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Health Action Schools

Pilot Research Project

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The Aga Khan University
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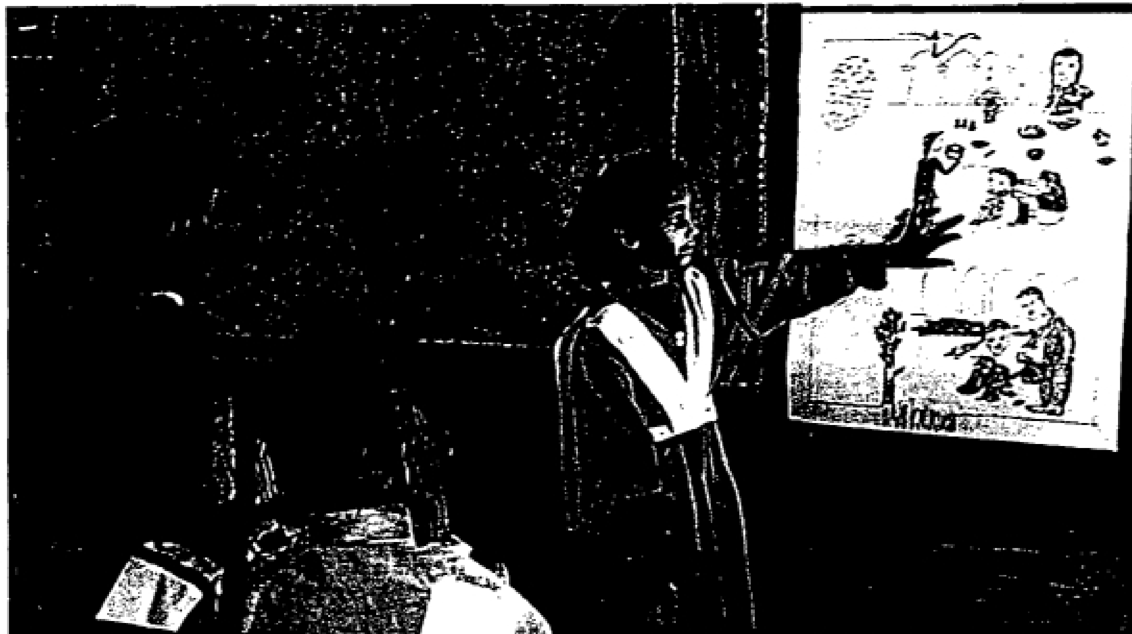

Mid Term Review

William Gibbs December 1st to 10th 1999

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Mid Term Review
Health Action in Schools
Pilot Research Project
IED Karachi

Introduction

The Terms of Reference for the Mid Term Review of the Health Action in Schools Project based at IED in Karachi were to review progress, to assess achievements, to identify weaknesses and challenges and to make recommendations for incorporation in the next phase of HAS.

My time was extremely well organised and my programme well designed so that in the ten days in Karachi I was able to meet and talk with nearly all the key people involved in the HAS project both at IED and in the project Schools.

The report is divided into three sections.

Section 1 considers the achievements of the HAS programme so far.

Section 2 compares these achievements with the original proposals.

Section 3 contains a collection of ideas and suggestions for the future development of the HAS Project.

My thanks to all those who made my visit so interesting and varied, especially to Dr Tashmin Khamis and the the HAS Team, Debbie, Farah, Shahida and Noordin. Thanks also to all those at IED for making me feel so at home.

William Gibbs **January 2000**

Index

Section 1.0 Achievements

1.1	Relations with schools	1
1.2	Using and staying with a variety of schools	1
1.3	Establishing HAS within the schools as a concept	1
1.4	Establishing lessons in Health Education as part of classroom teaching	2
1.5	Improving children's Knowledge and Skills	3
1.6	Improving children's Health behaviour	4
1.7	Developing Training Procedures	4
1.8	Developing Teaching skills and methods	4
1.9	Developing Planning Skills in teachers	5
1.10	Establishing a presence at IED	5
1.11	Establishing a National Presence	6
1.12	Documenting the Process	6
1.13	Materials production	6
1.14	The Has Team	7

Section 2.0 Comparing the programme with the proposals

2.1	Impact through Health education	8
2.2	Impact on the School Environment	9
2.3	The Health services	10
2.4	The School and Community	10
2.5	Reconsideration of the original comprehensive school model	11
2.6	Using the Base Line Study	11

Section 3.0 Reflections and suggestions

3.1	Health Education in School and Classroom	13
3.2	Developing Support materials	13
3.3	Developing FAME sessions	14
3.4	Developing an Outline Primary Health Curriculum	14
3.5	School Environment	15
3.6	Developing links with Health services	15
3.7	Consolidation of "writing up" Achievements; Case Studies	15
3.8	Research Questions	16
3.9	Dissemination strategies and spread of Ideas	17
3.10	Dissemination within IED	18
3.11	Sustainability	18

Appendix A Documentation of HAS Project

Appendix 1 Research Variable

Appendix 2 Picture Report

1.0 Achievements

1.1 Relations with schools

The Health Action Schools (HAS) team has established relationships based on trust and mutual understanding with its partner schools. This is indicated by the evident sense of partnership that Head teachers, teachers and children within which the HAS schools showed for the work of the HAS team. Teachers and Heads responses indicated;

- A clear understanding of what HAS can and cannot provide.
- An appreciation of the flexibility of the HAS team to different and changing circumstances.
- An understanding of the concept of health and health education within the context of the classroom, school and community.

Brought about by the responsiveness of the HAS team to

- the values and priorities of teachers and heads,
- the time available,
- the different character of each school.

1.2 Using and staying with a variety of schools

The schools involved are only a tiny sample of the wide spectrum of schooling in Karachi but they are all different in significant ways. 5 schools and 80 teachers have been involved in the programme.

Pir Mehfooz, Government school; split site, poor semi-urban area, mixed boys and girls, male teachers.
Attiya Bia; Government School, double shift school, poor urban area, girls only, female teachers
Meteroville; community school in narrow three story house above a store, all but one are female teachers
Sultan Mohammad Sha; Aga Khan Educational Services School, double shift, mainly female teachers
Generations, privately owned fee-paying school, mixed, high quality purpose built school, female staff.

The conditions in each school have meant that the programme has evolved differently in each. The Has team has overcome special difficulties to keep a programme presence in Pir Mehfooz caused by staff transfers, turnover of head teachers (4 in the last 18 months) and conflicts between staff.

1.3 Establishing HAS within the schools as a concept

Evidence through talking to teachers and head teachers involved in the programme revealed that they shared something of the vision of promoting health education within the schools, of the value of an active approach to learning, of the value of an approach that went beyond the classroom. The establishment of the concept has been aided by the appointment of one teacher within each of the participating schools as a *health co-ordinator.*

1.4 Establishing lessons in health education as part classroom teaching.

Each school has contracted with HAS to teach lessons in health education. The contracted number varies from 25 per year (SMS) to 36 per year (Generations). The records show that these targets have been reached and that some schoolls have added extra topics and lessons. Different schools have adopted different patterns (8 -10 lessons per topic in SMS, 4 or 5 lessons per topic in Atiya Bai and Metroville). Lessons range in length from 20minutes to 1hour and the time on an already full time table has been found in different ways.

- Time found within other subjects (SMS, Metroville, Generations within Ginn themes).
- In government schools a regular day and time (Friday 9.00) has been dedicated to the teaching of health lessons.

The evidence of lesson plans and observation reports confirm that health is being taught in all of the 5 pilot schools. As an example here is the data from one school:

School : Attiya Bai Term 3 1999

Class	Action Plan	Lesson Plan	Observation/Follow up
Class 2	Home safety	No plan in file	30/9/99
Class 3	Home Safety	Joint plan in file	15/9/99 16/9/99 23/9/99 30/9/99
			4/11/99
Class 4	Home safety	Joint Plan in file	16/9/99 23/9/99
Class 5	Home safety	Joint Plan in file	

In addition to the original School Action Plan, more teachers took health lessons and the range of topics was increased to include Lice and Hygiene. The classes 3,4 and 5 were covered by 2 teachers, class two was taken by a new untrained teacher funded by the Fallah foundation, a local NGO in response to the HAS programme.

1.5 Improving children's knowledge and skills

No comprehensive evaluation of children's health knowledge was carried out. However questioning of children in class, informal discussions with small groups, talking to individual children and looking at the work children's work revealed that children had gained and used a variety of health knowledge at a variety of levels.

For example at Attiya Bia School where the children had been studying Home Safety they were asked:

> *Where is the most dangerous place in the home?*
> *What dangers are in your home?*
> *What did you do about them?*

Answers to the first question (*In the kitchen*) reflected given knowledge. Other questions led to varied responses which revealed evidence of individual thought and indicated that it had arisen as the result of independent enquiry outside the class but within the framework of the health education topic.

Other evidence of children's learning is illustrated in this series of "snapshots" of collected during visits to schools.

A group reporting on road safety described different dangerous situations, and had created different posters with individual messages.

This class was able to intelligently discuss the safe and unsafe features on bicycles using the teacher's bike as an example.

A child who had made up a puppet play on Goldilocks was also able to improvise a play with "mother" and "father" and "daughter" puppets on what should go in a lunch box.

This child described how he had made this toy for a younger child.

Children in a Nursery class repeated in English the words of the teacher in a role play about drinking tap water. The "mother" took the sick child to the doctor who wrote ORS on a slip of paper and told the child not to drink tap water

A pupil at SMS displaying and describing his own First Aid Kit

Children acting as the "teacher" question others on good habits, probing with "Why " questions and "What do you do at home?"

1.6 Improving Children's Health Behaviour

Children share safe water

Examples of improved health behaviours due to the HAS programme were collected from teachers. These included reports of improved children's hygiene and the greater care children in HAS classes are taking of their physical appearance (Atiya Bai and Pir Mehfooz). Teachers in Genertations reported having a "Lice Free" school for the first time which teachers put down to using the Child to Child 6 Step approach in their health lessons.
Other reported changes included increased number of children bringing boiled water to school, children bringing healthier food to school in lunch boxes, and at the Government Schools, increased attendance on Friday, the day on which Health lessons are taught.

1.7 Developing Training procedures, materials, strategies, tracking, school based workshops

The HAS Team has shown imagination and flexibility in modifying and adapting training inputs to match the realities of each classroom, school and to cope with the problems caused by the high rate of transfer and the loss of teachers. This is especially evident in the rethinking of HAS inputs into Government schools. Here there have been problems of motivation with teachers reluctant to attend training which involved travel or the use of out of school hours. With the carefully won support of the Deputy Director Primary School Education intervention in the schools is now

a) in school hours and at a regular time,
b) related to the training level already achieved,
c) school based,
d) related closely to outcomes in the classroom.

This has led to a revival of the programme in the two Government Schools, Pir Mahfooz and Attiya Bia indicated by

- The creation of a regular weekly time slot for the teaching of health.
- The addition of new topics chosen by the teachers to their action plan.
- The use of activity methods introduced in training in the classroom.

The training programme has also been developed by the Team to become more responsive to the needs of individual teachers. A detailed recording system has been created which " tracks" and "monitors" the development of each teacher involved in HAS. This allows specific training to be provided, related to the specific levels and needs of individual teachers.

Overall in 1999 13 training workshops involving 79 teachers in the 5 schools have been run, and these have been backed up with monitoring of lessons and feedback meetings with teachers.

1.8 Developing teaching skills and methods

To supplement the training programme a series of workshops centred on particular active methods has been developed by the HAS team. These ***Fun Active Methods in Education*** (FAME) sessions provide HAS teachers with an introduction to using a

wider range of teaching strategies in their lessons. Topics covered includeusing pictures, writing and telling stories, role play and drama, using surveys, learning through games, making and using puppets, and increasing Life Skills and Self Esteem.

Role Play; safe water

Each school has been encouraged to select which sessions it would like from the menu of methods. Evidence of each of these methods was seen during school visits and in the Team's documentation of lessons observed. Some teachers involved in HAS also reported using FAME new methods in other subjects in the curriculum. This is of enormous significance and indicates that for some teachers the HAS programme is providing an effective school based form of "Teacher Training".

Health game

1.9 Developing Planning Skills in teachers

All HAS schools showed evidence of the use of the Child To Child approach to planning, and in particular the strategy of using the *Six Steps* to create a sequence of learning activities. Again the Team has thoughtfully adapted the approach by modifying it for different levels within the school so that lower primary classes use only the first four steps.

The original planning process has also been modified by the Team into a series of simpler steps based on the ideas of ***Small is Healthy*** developed by Hugh Hawes. In the first step teachers create a series of learning objectives within the three categories, *Know, Do* and *Feel.* Next the HAS teachers have created a series of lessons on a health topic which are then linked back to their chosen objectives. Evidence that teachers have been able to develop their own planning schemes and use them was found in the HAS School Files and during visits to schools.

1.10 Establishing a presence within IED and AKU

The physical location of the project within the Institute for Educational Development (IED) of the Aga Khan University has been of strategic importance. IED has a growing reputation both within Pakistan and abroad for providing excellence in both educational research and professional development related to school improvement.

In discussion with non-HAS staff at the Institute it is clear that HAS is seen as a dynamic and well structured part of IED and its presence is highly valued by the IED Directorate. The HAS team has already made contributions to existing courses including the

- Master Education Programme at IED,
- Visiting Teachers Programme at IED
- School of Nursing Courses at AKU

And has established close ties with the AKHS AKES Community Health Services (AKU) Institute of Human Development (AKU)

1.11 Establishing a National presence

The funding of the HAS programme by the Save the Children Fund (UK) has ensured that the project has strong links with an international NGO and has been able to feed information and training into SCF partner NGOs, most recently with the HANDS project in Sindh. Invitations to work on other programmes have been accepted and the team has provided training and developed materials for health programmes in other parts of the Pakistan, notably with the water and sanitation project, WASEP, in the north and the parent/teacher, PEP-ILE supported by GTZ and the Government.

