school alone. Children now account for as much as 40% of India's population and the school system provides an unmatched opportunity for influencing the knowledge, beliefs, attitudes and practices of the 136 million Indian children enrolled in elementary school.

Why is the health of school children important in India?

A healthy child is more alert,
will not miss school because of sickness and
will perform better at his or her studies.

•

School health services will help to identify health problems
so that they may be dealt with.

•

Health concepts and skills will be passed on to the parents and family.

•

Ideas and skills learnt at school will prepare a child
for health decisions in later life.

•

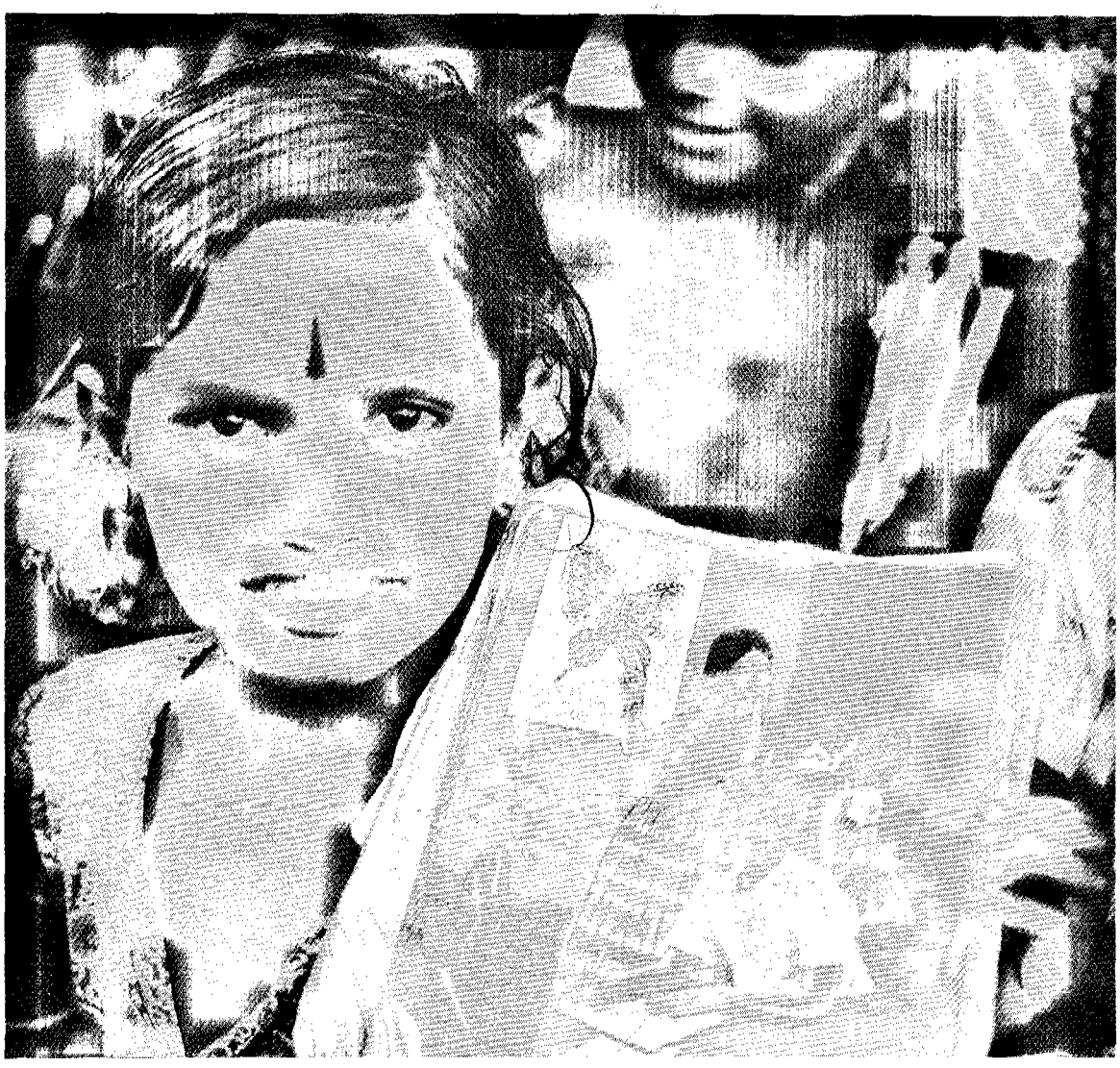
The community will benefit by an increased awareness
amongst its members about health problems and solutions.

6. The way forward - a need for action

An expansion of school health promotion in our schools would have a major impact on improving our nation's health. This vital area has been neglected for too long. There is a need for action.

At the state, district and community level

Most of the necessary administrative, curriculum and community structures already exist. The challenge is to generate the will, at a community, district and state level, to use these existing mechanisms to develop effective school health promotion. The role



of the state level is to review national policies for school health, to work with districts to develop a detailed action plan for the state and to provide the necessary support for the implementation.

- **The time for action is now! Everyone has a role to play in the process including health workers, teachers, policy makers, members of the community or parents.**

THE STRATEGY FOR ACTION IS:

- ***Form interfaces:*** establish working groups collaborative structures at State, District and community level.
- ***Review current situation*** in your community which might include research or practical assessments.
- ***Prepare and implement action plans*** that include relevant, realistic and affordable activities including training, support, supply of materials, mobilisation of available resources - we could also give a check list of possible activities.
- ***Monitor and Evaluate*** and use the feedback to improve the programme.
- ***Share/network with others.***

Strategy for action at state, district and community level

A. Form interfaces/action groups

B. Review current situation for school promotion

C. Plan and implment school health promotion activities

D. Monitor and evaluate activities

E. Share experiences/lessons with others

A. Form interfaces

Collaborative structures and action groups should be formed at the State, District and community level.

At the State level the role of action groups should be one of support especially at the policy and advocacy level. The district and community levels are the most important interfaces for implementation. The school health programme must seek to activate and involve parent teachers associations and local level groups to promote community involvement. It must also seek the co-operation of all village education committees.

Interfaces for developing school health promotion action

State level

State Ministries of Health
State Health Education Bureau
State Ministries of Education
State Social Welfare Departments
State Councils for Education Research and Training
Education department of Universities
State level NGOs dealing with health, education, women's affairs, Mass media.

District level

District level Departments of Education
District level Ministry of Health including school health services
Local NGOs concerned with health, education and social development
District level health and education training institutions
District level social welfare and community development agencies e.g. literacy, women's affairs, water supply etc.

Community level

Teachers
Parents
School children
Health workers
NGOs
Village/community level committees e.g. panchayats, village education committees

B. Review current situation

Once you have formed action groups, one of the first tasks is to review the current situation to decide priorities for action. This might involve holding meetings with schools, parents and other community members, meeting field staff and carrying out research and data-gathering.

C. Prepare and implement action plan

Activities should be

- ***meaningful*** and address issues of gender, poverty, teaching methodology and lead to improvements in health
- ***realistic*** within budgetary and human resources; and
- ***sustainable*** through establishment of on-going structures for implementation/ community participation and include some form of capacity building.

Examples of suggested activities at the state, district and community level

- ***Advocacy.*** This might involve forming a pressure group to increase the profile of school health activities in your community and to press for action. Pressure

A checklist for situation assessment

What is the status of health education activities in the classroom, school and community?

Does the school have a clear policy on health promotion, jointly prepared by staff and parents?

Is health taught effectively across the curriculum? In particular are the following topics covered; environmental health, reproductive health and population, personal health, safety and accident prevention, drug abuse, physical education, emotional health?

Are the health topics taught at school based on the needs in the community?

Are teaching methods learner-centred, using the environment as well as the school?

Are educational materials including visual aids and books available and used on health topics?

Are there water and sanitation facilities adequate, clean and well maintained?

Is there at least one teacher in the school trained to give first aid, detect simple health problems and refer children to health services?

Is there an effective and committed school health committee?

Are parents involved in health promotion activities in the school?

Are there well developed links with the community and local health workers?