1.12 Documenting the process

The Project has been most thoroughly documented from the start. Each visit, letter, conversation, etc. relevant to the development of the programme in each school is recorded and filed by team members. Where relevant each file note contains a highlighted comment, reflection of point for action

Each of the five schools has its own file with subsections as follows:

- Tracking record for each teacher
- School health action plans
- File notes Record of every meeting and discussion containing bullet points and highlights of reflection
- Correspondence
- Training and Reports
- Lesson Plans
- Lesson Observations notes and comments
- Examples of children's work
- Health Club records if applicable

In addition the Project has detailed records on the nature of each school at the start of the programme and at the end of the first year in the ***Situational Analysis File***. Consultancy Reports, Deliberations and Directions, Resource Centre papers, HAS Team Retreat Report, Correspondence with AKUSON, Correspondence with Child to Child are filed within a ***Directions File***. The ***Outreach File*** contains Articles, correspondence with NGO and Government Partners, Workshop details.
Further files record the work of the project in pictures, and its collaboration with other projects

The Team itself has written regular and detailed reports of its own and a list of these is contained in Appendix A. Among the documentation so far collected there is enough material to provide several PhD students with research data.

1.13 Materials Production

Translation and adaptation of Child to Child Readers, Materials and Activity Sheets into Urdu and the creation of culturally appropriate illustrations. The Child to Child Activity sheets which have been translated as part of HAS activities will, when published in 2000, become the first full IED publication.

1.14 The HAS Team

Through positive leadership a professional and reflective team has been created with a clear knowledge of what the programme is about. Even though membership of the team has changed regularly a clear sense of purpose and direction has been maintained and Dr Khamis' leadership throughout the programme has provided continuity of purpose. The sharing and delegation of responsibilities and the regular weekly meetings has created a strong sense of team responsibility, further fostered by team retreats. The Team are moving into a new set of rooms provided by IED which will allow for even closer communication and greater sharing of ideas and resources.

A Steering Committee was established at the start of the project and meets regularly and is well attended. Its members represent Provincial Government Education and Health services, community health and education sectors within the Aga Khan Development Network (AKDN), SCF and IED. The attendance and input demonstrated at the meeting on December 8th and minutes of previous meetings showed that this Steering Committee has helped to establish a group of varied interests and contacts with whom to share the progress of the project. It also helps to spread ownership and concern for the development of the project and provides an avenue of access to Government support and responsiveness to the impact of the HAS project.

2.0 Comparing the programme with proposals

This section will compare the achievements of HAS with the original intentions as outlined in the Project Proposal and consider the use of the Base Line Data collected at the start of the project.

The original proposal for a joint pilot and research project between IED and SCF (***Health action Schools in Pakistan,*** *Hugh Hawes and Tashmin Khamis, December 1997*) states that the principal aim of the project is to develop Health Action Schools using an integrated approach to health promotion which is based on a comprehensive school health programme. The three components originally envisaged were

1. *Health education*
2. *The school environment*
3. *The school health services*

In particular 6 sample characteristics were listed for an effective health promoting school;

- *Health priorities related to children's needs*
- *All teachers and communities should know and approve those priorities*
- *Teachers and children promote a healthy school environment*
- *The involvement of school health services*
- *Developing school to community and community to school links which promote health*
- *Designing the "action programme" to fit the needs of each school*

General Analysis

The programme so far has been focussed essentially, and in my opinion quite rightly and realistically, on the first of the three areas of action, the health curriculum. The success in this area, as has been outlined in Section 1, is clear and evident. Teachers are planning and teaching health lessons. By contrast there is much less evidence of HAS success in influencing improvements in the school environment and in involving the health services.

2.1 Impact through Health Education

Details and examples of HAS success in this area have already been highlighted. This section focuses on two factors which are effecting the quality of this intervention.

1) The use of a second language in Health Education

The least successful lessons observed were in English. Using a second language severely restricts the pupil's ability to express their own feelings, discuss their own ideas and so relate to learning to their own situation. In general it hinders participation in learning. It encourages simple formulas to be given by the teacher (*Go to doctor*) and memorisation of responses by children *(First aid is the* ....).

2) The need to set Health Knowledge in a real context.

The work produced by children on road safety exemplified the temptation for the teacher to provide simplified, unrealistic and irrelevant data. Children had been splendidly involved in producing posters on Road Safety. The majority had produced information on traffic lights and road signs and had pictures of Zebra Crossings. Only one pair had thought about the reality of crossing a road in Karachi where it is dangerous to believe in traffic lights and the safest way to cross a road is with lots of other people.

Focus of attention
Use of first language and relevance and accuracy of health knowledge and practices

2.2 Impact on the School Environment

Attempts to influence the schools attitude to its environment within the HAS programme have been of limited effect. There are reasons why this should be so. The most immediate and available target group has been teachers and they are first and foremost involved in teaching in the classroom. Their major concern is with transactions within the walls of the classroom and the school timetable .. They have been responsive to the structured intervention programme provided by HAS, which without too much time commitment, fits into the teachers needs to prepare for the next topic, the next lesson. By contrast the school environment is static and its improvement lies outside the concern and sometimes the power of the teacher. It is also hard to make the improvement of the school environment a joyful and creative teaching and learning experience. (No child should be asked to improve the faeces strewn blocked latrines at Pir Mehfooz). It is difficult to design general intervention strategies because of the varied nature of the schools chosen and enormous range in the school environments.

The Checklist

One of the major approaches tried by HAS was to encourage schools to monitor their own environment. Effort and time has been spent by the team developing and encouraging schools, teachers and pupils, to use a detailed school health Environmental Checklist. This list was developed and modified to help schools monitor their own school environment. It was based on an analysis of their own needs and to some extent reflected the nature of the different school environments. The records kept by HAS in each school file contains completed forms and below is a simple analysis of some of the data.

School	Number of Checklists Completed	Date Last Completed	Examples of comments on form
Attiya Bai	6	Mid 98?	Some forms completed by form 5
Pir Mehfooz	8	Oct 98	"We are very upset due to scarcity of water and need your co-operation" "No one is ready to run this programme. No one has appreciated them for doing this"
Generations	13	1/1999	
Metroville	13	4/1999	
SMS	10	1/1999	"After h(ealth) action now dustbins are present in many classes. These additional dustbins have been bought in by students"

Schools have now decided to stop using the checklist. The most detailed forms were completed by Pir Mehfooz and tell a story of repeated lack of water, fouled latrines, cries for help. These were not issues that HAS was able to help with directly and this helped to undermine the programme in this school for a period.

Lack of water and inadequate sanitation are the most obvious problems in creating a healthy school environment. They are also the hardest for HAS teachers to solve, especially in Government Schools. But the concept of a healthy School environment involves wider issues, and HAS schools have been involved in developing First Aid Kits and monitoring children's diet.

On the positive side, within the curriculum intervention programme there have been clear examples of lessons, topics and activities that have related closely to school environmental issues. Examples already within the programme include

Safety	Looking at safety in the school
Safe water	Looking at sources of water in the school, bringing bottled water to school
Hygiene	Developing a Lice Free School

Focus of Attention
Developing ways which involve creative monitoring of the school environment leading to achievable improvements.

2.3 The Health Services

The pattern of provision in the varying schools is different. In Government Schools the School Health service employs 2000 doctors to regularly visit (two days a week) the 2532 Government Schools in Karachi. These doctors have so far proved to be "invisible". No visits are recorded at HAS Government Schools. Schools, which are part of the Aga Khan Education service, are served by the Aga Khan health services and SMS has a school nurse Doctors have visited the school to check all children on entry to the school and do so again when they are about to leave. The Head (and owner) of Generations is a medical doctor.

Integration of the Health Services within the HAS programme has so far been difficult to achieve. Positive initiatives have been the

- involvement of the school nurse at training sessions (SMS) but she has been extremely reluctant to consider changing her role to include interaction with teachers and in the classroom. ("I will come but only if you do not ask me any questions")
- inputs by the team into the courses run by the School of Nursing and consulting with the school of nursing over their practicum in schools (Attiya Bia)
- Input into the training of Lady Health workers within the WASEP programme.

Focus of Attention
To develop practical strategies, where possible, which use and involve school health services within the HAS programme

2.4 The School and Community

The programme from the outset considered the community in which the schools are set and evidence of a considerable amount of data about these communities is to be found in the HAS Base Line Survey. The "community" as seen defined by HAS is essentially the families with children at HAS schools.

Evidence of children relating their health knowledge to their homes comes from the lesson plans and lesson observation reports. Simple examples found included

• Safety in my home on higher shelf?	Children listing objects at home that should be put on a
• Nutrition	Children making a list of desirable food for lunch boxes

But within the HAS programme so far there is little evidence of *developing community to school links which develop health* (Project Proposal) . In fact in Metroville, which is called a "community " school, there was very marked reluctance on the part of the Head teacher to countenance such an idea. It became clear in discussion with the Head that she was very keen to protect her teachers from parents and understandably so. All are unqualified and most are young and quite inexperienced. The school is fee paying and selective. Parents pressurise teachers.

Gradually during a general staff discussion on this issue the possibility of the parents being of positive benefit and combining to help in health actions began to emerge and without great conviction the Head talked of having a Health "Mela" or fair with the parents help. There was more enthusiasm for their own idea of children taking on the responsibility for being "Health Monitors" in the colony surrounding the school.

The most positive model of community co-operation within the programme is at Attiya Bai School where a local family is supporting this school and others through the Fallah Foundation. The Foundation provides materials and helps with the repainting of classes. As a direct result of the HAS programme the Fallah Foundation is employing two young teachers at the school and both have become participants in the HAS programme.

Focus of Attention
To explore specific and school related community school links that can be integrated with the HAS programme

2.5 Reconsideration of the original comprehensive school model

Diagrammatic representations of programmes and inputs can often be misleading, especially two-dimensional drawings to represent complex relationships. The triangular model that has been used by HAS to represent the relationship of Health Education/Health Services/School Environment has dangers of implying that all three areas of intervention are

- equally important
- equally amenable to influence
- naturally and dynamically linked.

These assumptions are not true of the HAS schools.

Focus of Attention
Need to conceptualise new models, probably school specific

2.6 Using the Base Line Study

As part of the research design for this project a baseline survey was carried out and the findings consolidated in a report (Health Action Schools, IED, Baseline Data report, Susie Pullan,1998). The report used a variety of strategies for collecting data including focus group discussions, activities such as Draw and Write, Sentence Ordering , creating Pond Picture, Picture Discussion, and What happens Next? Further data was collected through Home Observation and Health Knowledge and

Self-Esteem Questionnaires. The data was consolidated in a Situational Analysis Report and school profile of each of the 5 schools in the project.

The report contains an enormous amount of material which has helped the HAS team in its understanding of the needs of each school and in designing its programmes. However explicit in the document is the assumption that this data will be supplemented and used in combination with *post-intervention data collection.*

The use of the base line data in a pre/ post, now/ then analysis in any quantitative way will be extremely difficult and of limited value. As useful as the data has been it is essentially qualitative and should not be seen to drive an attempt to collect data for quantitative analysis. The one exception to this is the data relating to health knowledge. Unfortunately as the data on health knowledge exists in the Situational Report it is opaque and uninformative due to combination of discrete items. The raw data, however, still exists so that specific items on the health tests could be used again during the project and may provide useful data on the health knowledge of children within HAS classes and HAS schools.

Focus of attention
Formulating realistic, useful and achievable guidelines for reporting on the programme (Appendix R contains some thoughts on research questions)

Section 3 Reflections and Suggestions

This section contain thoughts and ideas which have arisen out of the Mid Term Review process and from discussion with the HAS team. It is hoped they will stimulate the Team in its development of the next phase of the programme up until March 2001.

3.1 Health education in school and classroom

Interrelated priorities to consider for the coming year to help sustain and improve the quality of the health education component are

- Developing guidelines for heads and teachers
- Developing an outline curriculum in waiting
- Collecting activities that have worked well and using them to stimulate other teachers
- Creating new FAME sessions

3.2 Developing support materials

HAS Starter Pack

This excellent idea, suggested by the Team, involves the creation of a simple *HAS Starting Guide,* a small guide for Heads and Health Co-ordinators in Health Action Schools. The guide would give background ideas and activities for a whole school workshops to be used to introduce the concept of the HAS school health improvement programme based on simplifying materials already used and developed by the team and including:

- *What is a HAS school?*
- *Health needs analysis*
- *What is Child to Child? - 6 step approach*
- *Developing a School Health Action Plan*

Simple Topic Workbooks for Teachers

The creation of workbooks for teachers to be used in training in HAS schools following and developing the model given by *Small Is Healthy*. Each workbook will be devoted to a single health topic such as Safety, Hygiene, Food etc. They will encourage thoughtful participation by the teachers by being *Workbooks* for teachers to complete and keep as resources to be used in their teaching.

Possible Structure for Workbooks

Part 1 Health Information simply and clearly presented with spaces for teachers to fill in locally appropriate information (eg sources of Vitamin C, local danger spots). "Reaction Boxes" will be set beside health information and filled by teachers with appropriate symbols:

I didn't know this	!!
I knew this	☺
I would like more information about this	??

Part 2 Topic Planner. This will be based on the format already developed by the team and successfully used in lesson preparation.

Stage 1 Some examples of objectives will be given and teachers will generate others in each of the three categories: ***Know, Do , Feel***. The ***Do*** category can usefully be subdivided into ***Do in the Classroom, Do in School, Do at Home***
Stage 2 Making Lesson Plans to cover a series of lessons on the topic and matching each lesson to Objectives.

Part 3 Activity Planner
This section will contain a range of simple activities, games, stories, role plays , surveys related to the given topic. The activities will be graded by level so that suitable activities are selected related to age of the children.

Where possible the activities will ideas collected by the Team from their observations of and discussions with HAS teachers so that they activities that other teachers have actually used successfully with their classes. In this section of the Workbook teachers will select and record which activities they will use with each of their planned lessons.

3.3 Developing new FAME Session

These sessions have proved themselves as an effective way of widening teachers strategies. New sessions to be added to existing menu could include:

1) Using simple evaluation techniques
Evaluation remains a difficult step for teachers. A FAME session on evaluation can introduce teachers to some alternatives to existing forms which can be built into their health lessons. The session could involve simple ideas related to continuous assessment and a include a variety of testing techniques including quizzes with individual or group responses, oral tests, children making up their own tests for other children, etc. Informal and formative evaluation can be based on children's picture, written or spoken record of "What we did", "What we found out.

2) Using Simple Resources
Ideas to stimulate teachers to make more use of what they have around them to make learning come alive.
Examples can include

- Using a bike to look for safe and unsafe features
- Using lunch boxes for making a graph
- Using children and their own bodies, observing teeth, looking at each others finger nails etc

3.4 Developing an outline Primary Health Curriculum.

Teachers and children need to see learning in health as a co-ordinated and planned sequence of activities. HAS can create and develop with teachers a planed Health Curriculum, a simple scope and sequence chart for the major health topics that have been chosen by schools. For example, a simple outline of the development of topic of hygiene can be created as the topic is met first at Lower Classes (1 and 2), then in middle classes (3 and 4) and finally in Upper Primary School (Class 5). Objectives and activities within the topic can be matched with class level, and a sequence of learning outlined which ensures both conceptual and learning development and also maintains reinforcement of important ideas and practices.