Do policy makers within health, education and other services provide support to school health promotion?

group activities might involve approaching key public figures, organising public meetings, marches and obtaining radio and newspaper coverage,

- ***Training of teachers and health workers.*** Setting up training programmes for teachers and health workers and reviewing the content and methods of the training given at teacher training institutions. Wherever possible training should be multi-disciplinary and bring together field staff from education, health and social development programmes to study jointly the issues and plan collaborative action.
- ***Development of educational materials.*** These might be either materials to be used in sensitisation of policy makers and the community to the importance of school health promotion, training of teachers or for use in the school environment. The best materials are those which are accurate, based on health problems in the community and encourage discussion and participation. Materials could be wall charts, flip charts, games and health readers. Materials should be well produced with pictures and appropriate language. Materials should be pretested with some of the intended audience to ensure that they are understandable, acceptable and appropriate.
- ***Setting up of pilot demonstration programmes*** to explore new approaches or to establish model programmes that can be used for demonstrating to others the importance of school health promotion. These might be programmes to try out new approaches e.g. using teachers for health screening or explore ways of dealing with issues that have been neglected in your community e.g. the girl child, disability, goitre prevention etc. Locations for pilot projects must be chosen carefully so that the lessons learned are relevant to other communities.
- ***Research/evaluation of existing school health activities*** to find out whether the existing school health promotion activities have been effective and what are the factors which have led to success or failure. Research might be useful to find out more about local problems in order to plan an intervention e.g. the reasons for early-drop-out or parent's views about using schools for health promotion.

D. Monitor and Evaluate

Monitoring and evaluation are essential components to any school health programme so that you can find out if the programme has been successfully introduced, if it is having an impact or if changes are necessary. Information is needed on:

Whether the health promotion activities have been successfully introduced?

Whether in the short term they are having an impact on the health knowledge and behaviour?

Whether in the longer term they are having an impact on health of the children and the community

Whether the improvements are being sustained over time?

Whether the school health programme is being supported by parents and the rest of the community?

Indicators for monitoring and evaluation

You should decide at the outset what ***indicators*** you will use to monitor and evaluate the programme. Indicators for monitoring and evaluation of school health promotion programmes should be: ***meaningful*** and ***measurable***. Some indicators for evaluation of school health promotion are listed below:

Health and nutrition status of school children: ie worms and dental health.

School surroundings - water and sanitation facilities and their use .

School health kits/first aid facilities - the amount of use,
the appropriateness of use.

Absenteeism due to ill health.

Detection of vision and hearing problems by teachers.

Sustainability

Sustainability: that which keeps a programme alive and, eventually passes on ownership to the target group or the community.

Sustainability at the school level

Sustainability at home and community level

Sustainability at district and state level

A sustainable school health programme will involve the following inputs:

- Training of teachers and health workers
- Participation by parents and the community
- Shared involvement of government and NGOs from health education and other community services.
- Mobilisation of local resources e.g. donations from private and community funds for purchase of educational materials, medicines and improvements in the school surroundings.

The main resource comes from teachers, children and parents - there is no school, however poor, that lacks the resource of children

Visits by health workers to schools.

Referral of children to health services by schools.

E. Share your experiences with others

Experiences that are gained should be shared with others. It is only by learning from your experiences and sharing with others that we can build up a body of knowledge on effective school health promotion in India. Information can be acted upon and shared in many ways:

- Through preparing a report on the project and distributing to others.
- Through inviting others to a workshop at the end of the activity where the results can be presented and the implications discussed.
- Preparing a case study using written information, video or slides on the project that can be circulated widely and be used in training courses..
- Writing an article for a newsletter such as *Health for the Millions* or *Health Action* - these are usually willing to publish short descriptions of programmes - especially if they are accompanied with samples of educational materials and photographs of activities.
- Writing a more detailed paper for a scientific journal.
- *Presenting a description of your project* at a district, state level or national level or at a meeting.

Evaluating the health curriculum

The nature and quality of school health education programmes should be evaluated by the extent to which they achieve:

Instruction intended to motivate health maintenance and promote wellness and not merely the prevention of disease or disability.

Activities designed to develop decision-making competencies related to health and health behaviour.

A planned, sequential pre-school to end-of-school curriculum based on students' needs and current and emerging health concepts and societal issues.

Opportunities for all students to develop and apply in real-life situations health-related knowledge, attitudes and practices individually.

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