3.5 School Environment

Developing ways which involve interaction with the school environment leading to achievable improvements.

Suggestions

1) Identifying topics and lessons and activities within each topic and level that can be linked to improving the school environment

For example

Class	Topic	Activity
Class 1, 2	Clean Drinking Water;	Who has clean drinking water? Do some children bring water? How can all children have clean drinking water? How much do we need?
Class 3 and 4	Safety in the school	Where are the dangerous places in the school? How can we make them safer?
Class 5	Hygiene	What kinds of different rubbish are in the school? Where does it come from? How does it get to school? What shall we do about it?

2) Considering the wider implications of the "healthy school" in terms of self esteem and self expression and the implications for the English Medium schools in terms of first language use in Health Education..

3) Experimenting in the one school Atiya Bai in which a local NGO is involved in a partnership approach to improving the school environment.

4) Monitoring and recording the benefits of school clubs, The Neat Club, The Safe Club and perhaps the First Aid Club on the school environment.

3.6 Developing links with the Health Services

To develop practical strategies, where possible, which use and involve school health services within the HAS programme

The most accessible Health Services with which the HAS project is in contact are those connected with the Aga Khan Network. Two possibilities are to develop the link already established with the School of Nursing at AKU and to persevere with cultivating the relationships with the Nurse and the Aga Khan Health Services in their work at SMS.

3.7 Consolidation and "writing up" of Achievement: Case Studies

Strong anecdotal and observational evidence exists of the effectiveness of the HAS approach to health education. This needs to be effectively filtered from the existing documentation, collected and collated and supported by further evidence. One way of doing this would be through Case Studies. Case studies can provide illustrative data to illuminate the factors that have been critical in the successes and failures of the project and provide data that the analysis of the successes of the programme becomes both sharper and deeper. Possible case studies are:

1) A detailed case study of individual schools. The story of keeping the programme alive in Pir Mehfooz is both dramatic and full of illustrations of significant problems and successes.

2) Case studies of selected teachers. As an alternative to asking teachers to keep a reflective journals short focussed interviews with selected teachers could be used to bring out their own experiences of changed attitudes, use of new methods, understanding of health education. These interviews need not be long and could be integrated into existing school visits.

3) Focus studies on particular changes brought about by the programme.
Identify three or four areas where change has already been evident and collect and examples, data, anecdotes and comments from teachers, children and parents. Such topics could include

- Change in Health Behaviours by children
- Growth in Health Knowledge of children
- Use of new methods by teachers
- Use of out of school health activities

4) Case studies in particular schools of the impact of the programme
The detailed story told through teachers and children's comments and pictures of the development of certain initiatives. For example

- *Creating a Lice free school*
- *Improving Children's Diet*
- *Bringing safe water to school*
- *Developing and designing school, class, individual First Aid Kits*

These "stories" might involve the "recreation" of some programmes or the transfer and monitoring of the idea in a different school.

5) Case studies of how ideas have spread from one teacher to another, one class to another, one school to another.

3.8 Research Questions

The design of the programme has meant that though only a limited number of schools are involved there is a wide range of variables which are impacting on its implementation. In Appendix 1 are listed some of these variables. All or some of these can be analysed as part of the final report on the Pilot stage of this programme and their impact on the effective implementation of the programme considered.

Decide now what the form of the Final Research Report is going to look like and structure documentation over the next year to feed into this.

3.9 Dissemination strategies and the spread of ideas

The HAS Project is still in the pilot phase but it is essential that at this stage the HAS Team plans how to widen the impact of the successes of the innovation as widely as possible. The potential for the replication, diffusion, and advocacy of the strategies and materials developed needs to be as fully realised as possible. Here are some suggestions for consideration to help in these processes.

Identifying the necessary factors that have led to successful implementation within the existing programme.

Creating a checklist of essential components of the programme covering the following issues;

- What is a realistic Time Frame?
- What level of funding is required?
- How are working "contracts" with participating schools established?
- What structure needs to be established in the school?
- What training is required?
- How much continuing support is required for each school?
- What makes a HAS Team?

Identifying a Strategy for the Replication of the Programme

In their work with other agencies the Team has used the strategy of inviting them to work alongside the team. A possible strategy for the replication of the model would involve

1) identifying an opportunity for working in another area or with another NGO in which the essential components of the programme could be guaranteed. Already approaches have been made for help with other programmes within SCF (HANDS) and within the next year even better opportunities may arise. Alternatively, replication within the AKES system can be linked to its Professional Development Centres (e.g. Gilgit).
2) Inducting any new HAS project team through working alongside the existing HAS team and HAS teachers.

Monitoring and investigating possible dissemination strategies that have naturally arisen during the project

The Team has already found that there has been a naturally spread of the ideas from the schools and teachers already in the project. This diffusion of ideas from what can be seen as model schools can be accelerated. The HAS team can consider which of the following opportunities can be fostered and developed:

Diffusion within the HAS Schools

- From morning session to afternoon session
- From HAS teacher to non Has teacher
- From Health co-ordinator to new teacher

Diffusion between schools

- Within schools of the same type especially those supported by the same organisations e.g. AKES schools, Schools supported by the Fallah Foundation
- From class to class via transferred teacher.

experimenting with active and creative approaches to health education and promotion in schools in Pakistan. Positive opportunities for real sustainability exist.

Through the Health Education Faculty at IED.
AKU is long term institution. The establishment of a Faculty of Health Education with IED is a substantial step in maintaining Health Education as an active force and a vital ingredient of every child's education. It can ensure that the lessons of HAS are known and used but it is also essential that at the end of the pilot phase the Health Education Faculty continues to be rooted and grounded an a continuing school action health programme.

Through the recruitment to the Faculty and to the HAS team of well qualified and motivated nationals.
The Health education component of the MEd programme can be seen as a key recruiting ground for nationals to take on the continuation of HAS programmes.

Through the production of written materials.

Through the advocacy of the Child to Child Network world-wide

Through integration of key HAS concepts into SCF programmes

Appendix A Documentation of HAS Reports

Reports

- **School Health Intervention Programme,** Report Water and sanitation Extension Programme, October 1999
- **SHIP Health and Hygiene Promoters Guide,** HAS Team 1999
- **PEP ILE Parent Teacher Relations,** Units 9-12, HAS Team IED, Dec 1999
- **Health Action in Schools in Pakistan, Annual Report** April 98-99, For SCF
- **Health Action in Schools in Pakistan, Progress Report**, The First 6 Months, April 98-Sept 98
- **Health Action Schools in Pakistan – a pilot Research Project**, Report of 5th Quarter, April-June 1999, for SCF
- **Health Action Schools in Pakistan, a pilot Research Project**, July- Sept 1999 for SCF
- **Health Action in Schools**; Teacher Training workshop, July 1999
- **Health Action Schools**; Teacher Training Workshop, Feb 1999
- **Health Action School**; Base Line Data Report, 1998, Susie Pullan
- **Health Action Schools and Special Education**, Farah Shivji, Dec 1999
- **Health Action Schools- from Practice to Policy**; a case study from Pakistan, Tashmin Khamis , June 1999

Appendix 1 Research variables

Research Report

There are many factors that differentiate the programmes being run in the five different schools. It may help when composing the final Research Report to reflect on which of these variables plays a significant role in the successful implementation of the project. Much of the data is already in the files but if there are variables that at this stage under documented now is the time to consider them and to prepare to collect more information.

Variables

Nature of Schools A wide range of Management Structures: Government, Government with NGO support, Community, International NGO Schools (SMS) , Private,
Gender: Boys / girls
Nature of Shift: Morning/afternoon One shift/whole school

Nature of Teachers
Untrained/ trained
Experienced/ inexperienced
Men/Women
Committed not Committed
Present/ absent
Number of teachers involved
Continuity of teachers in programme

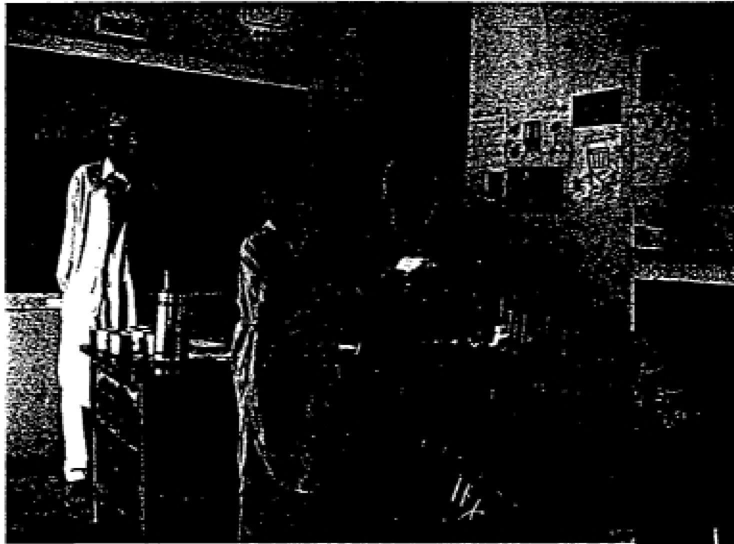
Nature of Intervention
IED training
School Based
Topic Based
Method Based

Nature of Classroom Intervention
First language/Second language
Integrated into other subjects
Enhancement of other subjects
Separate Health Education

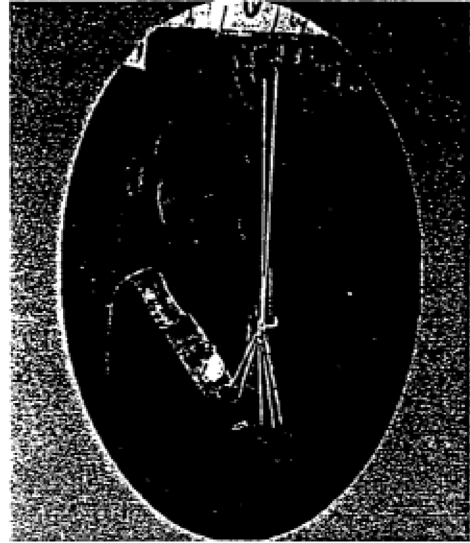
Level of input
Lower/Middle/Upper classes
Age of children
Weekly, irregularly

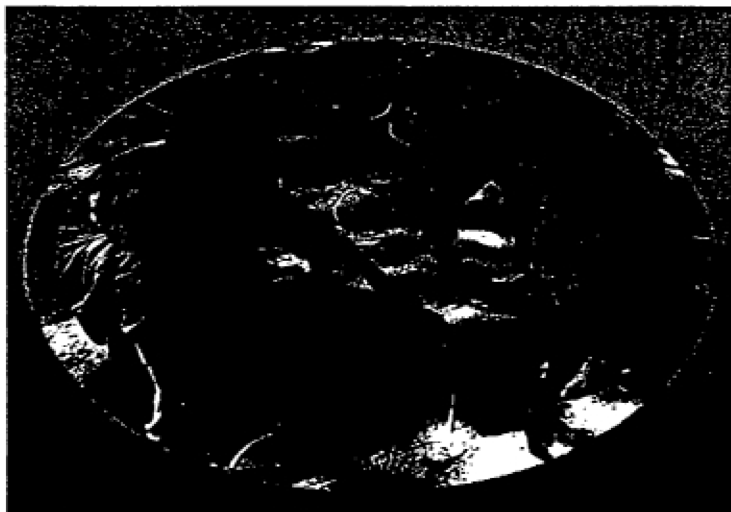
Picture Report
Pir Mehfooz

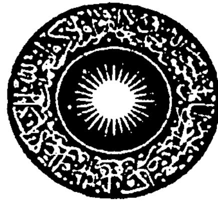
Talking about safety on roads around the school



Giving a report on safety at home







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THE AGA KHAN UNIVERSITY

Institute for Educational Development

Health Action Schools, Pakistan

Policy Dialogue on School Health Promotion

January 24 – 25, 2001

March 2001

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Contents

Executive Summary 1

1. Introduction: Why a Policy Dialogue of School Health Promotion? 3
2. The Pilot Health Action Schools (HAS) Action Research Project 4
   - 2.1 Lessons Learned from the HAS Pilot Action Research Project 5
3. Beyond the Pilot Phase 7
   - 3.1 Health Education Curriculum in Pakistan 7
   - 3.2 HAS Beyond the Pilot Phase – Needs Identified 8
   - 3.3 Participations' Suggestions for Action 9
4. Panel Discussion: Implications and Recommendations-What was Committed ... 11
   - 4.1 A Strategic Vision and Goals 11
5. Outcomes of the Policy Dialogue 13
   - 5.1 HAS Expansion – First Steps with the Sindh Ministry of Education ... 13
   - 5.2 Meeting with the Secretary of Education 13
   - 5.3 UNICEF 13
   - 5.4 Health Education Database 14
6. Conclusion 14

Appendices: Templates for Discussion

1. An agreed and published list of minimum health knowledge and skills that all primary school children in Pakistan should acquire before leaving Class V.
2. An agreed health entitlement for all primary schools in Pakistan, which both schools and those who provide and supervise them should strive to meet.
3. Proposed health education curriculum scope and sequence chart for Classes I-V to plan health education across a whole school programme.
4. A set of lessons around a priority health theme.
5. How can a school become a health promoting / health action school?
6. List of participants and organisations represented.

Executive Summary

Children who are healthy are happy and learn better.

A Policy Dialogue was held by the Health Action Schools Research Project based at The Aga Khan University, Institute for Educational Development on January 24th and 25th 2001. The overarching objective of the Policy Dialogue was to advocate health education and promotion as a key determinant of quality education based on the experiences of the initial pilot phase and outcomes of the Health Action Schools project.

The Health Action Schools project began as an initial three-year action research project in partnership with Save the Children, UK. The principal objective of the Health Action Schools project was to develop prototypes of health promoting schools in different social and educational contexts in Pakistan. The Health Action Schools' model is based on the WHO (1996) Global School Health Initiative and links school learning with health action in the home, based on the Child-to-Child Approach.

The Policy Dialogue attracted representatives from the federal and provincial ministries of health and education as well as public and private sector NGOs, INGOs, and international donor agencies. The Dialogue was facilitated by Hugh Hawes, Professor Emeritus Institute of Education University of London and co-founder of the Child-to-Child movement, and Dr. Tashmin Kassam-Khamis, Principal Investigator of the Health Action Schools project.

Results of the pilot phase of Health Action Schools were presented which have met success in the following areas:

- Health Education and School Improvement.
- Health Education and Teacher Development.
- Health Education, Quality Education, and Benefits for Children.

Lesson learned from the pilot project have included how best to impact children's learning, teachers' training and development, and school improvement using the concept of comprehensive school health promotion in Pakistani schools.

Participants at the Policy Dialogue agreed to the following as strategies to impact policy-makers as well as further implementation of health education across Pakistan:

- An agreed and published list of minimum health knowledge and skills that all primary school children in Pakistan should acquire before leaving Class V.
- An agreed health entitlement for all primary schools in Pakistan, which both schools and those who provide and supervise them should strive to meet.

- Proposed health education curriculum scope and sequence chart for Classes I–V to plan health education across a whole school program.
- A published set of lessons around a priority health themes.
- A published guide for schools to become 'Health Action/Health Promoting Schools'.

Upon the conclusion of the Policy Dialogue the Sindh Minister of Education, Professor Anita Gulam Ali, welcomed the advent of health action schools and committed the Sindh Education Department to develop a minimum of 40 models in at least two government schools in each district throughout Sindh. In addition through the Sindh Education Foundation 100 Community Supported Schools are including health education in their curriculum with AKU-IED conducting the training and SEF monitoring and implementing the project. Similarly, the UNICEF Education Officer is keen to develop a partnership between public sector agencies working in close collaboration with the private sector to promote health action schools throughout Pakistan. Save the Children, UK, the original partner of the HAS project with AKU-IED, has committed additional resources to extend the lessons of the project and to disseminate these throughout the region as well as develop a health education database.

***Emerging key issues, such as, computer literacy, population and environmental education, health education, AIDS education, and values education, ... shall be introduced and integrated in the curricula* (National Education Policy 1998-2010, Government of Pakistan).**

Health is a state of complete physical, mental, social and spiritual well being and not merely the absence of disease **(WHO 1996).**

1) Introduction: Why a Policy Dialogue of School Health Promotion?

People sometimes think of education as the accumulation of facts and basic skills. They sometimes think of health as the opposite of illness. But education and health are broader, richer concepts ... and they are inseparably linked **(WHO Global School Health Initiative, Geneva 1996).**

Over the last decade two global trends have emerged to make the provision of school health education an absolute priority. First, there has been the emergence of great health challenges which can only be met by a population that is literate in their knowledge about these health challenges and who have the skills of making decisions and taking actions that are required to overcome these challenges. The second reason – somewhat more subtle – is the awareness that health education extends far beyond the conventional hygiene learned at school. Health education now needs to encompass mental and emotional issues concerned with modern pressures of living, adopting safer lifestyles, and promoting healthier environments.

This Policy Dialogue Report, building on the lessons learned from a Pilot Health Action Schools (HAS) Action Research Project based at The Aga Khan University Institute for Educational Development (AKU-IED), highlights significant successes in meeting these health education challenges inclusive of the following areas:

- Health Education and School Improvement.
- Health Education and Teacher Development.
- Health Education, Quality Education and Benefits for Children.

The Policy Dialogue Report ends with recommendations made by a panel representing both federal and provincial level officers in the health and education sector as well as members of donor, NGO and the academic community in Pakistan.

The Aims and Objectives of the Policy Dialogue held in Karachi on January 24-25, 2001, were to:

- Share experiences and discuss the need for Comprehensive School Health Promotion (CSHP) in Pakistani schools.
- Identify what is possible in the area of CSHP based on lessons learned from the pilot Health Action Schools (HAS) research project.

- Consider whether there are minimum health entitlements for every school going child and how any school can achieve this.
- Consider how health education may be planned across a whole school programme and recommend whether and how a core set of lessons should be included in the curriculum.
- Consider and recommend whether a special category of Health Promoting / Health Action Schools might be created and expanded and how such schools might be supported.
- Receive a copy of the Urdu Child-to-Child activity sheet (*Sehat-Ki-Batein*) and learn from teachers and children how these materials have been used to teach health education in the pilot HAS schools.

***For all schools to become health-promoting schools, a variety of supportive actions are required by organisations at various levels. No organisation or sector can meet these requirements alone. We must take these steps together* (WHO Global School Health Initiative, Geneva 1996).**

2) The Pilot Health Action Schools (HAS) Action Research Project

Children who are healthy are happy and learn better.

It is now evident that the remit for health education has widened. However, health does not conveniently fit into the established patterns required by school subject panels, teacher educators or examination boards; health extends right across the curriculum.

The pilot HAS action research project provides important lessons to bridge this gap between newly identified health challenges and established systems of planning and delivery of health education.

Using the WHO Comprehensive School Health Promotion Model (1996), the HAS pilot action research project has integrated three components in comprehensive school health promotion that usually work separately in schools. Thus health education, health environment, and school health services or health care are integrated in one programme that aims at developing a Health Action School. Further, the HAS project uses the Child-to-Child Approach linking children's learning at school to the realities of the communities in which they live. Through this approach, children's learning at school complements what they have found out for themselves in the community. Thereby, children's learning is intrinsically linked to their behaviour and actions.

The HAS project has been working in five (5) primary schools, including pre-schools, representing different social and educational contexts over the last three years: 1998-

2001. Two government, two private and one community-based school comprise the original HAS pilot schools representing urban and peri-urban contexts.

2.1 Lessons Learned from the HAS Pilot Action Research Project

Whereas all three aspects of CSHP are important, teachers and schools have benefited most from the health education provision with the school environment and school health services augmenting the provision.

Children tending to the health environment

For Schools:

- Health education content can be taught in 30 lessons per year or one lesson per week.
- Health education topics can NOT be taught in one lesson, but over a series of steps that link lessons at school with action at home or in the community.
- Health education can be taught either separately, as some schools have decided upon, or across the curriculum using other carrier subjects such as English, Mathematics, Islamiat, Science, and Social Studies. All these subjects have content matter in the curriculum related to health, or health content that can be used to enhance the teaching of skills of these subjects.
- Schools, teachers, and children are drawn to health education as it relates to their daily lives, it is personal, it is child-centred, and helps teachers to use methods that promote understanding and relevance.

Children learn and have fun at the same time when we teach health. More children come to school on the day when health is taught.

We used to have at least five accidents a day in the school. Now after the topic 'Preventing Accidents' the nurse only has to attend to one or two accidents a week.

For Teachers:

- Teachers now regularly plan lessons and use active methods to teach health education which requires children to apply what they have learned at school and rely on the situation in the community to further inform their learning at school.

This is the first time I have used stories in my teaching over the last eight years and the children really enjoyed it. They were all listening.

For the first time our school is lice-free! The children understood the problem and found the solutions themselves. I think it was the Child-to-Child approach that did it.

- Teachers have started planning their lessons and using active approaches in the other subjects they teach, once they have gained confidence to teach using these skills in health. The absence of examinations or a set curriculum in health gives teachers room to experiment with new teaching approaches.

For Children:

- There is marked improvement in children's health knowledge, skills, and behaviour. That is, health knowledge is being translated into health action and healthy behaviours as the following quotes from children show.

We do not buy food from hawkers because there are many flies, which cause germs. We like to bring clean food from home to eat at school.

We enjoy making charts, performing dramas, and conveying health messages to others at school and at home.

- Evidence from the ongoing research shows that life-skills and self-esteem has also improved as children feel:

    - Concerned about the safety and cleanliness of their school environment.
    - Responsible for conveying messages, for example, about road safety to those at school, at home, and in the community.
    - Confident in spreading awareness, for example, through posters about drinking clean and safe water.
    - Pride in taking action on issues such as food hygiene through pictures and dramas.
    - Empowered to conduct surveys about health issues in the community.

3) Beyond the Pilot Phase

The HAS project has had significant success and has expanded nationally and regionally. Lessons that have been learned have been shared with other agencies who have, in turn, requested services from AKU-IED and SC-UK in terms of training health educators/promoters; developing curricula; consulting on the development of their own programmes that include health education which aim at both raising health awareness as well as improving the quality of education children are receiving. The following organisations have asked for assistance from HAS to inform their own work:

- Northern Areas and Chitral: School Health Intervention Programme, Water and Sanitation Extension Project (WASEP).
- North-West Frontier Province (NWFP): Primary Education Programme-Improving the Learning Environment (PEP-ILE) and Afghan Relief and Rehabilitation (ARR).
- Interior Sindh: Health and Nutrition Development Society (HANDS).
- Afghanistan: Save the Children (UK).
- Karachi: In Karachi, HAS has worked with more than 3,000 children and 250 teachers, health and community workers.

3.1 Health Education Curriculum in Pakistan

***Emerging key issues, such as computer literacy, population and environmental education, health education, AIDS education and values education, ... shall be introduced and integrated in the curricula* (National Education Policy 1998-2010, Government of Pakistan).**

Both official government policy and subsequent additions to the national curriculum have highlighted the importance of health education in schools. The 1995 and 1974 curricula consider health education as important and crucial for the needs of the overwhelming majority of the population and an essential component of the education system. Areas of health education covered in the current curriculum are: personal hygiene, elimination habits (smoking, spitting), accident prevention, food and nutrition, environmental

sanitation, communicable diseases, growth and development, and human physiology which covers the broad range of health related issues.

A review of primary level textbooks reveals a host of health-related topics that have mention:

In Science areas covered included: animals, plants, environment, water, air, pollution, microbes and diseases.
In Social Studies: environment, community around us, our neighbourhood, healthy habits, rights and duties, and safety from accidents.
In Islamiat: ways of eating, cleanliness, prayers and punctuality, love for religion and country, and taking care of others.
In Language Subjects: play, crossing the road, beneficial plants, and food for the family (English); taking care of health, immunisation, and helping others (Urdu).
In Mathematics: measurement – height, weight, and volume, including ORS, and graphs, for example, growth charts.

It is evident that scope exists within the present educational system to further enhance health education since:

- The education policy acknowledges the importance of health education; and
- The curriculum and syllabus offer ample space to teach health.

3.2 HAS Beyond the Pilot Phase – Needs Identified

The overarching aim of the post-pilot phase of HAS is:

To advocate health education and promotion as a key determinant of quality education.

In order to move expeditiously towards the above aim five actions need to be taken by the relevant authorities, which were endorsed by all the participants at the Policy Dialogue. Further, the participants deliberated upon the following proposed activities to facilitate schools to become health promoting:

1) An agreed and published list of minimum health knowledge and skills that all primary school children in Pakistan should acquire before leaving Class V.
2) An agreed health entitlement for all primary schools in Pakistan, which both schools and those who provide and supervise them should strive to meet.
3) Proposed health education curriculum scope and sequence chart for Classes I-V to plan health education across a whole school programme.
4) A set of lessons around a priority health theme.
5) A published guide for schools to become health promoting / health action schools.

The templates that served to initiate discussion leading to the proposed activities are appended to the end of this report (Appendix 1-5).

A further step taken by AKU-IED in partnership with SC-UK has been to develop a Child-to-Child Resource Centre as a first concrete step towards the above five actions. The resource centre is already operational and based at the AKU-IED. It assists teachers and children from HAS schools to develop their own health education materials in addition to serving as a venue for continued training and developmental needs for other schools who wish to become health promoting.

3.3 Participants' Suggestions for Action

3.3.1 An agreed and published list of minimum health knowledge and skills that all primary school children in Pakistan should acquire before leaving Class V. (Appendix 1)

Participants agreed that such a published list would be a useful document for future health education planning. Discussions highlighted the importance of using culturally appropriate language to support children to disseminate ideas about sensitive health issues such as HIV/AIDS. Participants emphasised the crucial importance of developing a simple to understand document for easy comprehension.

Further, it would be useful to translate such a document into local / provincial languages by representative stakeholders comprising of the Ministry of Health and Ministry of Education as well as parents, teachers, and other private sector organisations so that a broader target audience can be reached.

3.3.2 An agreed health entitlement for all primary schools in Pakistan, which both schools and those who provide and supervise them should strive to meet. (Appendix 2)

The participants agreed on the need to publish a document listing the health entitlement for all schools. Participants noted that teachers and children themselves must be involved in the materials development process to aid the relevance of such materials and so that the materials can be localised and owned by the beneficiaries of the materials.

Participants suggested the development of provincial networks to enable sharing of experiences and creating of synergy between and among the provinces. Materials that have already been developed with the assistance of HAS were endorsed as good models for other organisations and the government as were other materials developed by WASEP and the Punjab Middle School Project.

3.3.3 Proposed health education curriculum scope and sequence chart for Classes I–V to plan health education across a whole school programme. (Appendix 3)

It was considered by participants of the Policy Dialogue that the scope and sequence charts would best be promoted through the provincial textbook boards, health and education departments, subdivision offices, examination boards, teacher education institutes – especially the Provincial Institutes for Teacher Education, which have now been established throughout the country.

A further recommendation was that there is a concurrent need to devise health education programmes for headteachers who can provide teachers with the required classroom-based support.

3.3.4 A set of lessons around a priority health theme. (Appendix 4)

The importance of identifying specific material linked with essential health priorities was acknowledged by the group and had general agreement to publish such a document.

It was the considered view of the participants that teachers require their training to be adapted using a stepwise approach to health education according to the time and resources available in their context.

The Policy Dialogue advocates for training master trainers who would, in turn, train teachers to teach health education. To ensure sustainability, experience from ongoing projects suggests that school-to-school interaction will be necessary to share experiences and resources.

3.3.5 How can a school become a health promoting / health action school? (Appendix 5)

A published guide for schools to become 'Health Action/Promoting Schools' was considered to be important by the participants of the Policy Dialogue. Participants felt that the idea of developing 'Health Action Schools' will be more plausible in rural contexts where 'community' is more easily defined and because of the lack of examination pressures which allow more experimentation and uptake of innovations.

To encourage sustainability of health education initiatives in all schools, it will be crucial for schools themselves to lead the initiative and for the head of the school to be committed from the outset. Schools will need to involve their communities, possibly through the existing village education committees, parent-teacher associations, prominent community leaders, and *imams* of mosques who can participate in the relevant decision-making as it affects health education in the schools.

Associated with basing the initiative in schools, associated and complementary action needs to be taken at the federal, provincial and local government levels to create awareness and support initiatives within communities. Awareness campaigns on the

theme of the desirability of establishing Health Promoting/Health Action Schools were envisaged by the participants of the Policy Dialogue.

Associated with the development of health promoting schools is a requirement of an oversight mechanism such as a steering committee at federal and provincial levels, publication and training committees at district and local level, and networks of private and public sector organisations to ensure that a programme to reach all schools is implemented.

4) Panel Discussion: Implications and Recommendations – What was Committed

The two-day Policy Dialogue offered ample room to discuss and debate possible avenues for expansion of health action schools; policy level options; and collaboration potential between public and private sector agencies. Issues of going to scale and how quickly; a review of existing policy and its implications for health education; examples of good inter-sectoral partnerships that are bearing fruit; and questions of relevancy and flexibility came under discussion. Below is a list of statements that were consensually affirmed by all the participants of the Policy Dialogue.

4.1) A Strategic Vision and Goals

Participants of the Policy Dialogue affirmed:

- That health promotion and education is a vital component in both the organisation and teaching/learning process in primary schools and that **health in schools is a key determinant of quality** both for children now and when they grow up into healthy citizens.
- That the concept of comprehensive school health promotion suggested by the WHO (1996) integrating the three components of health environment, health education, and health services for and from the school is valuable and acceptable. These components now need to be co-ordinated both at school and higher levels.
- That the concept and practice of **identifying and supporting health action schools is educationally valuable** in the government and private sectors.
- That particular gains may be expected in developing this process in rural schools.
- Development of **health action schools needs to be guided by certain established criteria** and require commitment, advise, and support particularly at the initial stages.
- **Expansion of health action schools should be gradual** and will depend on two factors:
  - A statement of current interventions in health education.
  - Pilot and small health education programmes as part of existing NGO initiatives.
- That the concept and practice of children taking health messages and taking part in practical action in the home and community is commendable and reinforces learning in health education.

- That all **messages and actions should reflect and respect cultural values** within the community.
- That a **statement of minimum health competencies necessary to be acquired by all school leavers in Pakistan needs to be made nationally and locally** as a basis of further planning. The statement should link the health of the individual with the health of the environment.
- That **the statement should be widely available** and reflect maximum consultation.
- Consideration needs to be given to **deciding and describing the entitlement to health of children from schools** and the measure of support which schools will need to deliver such an entitlement, which reflects all three areas of the WHO definition.
- At the local level **statements could involve children** both in discussion and in the illustration of any locally produced statements.
- Facility surveys currently being undertaken should be used when determining entitlement.
- **Health is already strongly represented in the government's curriculum document** both in a separate listing for upper primary classes and across the curriculum. It needs to be extracted in a separate document the content of which can be made widely available.
- In the longer term, and in view of its importance, **consideration may be given to offering health as a separate subject** or as a dedicated part of existing high status subjects.
- **Textbook revision should reflect emerging health themes** and examples could be integrated into new content.
- **Materials for teachers to reflect a methodology which links learning with action are essential.** Such materials need to be developed at various levels and must be introduced into teacher preparation courses. The new Child-to-Child Resource Centre at AKU-IED among others can be used as a source of a growing bank of materials to be used by planners and teacher educators.

Spreading health messages through active methods

5) Outcomes of the Policy Dialogue

5.1 HAS Expansion – First Steps with the Sindh Ministry of Education

The Sindh Education Minister Professor Anita Ghulam Ali who is also the Managing Director of the Sindh Education Foundation asked for a presentation by Dr. Tashmin Kassam-Khamis, Principal Investigator of the HAS team, upon which the Minister committed to begin health education in 100 Community Support School (CSS) supported by SEF. HAS' pilot phase work was shared with the Minister Education at the SEF office immediately following the Policy Dialogue, where she stated:

Children who are healthy are the ones who benefit from schooling.

An outcome of the meeting and thus the Policy Dialogue has been the commitment of SEF to implement and monitor its own programme of Health Education by establishing a 'Health Education Unit' within SEF. AKU-IED via the HAS project will support a needs identification study, train teachers, assist in capacity development, and material and curriculum development.

The Minister of Education further stated the need for the involvement of the Ministry of Health as such an initiative is inter-sectoral and thus will herself approach the Sindh Minister of Health, Major General Ahsan Ahmed (Retd), HI (M) , in order for both ministries to take the joint initiative forward.

5.2 Meeting with the Secretary of Education

The Sindh Secretary of Education, Mr. Nazar Hussain Mahar, expressed a keen interest in benefiting from the HAS project and the outcomes of the Policy Dialogue.

[Our] students are from poor class/society. They require this education on a priority basis because we believe that educating children on health, sanitation and environment issues would lead to transfer of awareness to the whole family and surrounding abadies.

He endorsed the idea of expanding health education in government schools initially in five (5) districts in Sindh: Karachi, Hyderabad, Sukkur, Larkana, and Mirpurkhas to reach 40 schools.

5.3 UNICEF

Ms. Stanela Beckley, UNICEF Education Programme Officer, stated during the Policy Dialogue that UNICEF would want to support the expansion of health promoting schools in Pakistan. Discussions are currently underway between UNICEF and AKU-IED to

support such a joint venture targeting public sector schools, which forms a part of UNICEF's broader inter-sectoral strategy to improve the quality of education via the avenue of health education.

5.4 Health Education Database

Another outcome of the Policy Dialogue has been the identification of other organisations involved with health education in schools. Many such organisations are able to conduct relevant and context-specific training throughout Pakistan for other organisations interested in promoting health education. Mr. Steve Ashby, Country Director SC-UK, has committed SC-UK to work with AKU-IED to develop a comprehensive database of organisations and projects working in the area of health through schools. Such a database will facilitate sharing, dialogue, and information dissemination in an efficient and targeted manner.

We expect schools to be places of learning. We expect investments in education to yield benefits to individuals, communities, and nations. Schools are in a position to contribute to social and economic development, increased productivity, and a better quality of life for all. ... This could be achieved if all schools could promote the healthy development of young people as actively as they promote learning **(WHO 1996).**

6) Conclusion

At the end of it's three-year pilot phase, the HAS project has been successful in developing prototypes of Health Action Schools in different social and educational contexts in Karachi. These lessons have been applied to other health education programmes throughout Pakistan. The findings of the action research project formed the basis of the Policy Dialogue on School Health Promotion. Participants endorsed that health education and promotion is a key determinant of quality education particularly in Pakistan's primary schools. Strategies to promote health education were agreed upon and work has begun in this regard at AKU-IED with partners in the government and the NGO community.

TEMPLATE 1

AN AGREED AND PUBLISHED LIST OF MINIMUM HEALTH KNOWLEDGE AND SKILLS THAT ALL PRIMARY SCHOOL CHILDREN IN PAKISTAN SHOULD ACQUIRE BEFORE LEAVING CLASS V.

Justification

Although mere knowledge does not necessarily lead on to effective health action, action must be based on knowledge. The great take-up of UNICEF/WHO's 'Facts for Life' indicates that governments see value in lists emphasising such knowledge. What is proposed here differs from 'Facts for Life' in two respects. First it is targeted on children. Here we specify primary school leavers. Second it also includes some essential 'doing skills'.

This document could be generated and made available to schools with minimum difficulty. It would be most valuable if it were supplemented with additional information and, perhaps teaching tips. Local authorities and teachers colleges could choose how and how far they supported its use.

Text

Children should achieve mastery of basic concepts and skills in the following six priority health areas. Mastery is defined as knowledge + understanding and effective performance by 80% or over of the target group. Mastery needs to be understood in the context of the age and experience of the child.

The concepts and skills listed are not the only ones which need to be taught. Its is hoped that schools will attempt to teach far more and in greater depth. The knowledge and skills listed are those deemed necessary for survival of any citizen rather than those which are merely socially desirable like good grooming.

The six priority health areas are:

A. Personal Hygiene and Community Hygiene.
B. Disease Prevention and Management.
C. Nutrition and Food Safety.
D. Growth and Development.
E. Safety & Safe Lifestyles.
F. Social Health.

Minimum knowledge and skills in the six areas are listed as follows:

A. Personal Hygiene and Community Hygiene

All children should know:

1. That germs from faeces can get onto fingers and from fingers to food. Such germs can cause serious illness.
2. That hands must be washed with soap before eating and after touching stools including cleaning up after younger children.
3. That flies spread germs from dirty places (especially human and animal stools) onto food. They can also bring infection to eyes.
4. That covering food and burning or burying rubbish prevents flies from spreading disease and breeding.
5. That illness can be prevented using clean drinking water, which should be boiled for 20 minutes if it is not from a safe piped supply.
6. That illness can be prevented by using latrines.

B. Disease prevention and management

All Children should know:

1. That deaths from diarrhoea (and they are very common in babies) are caused from dehydration (the body does not have enough water). Those with diarrhoea should be given plenty of clean water to drink and preferably oral rehydration salts (ORS).
2. That pneumonia is one of the greatest killers of Pakistan's babies. A baby with possible pneumonia needs to be taken speedily to a doctor or clinic.
3. How to recognise signs of possible pneumonia in a baby.
4. How to protect themselves from mosquito bites, especially at night.
5. That immunization protects against several dangerous diseases. A child who is not immunized is more likely to become undernourished, to become disabled and to die.
6. That a child recovering from fever (or other disease) needs plenty of liquids and food.

C. Nutrition and Food Safety

All children should know:

1. Breast milk alone is the best possible food and drink for the baby. No other food or drink is needed for about the first six months of life.
2. Children need food for their minds as well as their bodies. Good food in the first years increases potential for doing well at school and living a successful and happy life.
3. Breastfeeding helps to protect babies and young children against dangerous diseases. Bottle-feeding can lead to serious illness and death.
4. All children need access to the best food available in the family, girl as well as boys.
5. Raw food is often dangerous. It should be washed or cooked. Cooked food should be eaten straight away, not left to stand. Warmed up food should be thoroughly reheated.
6. That orange or yellow fruits and vegetables, and dark green leafy vegetables, are easy to grow and necessary for providing vitamins which protect the body from illness. A small amount of oil is necessary in every diet because it helps the body absorb certain important vitamins.

D. Growth and development

All children should know:

1. That children from birth to the age of three years should be weighed every month. If there is no weight gains for two months, something is wrong.
2. That all children need to be given the opportunity and encouraged to eat frequently, they need a variety of available food to help their growth.
3. That small children have small stomachs. A child under five years needs food 5-6 times a day.
4. That babies begin to learn rapidly from the moment they are born. By age of two the growth of the human brain is already complete. For good mental growth the child's greatest need is the love and attention of adults.
5. That play is important to a child's development. By playing, a child exercises mind and body, and absorbs basic lessons about the world. Parents and older siblings can help a child to play.
6. That children need frequent approval and encouragement. Physical punishment is bad for a child's development.

E. Safety and Safe Life Styles

All children should know:

1. That children under four years old are particularly at risk in the home. This is where most deaths and serious accidents occur. Almost all can be prevented.
2. That children under five years old are particularly at risk on the roads. They should be watched and taught appropriate safety behaviour as soon as they can walk.
3. That all families need to know simple first aid- particularly that relate to burns, cuts and wounds, and swallowing poisons and other objects. Many common practices are dangerous to health.
4. That medicines should only be used when it is needed. Often rest, plenty of drinks and good food are enough for the body to fight off the disease and get better. Injections are not usually better than medicines taken by mouth and should only be received by a trained person.
5. That smoking injures people's bodies. It causes cancer, bronchitis and heart diseases.
   It is easy to start smoking, but it can be difficult to stop. The body gets hungry for cigarettes.
6. That AIDS is an incurable disease. It is caused by a virus, which can be passed on by sexual intercourse, by infected blood, and by dirty hypodermic needles.

F. Social Health

All children should know:

1. That it is very important that children who see and hear well play and learn with those who do not.
2. Never to bully or make fun of people with a mental disability. They may not seem to understand what people are saying, but they can be very upset by unpleasant comments or gestures. Jokes about handicaps encourage bad attitude.
3. That disabled children need to be accepted by other children as friends and fellow pupils. They should be helped only when necessary and never pitied.
4. That young children who are sick need companionship, comfort, lots of drinks, food, cleanliness, sleep and play.

DISCUSSION

VALUE AND USE

1. Would it be useful to produce such a document?
2. Who would produce, agree and recommend its contents?
3. How far would it be likely to be used and would there be any way in which the mastery could be stimulated and tested (e.g. through certificates and badges)?

THE CONTENT

1. Are the areas suggested those which would be most valuable?
2. Given that the strength of the proposed document lies in its selection (e.g. small number of vital health messages) how would they be selected?
3. What should be policy with regard to culturally sensitive messages e.g. on HIV/AIDS?

GENERAL

1. What gains or problems may be anticipated in producing such a document?

TEMPLATE 2

AN AGREED HEALTH ENTITLEMENT FOR ALL PRIMARY SCHOOLS IN PAKISTAN, WHICH BOTH SCHOOLS AND THOSE WHO PROVIDE AND SUPERVISE THEM SHOULD STRIVE TO MEET.

Justification

Primary schools in Pakistan vary in their context and conditions. Yet every school needs to be mindful of the health and safety of its teachers and pupils and also has a right to certain support from the authorities under which it operates to enable it to perform these functions.
Listing such an entitlement under the four areas of comprehensive school health promotion, advocated by the WHO and the Child-to-Child Trust, indicates a goal for schools to achieve and the concept of *entitlement* has a political force which a mere directive lacks.

Text

Every school and the authorities who provide for it needs to provide for four aspects of health:

1. Provide a healthy school environment
2. Health teaching to develop basic health knowledge, skills and attitudes.
3. Help and guidance when children are unwell, injured or in distress.
4. A school health policy and someone responsible for it.

The ability to perform these functions will vary according to school conditions but *some action is necessary in every school in respect* of each of the four listed areas below.
Each of the functions has two aspects:

i. Entitlement of the learners from the school
ii. Entitlement of the school from its managers

Schools in Pakistan vary in their ability to meet the entitlement and while all can do something in each of the categories no school should be asked to do what is impossible (and then blamed for not doing it!).

1. A Healthy School Environment

Entitlement	For the Children and Parents from the School.	For the School from its Managers
Clean classrooms and surroundings	Encouragement for children to participate with teachers and parents to support a clean school policy.	The best possible school facilities together with support and encouragement for the efforts made by the school.
Provision of sanitation	Encouragement of the best toilet hygiene policies given the provision available.	Best efforts to supply school as soon as possible with hand washing and latrine facilities.
Provision of clean water	Encouragement of all pupils to make use of available facilities, to provide and monitor clean water for drinking and handwashing and encourage little ones to develop safe habits.	The best possible facilities of clean water or else a policy to encourage clean drinking water to be brought from home.
A school environment safe for children to learn and play in.	Encouragement to practice safe habits when playing and implementing a policy against bullying and with equal participation from girls and boys.	Ensuring safety standards including good ventilation and light, safe furniture, building and boundary walls.

2. Health Teaching to Develop Basic Health Knowledge, Skills and Attitudes.

Entitlement	For the Children and Parents from the School.	For the School from its Managers
Effective coverage of key health topics: Children should be taught basic knowledge and skills in the following areas. 1. Personal Hygiene and Community Hygiene 2. Disease Prevention and Management 3. Nutrition and Food Safety 4. Growth and Development 5. Safety and Safe Lifestyles 6. Social Health	➢ Correct health knowledge based on an appreciation of National and Local priorities. ➢ Leading to **mastery** of a manageable number of key concept and skills which all children need to know and do to stay healthy.	➢ Essential and up to date knowledge made available to teachers based on realistic knowledge of what teachers are able to teach and what pupils are able to learn. ➢ Access by teachers to up-to-date health knowledge based on emerging health issues in the community.
Taught in a methodology which links learning at school to health action at home and in the community.	A teaching style which ensures that children think and do and not merely memorise and copy.	➢ Written help on methodology which takes into account conditions in which teachers teach. ➢ Inservice help for teachers at a practical and affordable level.
Needs to be accompanied by a list of basic competencies in the six health areas in which mastery is vitally necessary for all children **(Template 1)**		

3. Help and Guidance when Children are Ill, Injured or in Distress

Entitlement	For the Children and Parents from the School.	For the School from its Managers
Knowledge of how to identify sickness and apply simplest first aid.	Schools ability within reason to identify: ➢ When children need to be sent home or to see health workers. ➢ When children are unhappy and may have emotional problems. ➢ Simplest first aid within the capability of the school .	➢ Guidance to schools on procedures, what teachers should or should not do. ➢ Simplest First Aid provisions e.g. First aid box
Knowledge of where and how sick children can get the best available help.	Schools should know where different kinds of help are available (paid or free).	Co-ordination between education and health services to best provide what health services are available.
Ability to deal with long term health problems.	Sympathetic help and encouragement to children with disabilities.	➢ Advice and simplest training available. ➢ Reports and follow-up procedures.

4. A School Health Policy and Someone to Administer it.

Entitlement	For the Children and Parents from the School.	For the School from its Managers
A recognition of health priorities and a simple plan to deal with them.	To know what priorities are and how they may participate in helping to meet them.	Help schools to set priorities according to knowledge of local and national needs.
Some one responsible for making that policy work.	To know who is responsible for planning, taking and evaluating health action and how they may be assisted.	Provide support and training for those responsible in schools.

DISCUSSION

VALUE AND USE

1. Is there value in the concept of an 'entitlement'. Or might it me more valuable to devise a more conventional booklet entitled, *Health in Our Primary schools?* In either case would such a document be potentially useful?
2. Who would produce, agree and recommend its contents?
3. How far would it be likely to be used?

THE CONTENT

1. Are all four areas desirable or should they be reduced?
2. How can the document be made more readable and relevant ... especially to poorer schools who need to be convinced that they can contribute in all areas despite their poverty?

GENERAL

1. What gains or problems may be anticipated in producing such a document?

TEMPLATE 3

PROPOSED HEALTH EDUCATION CURRICULUM SCOPE & SEQUENCE CHART FOR CLASSES I - V TO PLAN HEALTH EDUCATION ACROSS A WHOLE SCHOOL PROGRAMME

Justification

Health is at present not a core subject at school. However, for a school to teach health education linked with health action an effective plan has to be developed. A scope and sequence chart would facilitate schools to make decisions on what should be taught in each class.

Text

Template 1 identifies six priority health areas that all children leaving primary school in Pakistan should know about. These priority areas or health themes fall under three main strands:

STRAND	HEALTH THEMES
Hygiene and Disease Prevention	Personal Hygiene Nutrition and Food Safety Disease Prevention and Management
Environmental and Community Health	Community Hygiene Safety
Family and Social Health	Growth and Development Safe Lifestyles Social Health

These strands and health themes are sequenced into units or health topics for particular age groups and classes in the primary school in **a scope and sequence chart** as below:

CLASS	HYGIENE & DISEASE PREVENTION	ENVIRONMENTAL & COMMUNITY HEALTH	FAMILY & SOCIAL HEALTH
1	• Clean Hands • Clean Teeth	• Clean Schools • Clean Homes	• Playing with young children • Understanding Children's Feelings
2	• Food at home • Food Hygiene	• Home Safety • Preventing Accidents	• Caring for sick children • Proper use of Medicine
3	• Balanced Diet • Growing Vegetables	• First Aid • Road Safety	• Children with disabilities • Children who can not see or hear well
4	• Coughs & Colds • Immunisation	• Diarrhoea • Clean Safe Water	• Feeding young children • Breastfeeding
5	• Polio • Malaria	• Safe Stools • Intestinal Worms	• HIV/AIDS • Smoking

- The strands could be used as School Health Themes with the units / topics as class health themes.
- Each unit or topic would be taught in a series of 4-6 lessons and steps (Template 4) that links learning in class with action at home.
- Per term one school health theme may be chosen so that in a year 2-3 health themes are covered.
- Some 4 -6 health topics would be covered in each class in a year over some 30 health education lessons.

DISCUSSION

VALUE AND USE

1. Would such a scope and sequence chart be a useful document to define a core health education curriculum?
2. How might it be sanctioned and used to teach health education as a core subject?
3. How might these core health themes and units be widened across the curriculum?

THE CONTENT

1. Do the health topics / units in the scope and sequence chart appear appropriate for the particular age groups?
2. Are the areas suggested those which would be most valuable?
3. Is there overlap in health topics in the scope and sequence chart with similar topics in other subjects in the curriculum e.g. science, social studies, language, maths, islamiyat?

GENERAL

1. What gains and or problems may be anticipated in producing such a document?

TEMPLATE 4

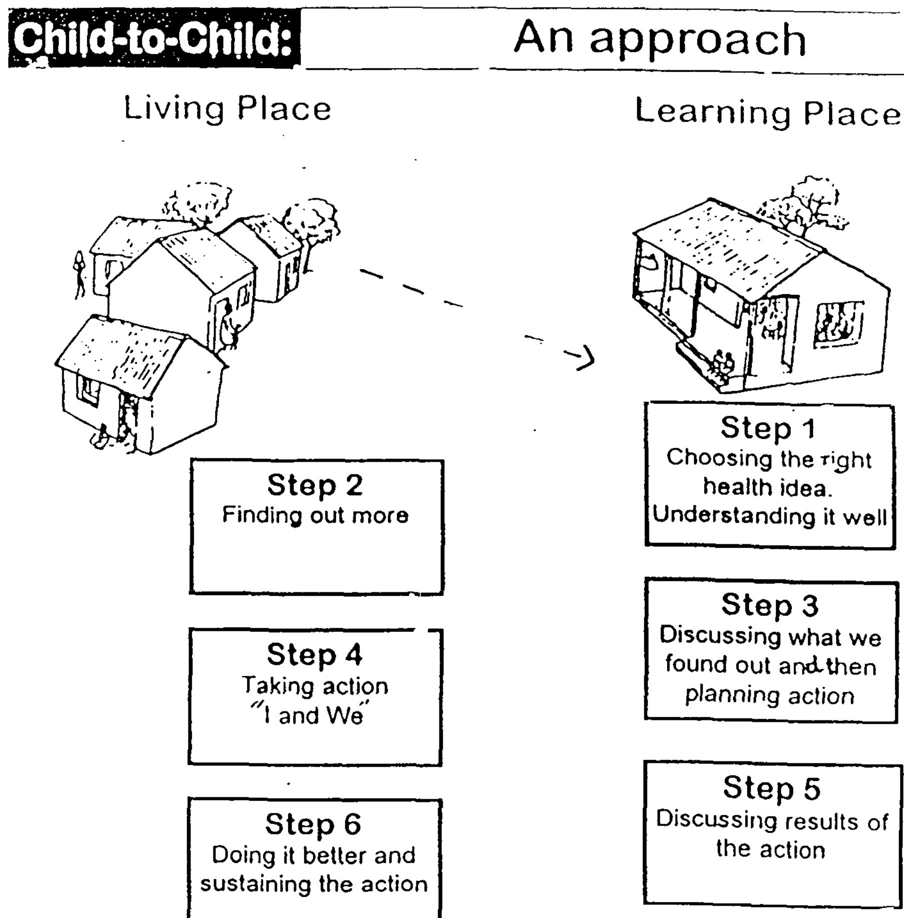
A SET OF LESSONS AROUND A PRIORITY HEALTH THEME

Justification

If we believe that health is about learning (knowledge) and doing (behaviour) we can not think of it being merely classroom based. That means that health topics will have to be targeted over a series of lessons rather than just in one classroom period. Some of the action in the series takes place at home (e.g. a child finds out something; takes some action; passes on a health message) and this is discussed later in class.

Text

The Child-to-Child step approach has been used with success in the Karachi as well as in the Water and Sanitation Extension Programme (WASEP) Northern Areas Health Action Schools to teach health topics across a series of activities both in the classroom and in the home and community.



Knowing about health priorities needs to be transferred into *Active Thinking* and *Action for Health* or **Doing** health in order for there to be behaviour change. However, for a change in behaviour to occur there must be a change in attitude i.e. to **Feel** the need to want to change.
The example below shows how KNOW, DO, FEEL objectives can to set on a particular health topic (Road Safety) and how these are covered over a series of steps both in lesson time and outside of the school in the home.

AN EXAMPLE ON ROAD SAFETY

Objectives : By the end of the topic, children should:

KNOW:

K1) Why road accidents happen when children are walking
K2) Why children get into accidents when riding a bicycle
K3) The ways drivers can cause accidents
K4) Rules for crossing the road during day and at night

DO:

D1) Obey road safety rules and teach them to others
D2) Obey bicycle safety rules when riding a bicycle
D3) Report accidents they see on the road
D4) Cross the road safely at night

FEEL:

F1) Feel responsible for the safety of themselves and others
F2) Feel pride in knowing safety rules and spreading them to others

STEP 1 (Choosing & Understanding)

INTRODUCTION (10-20 mins)

- Ask children how much they already know about the topic like: *What do you know about road safety? How many of you have seen or been in an accident before?*
- Tell story about a road accidents or show students pictures on accidents and ask some questions like, *What is happening in the picture? What will happen next? What message about road safety is this picture conveying?*

MAIN ACTIVITY (20-40 mins)

- Ask children either individually, in pairs, or in groups, to do an activity based on 1 or 2 health messages related to road safety. They may **draw pictures, write up their own story, make up a song or game** about road safety.

ENDING (10-15 mins)

- Children can share what they have done in the main activity with the whole class or in small groups.
- Teacher reviews with the children what they have learnt about road safety by asking them questions like *What are some of the causes of accidents? How can accidents be prevented? What are some of the rules for crossing the road (day & night)?*
- **If step 2 is to be done at home,** either give students one or two survey questions to conduct a survey in the school, home, or community or if the children are older and more familiar with surveys, encourage them to come up with their own questions as a class.

STEP 2 (Find out More)

INTRODUCTION (10-20 mins)

- Either the teacher or class decide 1 or 2 survey questions. For example, the question could be " **How many times have you been in an accident?**"
- Ask children if they will go to another class to ask questions **or** do the survey in the class.

MAIN ACTIVITY (20-40 mins)

- The teacher records the survey information on the board or on chart paper and asks children the question, *What do the results of the survey tell us about road safety?*

ENDING (10-15 mins)

- Allow a few volunteers to tell the class what they have already learnt about the topic on road safety.
- Ask children if they have any questions about the topic.

STEP 3 (Reporting, Discussing & Planning Action)

INTRODUCTION (10-20 mins)

- The teacher can ask children what they have found out in the survey and record the results on the blackboard or on the chart paper.
- After recording the results, the teacher or children can report the results of the survey.

MAIN ACTIVITY (20-40 mins)

Ask children the following questions to help them discuss and plan the action they will take in the next lesson (step 4):

What did you find out from the survey?
Why are you going to take action?
What messages are you going to spread?
Are you going to take action at **HOME**, *at* **SCHOOL**, *or in the* **COMMUNITY**?
Who is the action going to impact? (i.e. Younger siblings, peers, another class, family members, community, our own class, whole school)
How are you going to spread messages and take action? (i.e. poster, play, puppet show, etc.)

Encourage children to start planning for the action to use this time effect effectively.

ENDING (10-15 mins)

Ask children questions to review the KNOW, DO and FEEL objectives.

STEP 4 (Taking Action)

INTRODUCTION (10-20 mins)

- Review the plan for action the class came up with in the previous step.
- If students are going to do a play, puppet show, song, story telling, or other activity for another class or school, remind them of some tips on how to do a good performance. (i.e. *use loud voices, don't forget health messages, ask the audience questions, face the audience)*
- Help children decide how they are going to evaluate the action if is a performance. (*i.e. ask audience questions to see what they learnt*)

MAIN ACTIVITY (20-40 mins)

- Children can either use this lesson to prepare for the action (*i.e. making posters to take home)* or take action if they are doing it at school (*i.e. drama, puppet show, etc…*)

ENDING (10-15 mins)

Tell children that in the next lesson (STEP 5) they will evaluate the action they have taken or worked on in this lesson.

STEP 5 (Discussing what we did) & STEP 6 (Doing it better)

INTRODUCTION (10-20 mins)

- Ask children some of the following questions that they can either write about, draw pictures, or discuss as a class, in pairs, or in small groups:
- *What health messages did you spread through your action?*
- *What was successful? What was challenging?*
- *What action would you take next time to improve? (if successful, what can be done to do it even better?)*

MAIN ACTIVITY (20-40 mins)

- If the class felt the action did not work, plan another action and allow students time to prepare for it.
- If the class felt the action worked, allow students time to prepare to repeat or improve it for another audience.

ENDING (10-15 mins)

- Ask children what worked and did not work this time when they took action.
- If time, review KNOW, DO, FEEL objectives with students to end the topic.

DISCUSSION

VALUE AND USE

1. Would it be useful to have detailed guidance on key health topics, laid out over a series of lessons and possibly also in relation to the life of the school and its interactions with the community? Health topics might be identified according to need and gradually accumulated and refined.
2. What is your view of the approach and content of the model provided? (See more detailed questions below on content) In particular how important do you see it to base activities around the Child-to-Child Six-Step approach.
3. What other models might be available?
4. What might be the possibilities on taking action on this issue in the short and in the long term: What difficulties might be envisaged?

CONTENT

1. Is the document too detailed and prescriptive for teachers'?
2. Should teaching aids (e.g. pictures) be included?
3. How could the document be made more interactive to tap into teachers' own ideas and creativity?

GENERAL

1. What gains or problems may be anticipated in producing such a document?

TEMPLATE 5

HOW CAN A SCHOOL BECOME A HEALTH PROMOTING / HEALTH ACTION SCHOOL?

Justification

To integrate health fully into our primary schools in Pakistan will require planning, thought and commitment. One effective way to do this is through establishing a number of model 'light house' schools to show the way. Such schools are growing up all over the world called Health Promoting Schools. In Karachi such schools, called Health Action Schools, have been established and have been shown to improve the quality of learning as well as the quality of health.

Text

Let us agree on what is involved in becoming a health promoting school.
There are 4 components to a school health programme:

1. Basic Health Instruction: Health Education

Children need to understand specific health facts and ideas. They need to be taught in a methodology which develops life skills and self esteem so that health knowledge can be translated into health action. ***In order to do this there has to be time available and set aside on the timetable for health education.***

2. Good health practised around the school: Health Environment

This involves making the school a safe, clean place with the best possible nutrition for the children. ***In order to do this the school needs to set policies and school health rules with children, teachers and parents taking active responsibilities to see these through.***

3. School Health Services

Links need to be established with health workers so that **together** with the school ill health can be prevented, the health of children can be monitored, simple conditions can be treated, correct messages can be passed on to the community and children who are unwell or need special attention can be referred for further care and be supported.

4. Joint Health Action between the School and Community

This involves ***active community participation in school health promotion,*** through the involvement of parents and the transfer of knowledge from school to community e.g. through the Child-to-Child approach (Template 4).

10 Steps necessary for a school to become health promoting:

1. The school identifies health priorities (health themes) to be covered in the year.

2. The school commits to 30 planned lessons of health education a year (approximately 10 lessons per term) for each class.

3. Each class identifies 1-2 topics per term to be taught over a series of lessons and homework.

4. Teachers teach health using approaches which encourage thought, link learning with doing and make learning interesting and relevant for children.

5. Health teaching is enriched and enhanced in other subjects of the curriculum where possible.

6. The school defines a set of health rules to ensure a safe and clean environment that promotes good food habits.

7. The school identifies how such rules will be promoted and monitored e.g. through school health committees, children's health clubs, health monitors.

8. The school builds partnerships with health workers around the school in order to provide services for, from and by the school to prevent ill health, identify and manage problems and take early action.

9. The school decides on any school / community events which might be organized during the year e.g. health melas and campaigns.

10. The school agrees on how the programme will be managed and monitored e.g. by appointing 1 or 2 teachers in charge (health co-ordinators); school health committee meetings; health checklists.

DISCUSSION

VALUE AND USE
1. Does such a document help in guiding schools on how to become health promoting?
2. How can the gradual spread of such health promoting schools be facilitated?
3. What support is necessary for schools to become health promoting?

CONTENT
1. Is the document useful, clear and easy to follow?
2. Are there gaps that need filling?

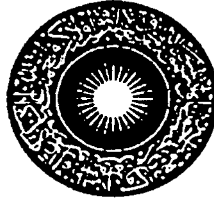
GENERAL
1. What gains or problems may be anticipated in producing such a document?

Please note that this document is a summary of a larger and more 'user friendly' document produced by HAS. The present content merely illustrates the points covered in the larger document.

Policy Dialogue
Name of the Participants

S.No.	Name	Designation & Institutions
1	Altaf Hussain Agral	Joint Educational Advisor Curriculum Wing, Ministry of Education
2	Anil Khamis	Assistant Professor, AKU-IED
3	Ann Castellino	AKUSON
4	Asif Fancy	Chairman, AKRSP
5	Asif Zaman	Deputy Director of School, School Health Service
6	Atiya Hussain	Senior Instructor, AKU-IED
7	Aysha Manjoo	Health Co-ordinator, Generation's School
8	Barbara Toye Welsh	Aga Khan Education Service, Pakistan
9	Beena Manzar	Idara-e-Taleem-o-Agahi
10	Bela Jamil	Technical Advisor-Ministry of Education, Europeon Comission
11	Camer Vellani	Rector, AKU
12	Faqir Mohammed	Save the Children (UK) Peshawar
13	Farhat Qureshi	DEO Primary, East (F)
14	Fatima Ali	Director, FOCUS
15	Fauzia Aman Malik	CHS-AKU
16	Fauzia Shamim	Associate Professor, AKU-IED
17	Frank White	Chairman, CHS-AKU
18	Gazala Siddique	Head, Generation's School
19	Gordon Macleod	Acting Director AKU-IED
20	Gulzar Kanji	Head, PDC,N
21	Iffat Farah	Associate Professor, AKU-IED
22	Ilse Voss	Sr.Advisor Teacher Education, CTA PEP-ILE
23	Jewan Das	Programme Officer, Save the Children (UK)
24	Khalid Mehmood Somroo	Chairman, Sindh Text Board
25	Khatija Mansoor	Representator, BEHBUD ASSOCIATION
26	M. Hussan Meher	District Education Officer Malir
27	Mehnaz Mehmood	Teacher Resource Centre
28	Melanie Ogorman	Aga Khan Foundation
29	Mohammad Memon	Associate Professor, AKU-IED
30	Mohammed Fahim Akhtar	Planning Officer Planning, Department of Education
31	Mohammed Iqbal	Vice. President, WADELA BALOUCH Social Walfare Org
32	Mujeeb Rahu	HANDS/Head Pediatrics AKU
33	Mujeeb-un-Nissah Essani	Director Primary School Education
34	Nabi Buksh	Head, Pir Mehfooz School
35	Nafeesa Farooq	Head, SMS Aga Khan Schools Boys Primary Section
36	Nagma Rizvi	AKUSON
37	Naila Zakaria	Head , Metroville School
38	Nargis Rehman	President, Falah Foundation
39	Nasir Ahmed Sheikh	Deputy Director of Primary Education
40	Nisar Ahmed	Representator, Faran Education Society
41	Noordin Merchant	Project Secretary, Health Action Schools, AKU-IED
42	Noshaba Khatoon	Programme Associate, Sindh Education Foundation
43	Noshaba Mobeen	CHS-AKU
44	Pervaiz Nayani	Health & Population Consultant, Europeon Commission
45	Qadeer Baig	Programme Manager, NGORC
46	Qamr-ul- Islam Siddique	Health Education Advisor, Ministry of Health Islamabad
47	Raiha Idrees	Programme Associate, Sindh Education Foundation
48	Rana Nazir Ali	Senior Instructor, AKU-IED
49	Riaz Ahmed	Faran Education Society

50	Saba Ishrat	SMS Aga Khan School Girls Primary Section
51	Sadia Muzaffar	Education Co-ordinator, Health Action Schools, AKU-IED
52	Sadrudin Pardhan	Director (Admin) AKU-IED
53	Seerat Shahina	Asst. Director DG, Health
54	Shahida Khan	Assistant Researcher, Health Action Schools, AKU-IED
55	Shahla Rashiddudin	UNICEF
56	Shaista Mir	Senior Researcher, Health Action Schools, AKU-IED
57	Shazia Basaria	CHS-AKU
58	Shazia Premji	Karachi Reproductive Health Project, AIDS Awareness Programme
59	Shiraz Merchant	Manager, Finance and Admistration
60	Shreen Rehmatuallah	ISRD
61	Staneala M. Backley	Chief- Education Section, UNICEF
62	Stephen Ashby	Programme Director, Save the Children (UK)
63	Sughra Choudhary	Programme Officer, Aga Khan Foundation
64	Sumera Qazi	School Health Service
65	Taj Mohammed Baloch	Representator, Sindh Graduate Association
66	Tameez Ahmed	WASEP
67	Tashmin Khamis	Assistant Professor, AKU-IED
68	Yasmin Amersi	Director, AKUSON
69	Zafer Ahmed Fatmi	CHS-AKU



آغا خان یونیورسٹی
THE AGA KHAN UNIVERSITY
Institute for Educational Development

Health Action Schools in Pakistan

a Pilot Research Project

By Dr. Tashmin Kassam-Khamis

3rd Annual Report

December 2000

TABLE OF CONTENTS

1.0 IDENTIFICATION 1

2.0 PROGRESS REPORT 1

2.1 CHANGES IN PROJECT CONTEXT 1

2.2 BENEFITS ACHIEVED AND OTHER OUTCOMES 2

- 2.2.1 School Improvement and Professional Development of Teachers 2
- 2.2.2 Situational Analysis 2
- 2.2.3 School Status Report 3
- 2.2.4 Children's Participation 4
- 2.2.5 Outreach and Dissemination 4
- 2.2.6 Professional Development of HAS team members 5

2.3 CONSTRAINTS 5

- 2.3.1 Teachers Turnover......... 5
- 2.3.2 Institutionalising HAS 6

2.4 PROGRESS TOWARDS OBJECTIVES 6

- 2.4.1 To develop prototypes of health promoting schools 6
- 2.4.2 To encourage policy makers to support the project 7
- 2.4.3 To share lessons with other systems 7
- 2.4.4 To introduce school health education into IED's programme 7

2.5 PROGRESS TOWARDS LEARNING OBJECTIVES 8

2.6 ACTIVITIES/PROGRESS COMPLETED 8

3.0 FORWARD PLANS 9

4.0 RESOURCES 9

5.0 SUPPORT AND ADVICE RECEIVED 10

6.0 ISSUES RAISED BY PARTNERS/BENEFICIARIES 10

7.0 APPENDICES ....

- Appendix 1 A Long term partnership between IED and SC (UK)
- Appendix 2 Third Situational Analysis & a comparison with Situational Analysis I and Situational Analysis II.
- Appendix 3 School Status Report
- Appendix 4 A Steady Climb on the Six Steps to Health: Experiences from Teachers in Health Action Schools (HAS) in Pakistan
- Appendix 5 A Journey from Clubs to Houses (Generation's School) & Junior Health Workers Report (SMS)
- Appendix 6 Reflection on SHADE Workshop

Appendix 7	Health into M.Ed Primary Module & English VT Programme (Reports)
Appendix 8	HAS Brochure
Appendix 9	Health Input in Sindh Text Books (Social Studies & Science)
Appendix 10	Children's Participation in Health (29th August – 15th September2000)
Appendix 11	SHAP (All Schools)
Appendix 12	Outline for M.Ed Elective

Health Action Schools in Pakistan – a pilot research project

1.0 IDENTIFICATION

1.1 **Project Name:** Health Action Schools in Pakistan Pilot Research Project
1.2 **Project code:**
1.3 **Location:** Karachi
1.4 **Reporting Period:** April 2000 – December 2000
1.5 **Author of Report:** Dr. Tashmin Kassam-Khamis
1.6 **Date of Report:** December 2000
1.7 **Name of implementing partner agency:** The Aga Khan University, Institute for Educational Development
1.8 **Funding Sources:** Save the Children (UK) and AKU-IED
1.9 **Project duration:** 3 years

2.0 PROGRESS REPORT

This report is the third annual report of the Health Action Schools (HAS) pilot action research project and follows the 10th quarterly report submitted to SC (UK) in September 2000.

2.1 CHANGES IN PROJECT CONTEXT

Following the external mid term review the HAS team held a retreat to process the suggestions and recommendations made which we subsequently discussed in meetings with SC (UK). The following changes have been agreed to by both parties:

- An extension year is required in order to consolidate lessons learned and produce materials based on this to aid expansion and sustainability of the programme. A proposal has been submitted to SC (UK) for funding. The main activities envisaged are; developing a guide to becoming a health action school for self-identified expansion schools; developing interactive workbooks for teachers to help them teach specific health topics; developing a curriculum in waiting on health education for Pakistani primary schools and a scope and sequence chart based on this. In addition an international school health forum hosted by IED is planned for next year to bring together those working in the school health field in the region, to share and learn lessons from each other's experiences.
- The Sports Aid Trust through SC (UK) has funded the Child-to-Child (CtC) Resource Centre which will be a part of the Primary Education Resource Centre at AKU-IED named *"Primary Education and Child-to-Child Resource Centre"*. The CtC resource centre will also be mobile and will provide a place for teachers and children to come to be supported with training and materials for health education using CtC approaches. Ms. Shahista Mir, formerly with WASEP in the Northern Areas where she was trained by HAS on CtC, has joined the team to look after this area.
- Building on this SC (UK) hopes to raise monies from the EC to allow AKU-IED to take CtC nationally over the period 2002 –2004. A concept paper by Khamis and

Ahmed (March 2000) was submitted to SC (UK) chalking out a pathway to longer term partnership between AKU-IED and SC (UK) (Appendix 1).

- Due to the extension year SC (UK) has agreed to a no cost extension to allow the final external evaluation to take place nearer the end of the fourth year. As per recommendations made by the mid term reviewer (Gibbs, December 1999) the final internal research report will be based more on qualitative (case) studies rather than a repeating the baseline study to compare more quantitative data in a before and after way as was initially envisaged.
- In line with the mid term review suggestions, the final year of the three year pilot would focus more on health education based on it's success, with the areas of health services and the environment less of a foci but linked to the health education curriculum.
- In the extension year it is envisaged that production of the second publication of translation and adaptation into Urdu of CtC materials (*Children for Health and Health Promotion in Our Schools*) will be completed once UNICEF publishes the new *facts for life* on which *Children for Health* is based. This has caused the delay in the second publication.

2.2 BENEFITS ACHIEVED AND OTHER OUTCOMES

2.2.1 School Improvement and Professional Development of Teachers

The area of School Improvement and Professional Development of Teachers continues to be the area of main impact as documented previously by the mid term reviewer as well as is evidenced in the third Situational Analysis (Appendix 2). The reasons for this appear to be due to the following:

- Training individually tailored based on the needs of the particular schools.
- School based training.
- More follow up in schools linked directly with the training.
- Teacher support in schools linked with lesson observations.
- Fun Active Method Enhancement Sessions (FAME) as requested by individual schools for both HAS and Non-HAS teachers.
- Despite training's being short (a few days/hours) a sequence of trainings are provided based on need and the levels developed. In total 13 workshops were conducted for HAS schools in 2000.
- **Health Education is related to daily life and hence easily made personal thus naturally child-centred. Once teachers try out child-centred methods in the health classes and find that the children enjoy them, take an interest and appear to be more involved, especially when linked with life at home, they gain the confidence to try out such methods in other subjects also.**

2.2.2 Situational Analysis

Appendix 2 reports on the 3rd Situational Analysis (based on the checklist of Hawes 1997 –See First Six Monthly Report for Details) conducted in March-June 2000. Whilst each school must be viewed separately and quantitative data viewed with caution, due to the subjective nature of assigning scores to what is viewed qualitatively by the researcher, overall an improvement is seen in all indicators of the health programme i.e. the school

environment, health education and health services. However, the quantum of change in most cases is less between the 2nd and 3rd Situational Analysis than was seen between the 1st (baseline) and 2nd *situational* analysis. This might suggest that any small change was initially viewed as a major improvement from what existed previously. However, further change appears slow particularly in areas that are not directly linked with the curriculum for which teachers have little control over e.g. school infrastructure related to the environment -the lack of water in the school and health services. Whilst the programme had focused all areas of comprehensive school health promotion i.e. the school environment, health education and health services as well as management of the programme, teachers were the main target as they were to implement the programme. In addition in order to ensure sustainability and ownership no financial incentives or inputs were given e.g. for improvement of infrastructure with teacher training, school support and teaching materials being the main inputs from the IED HAS team.

2.2.3 School Status Reports

Appendix 3 gives an overview of current school status for each of the pilot schools identifying the highlights, constraints faced and main lessons learned this year. In total some 134 teachers of HAS pilot schools have been trained and over 170 teachers, health and community workers have benefited from CtC training's. This translates to over 3,000 children who have had some direct benefit from HAS with several thousand more potentially benefiting from health promotion activities that these children take home to their siblings, families, friends and communities.

- One benefit witnessed this year has been the expansion from one pilot school section to another. For example in SMS the girls section is now a HAS although we have only intervened in the boys school. In Generation's a similar thing is happening with the expansion of the programme this year from the pre-primary and junior sections to the middlers.
- Sustainability will only occur if the HAS programme is an integral part of school life. In two schools, SMS and Metroville health education is now a part of the ongoing assessment.
- In the Community school, Metroville, health messages have been disseminated to the community in the colonies the school serves through campaigns such as the diarrhoea campaign. This has meant even non-school going children such as the Afghan refugees in the area have had some exposure to health education.
- One major highlight in Atiya Bai Government school has been 100% retention of the HAS trained teachers this year with none transferred. This has helped ensure smoother running of the programme. In addition the programme has had a positive influence in both Government schools of ensuring full staffing of the schools. In Pir Mehfooz the Directorate has now assigned 6 teachers including the Head so that the school is now no longer multi-grade and each class has a teacher. In Atiya Bai the supporting NGO, Falah Foundation, has supplied an extra teacher to the school whose salary they pay as this KMC school is understaffed, as the NGO saw the benefit to the children of the HAS programme.

2.2.4 Children's Participation

The Child-to-Child approach enhances children's participation through linking the school with the home as part of the health topics explored by children (See Khamis article on Six Step Approach for CtC newsletter, Appendix 4). In this third year we have seen more ownership of the HAS programmes by children in some of the schools, particularly in the areas of the health environment and health services when defined broadly to include safety, nutrition and hygiene. Both the private schools have organised children's 'health clubs' or 'junior health workers' that monitor the school environment and work on health promotion in school as well as areas such as safety (See Appendix 5 for reports on these). Whilst such a system has not yet developed in the government schools the level of confidence of children attending these has been shown to have increased since the start of the project. Visitors familiar with Pakistani Government schools comment on the questions asked of them by the children *which shows something positive is going on here.* At the HAS room opening (9th QPR) the children from these schools were visibly more confident that those present from other HAS schools in performing their skits and poems.

2.2.5 Outreach and Dissemination

Interest in the project continues both nationally and internationally. The mid term review was disseminated widely and networking through the CtC Trust (UK) and SC (UK) has definitely helped in this process. Major outreach impact has occurred through WASEP in the Northern Areas of Pakistan, PEP-ILE in NWFP, SC (UK) Afghanistan in refugee camps in Quetta, NWFP and Afghanistan and HANDS in rural Sindh (See 2nd Annual Report). In the last quarter the following outreach activities have occurred (for previous activities see QPR 8 and 9).

- The Principal Investigator (TKK) had the opportunity to present to the AKU Board of Trustees forum, at which the Chair, Saheb Zada Yaqoob Khan was present and took a keen interest in the project (November 2000).
- Jim Irvine, Education Advisor for UNICEF (Bangkok) (December 2000).
- Three visitors from the lead in Professional Development Centre (PDC) of IED and AKES in East Africa (November 2000).
- A Faculty Research Seminar was held at IED looking at an advocacy and dissemination strategy for HAS (November 2000).
- Mr. David Norman SC (UK) education Advocacy officer visited HAS (October 2000)
- Workshop to SHADE (School Heads Association) was held on HAS for 50+ Head teachers from Karachi, some of whom have shown an interest to become health promoting (October 2000) (Appendix 6).
- Teaching on IED Visiting Teacher courses such as the MEd. Primary Module and English VTP (Appendix 7). This has additional benefits with teachers on these courses having developed health action plans for their particular schools and requested help from the team.
- Dissemination of HAS brochure and *Sehat ki batein* (Appendix 8).
- Sindh Textbook Review of health content in the Social Studies and Science Textbooks (Appendix 9).

2.2.6 Professional Development of HAS team members

With the pilot phase coming to an end and the area of school health promotion becoming a core area of IED activities in the next phase the professional development of local staff has been a priority to strengthen sustainability. HAS staff have attended the following courses:

- Ms. Sadia Muzzaffar has attended a two and a half weeks course on *Children's Participation* facilitated by the CtC Trust (UK) at the Institute of Education, London University (Appendix 10). At the course examples of HAS in Pakistan were used to share with participants what was possible when using the CtC approach in schools.
- Ms. Shahista Mir attended a three-day library workshop at IED on *Managing Library in Schools*. This will help her with setting up the CtC resource centre.
- Mr Noordin Merchant attended a two-day course on basic SPSS.

2.3 CONSTRAINTS

2.3.1 Teacher Turnover

Since the start of the project we have trained 124 HAS teachers of which 72 are still with us i.e. 58% of those we have trained. The other 42% have left the pilot HAS schools. This of course interferes with the running of the programme and is a cause of concern for sustainability of the health programme in the pilot schools. Whilst it is hoped that trained teachers will apply the methods learned in the new schools they may have joined or been transferred to, we know that many teachers leave the teaching profession altogether.

Table to Show HAS Staff Turnover since the start of the Programme (1998-2000)

School	Retention Rate of teachers	Number of Heads	Number of Health Co-ordinators HC
Atiya Bai Govt.	33% (1/3)	2	2
Generation's Private	68% (15/22)	1	3
Metroville CBS	35% (7/20)	2	3
Pir Mehfooz Govt.	33% (2/6)	3	2
SMS Private	18% (4/21)	1	3

As the table above shows no school has had the same health co-ordinator since the start of the programme. Until recently one of our best teachers, the HC of PM school, was the one HC who had been with HAS since the start of the programme and was instrumental in the success of HAS in his school. He has now left PM. Whilst both Private schools have the same Head who had committed to the intervention, SMS has the worst retention rate of HAS teachers. In all other schools we are now dealing with the second or even third Head teacher since the beginning of the programme with only a third of teachers who initially began the programme still teaching in these schools. This has undoubtedly caused constraints to the programme as more teachers have needed to be trained and trainings have had to be repeated. It is hoped that the activities planned for the next year of extension that allow materials to be produced for HAS to expand, will also help these schools where all teachers teaching health are not trained and may not receive the same school support and follow up as their predecessors did in the pilot phase. Our materials are being pilot-tested on the new groups of teachers.

2.3.2 Institutionalising HAS

The HAS project was based on a bottom up approach with ownership coming from the schools and action planned based on individual school needs. However, more and more a constraint to progress has been the lack of an equal reinforcement in a 'top down' manner. For example in the Government schools we still see a lack of commitment from teachers with high absenteeism not only of the teachers but the Head as well and in one Government school frequent transfers. In Private schools also, until the management do not see HAS as a routine part of the school culture it will continue to be an additional 'programme' and hence less important than other school activities.

In January 2001 a policy dialogue is planned which the Sindh Education Minister will preside over where HAS hopes to advocate for approaches and content to health education with recommendations to policy makers to ensure implementation of health promotion in primary schools. We hypothesise that for greater sustainability both a top down as well as a bottom up approach is required.

2.4 PROGRESS TOWARDS OBJECTIVES

2.4.1: To develop prototypes of health promoting schools

- Each school has developed their own school health action plans which are being executed (Appendix 11) with some 20-30 health education lessons per year. Whilst schools with better resources and trained teachers are now enhancing their curriculum using health (e.g. Generation's, SMS) the schools with less resources and teachers not used to using the newer methods prefer to teach health education as a separate subject usually one lesson per week. Of the initial comprehensive school health promotion model used (WHO), health education is seen as the fulcrum with health environment and health services viewed broadly and linked where possible to the curriculum.
- The Situational Analysis and school status reports show progress towards objectives set (Appendix 2 and 3). As has been mentioned before, in-service training both of project staff as well as of teachers and Heads has continued to be a main activity this year with issues of sustainability and evaluation being tackled in such training's. However, the high teacher turnover continues to be a challenge to the process.
- A clear pathway to develop teaching materials has been defined and will be the main activity for the next year with the CtC resource centre supporting teachers to use these materials.
- Some internal mechanisms of monitoring are being developed with health co-ordinators in some schools now holding the monthly teachers sharing experience meetings rather than the HAS team and teachers also planning topics with less support from the IED team. Children's involvement in managing aspects of the programme such as the environment has been rewarding to see but parents are still not as involved in managing the project as we had hoped, although their participation through the use of the CtC six step approach has been documented.

2.4.2 To encourage policy makers to support the project

The steering committee has met regularly (one every two months) and lent their support -different constituencies to differing levels. The school health services in Sindh have cut back on activities and operate on a much smaller scale. However Government representation is strong on the steering committee from both education and health sectors.

On January 24th and 25th 2001 Hugh Hawes, co-founder of CtC and friend of HAS, will be helping us facilitate a policy dialogue where Sindh MoE Anita Ghulamali will be Chief Guest for the opening ceremony. We expect representation from Federal and Provincial levels of both Education and Health, including the curriculum bureau and text book boards, as well as the private and (I)NGO sector. The aim is *to advocate for content and approaches for health education in schools based on the concept of comprehensive school health promotion.* It is hoped that the outcome will be a report addressing recommendations made for content and approaches to health education to be disseminated to the policy makers. The publication *Sehat ki batein* (Urdu CtC activity sheets) will be launched and distributed at the closing ceremony.

2.4.3 To share lessons with other systems

As has been mentioned under outreach this continues to be one of our major areas of impact both nationally and regionally and will be an area of concentration as we expand in the coming year through self identified HAS and the materials development projects aimed to support this expansion. The CtC resource centre also aims to be a centre of training to support sharing of lessons in order to enhance expansion.

2.4.4 To introduce school health education into IED's programmes

One important vehicle to sustainability is through teacher education institutions like the IED. The professional programmes co-ordinator has instructed ALL professional programmes at IED to have at least 2 days of health education as part of the training offered, and this is now being implemented. In addition a six week M Ed. Module elective in *Health Education in Action: health promotion through schools* is being proposed for the first time at IED (Appendix 12 for Outline). The graduates of this module will add to improving the human resource capacity available in the area of school health promotion both at IED and in schools nationally and in the region. The aim of the module is: ***To enable CPs to promote health through schools as a vehicle to school improvement.*** It is envisaged that a more symbiotic relationship will be built between the Health Action Schools and IED through graduates learning from practising in these schools and continuing to strengthen the programme through the research they may conduct, so that beyond the pilot phase the school-university partnership continues.

2.5 PROGRESS TOWARDS LEARNING OBJECTIVES

The main areas that SC (UK) has gained from lessons learned through HAS are:

- Use and application of Child-to-Child as a child centred participatory approach

SC (UK) partner NGOs have directly benefited through CtC training's that the HAS team has conducted for them as well as for the SC (UK) Afghanistan office.

- Advocacy

HAS' experience of using action research as a strategy for advocacy has been used by SC (UK) an example in it's recently published advocacy manual. In addition the Education Working Group (EWG) of SC (UK) may learn lessons from the way HAS has worked with Government through the steering committee and their liaison with Government schools. The policy dialogue will be an important forum to share lessons of trying to influence policy from lessons of a pilot project such as HAS.

- Materials Development

Sharing of materials has and will continue to occur through publications such as *Sehat ki batein* which is to be shared with all SC (UK) partners as well as materials to be generated to support teachers and those planning school health or CtC programmes.

- Sharing Information: The Child-to-Child Resource Centre (CtC RC)

The newly established CtC RC will enable SC (UK) partners to obtain support with CtC training as well as resources. Partners will gain from sharing of materials and support with their CtC programmes.

- Areas of New Emphasis

HAS has gained experience in areas not initially envisaged as part of it's remit such as ECCD, Inclusive education, HIV/AIDS and Refugee education. These are all areas that SC (UK) Education Strategy aims to target in the region and lessons can be learned from HAS in this regard. The multisectoral nature of most of these areas also teaches us lessons as to how to work in an interdisciplinary area.

2.6 ACTIVITIES/PROCESSES COMPLETED

As per the project proposal and LFA activities have occurred as planned with the pilot schools implementing the programmes as per their School Health Action Plans. Teachers have received training, school support, encouragement, monitoring and advice and children have also been involved in activities and in some cases managing of the programme. Materials development continues with one book already published and work has begun on expansion of the programme through outreach activities as well as self-expansion schools coming forward. Progress is monitored through ongoing lesson observations, topic plans and school meetings all of which are well documented, as well as periodically through the Situational Analysis. The suggestions made in the mid term review have been taken on board and are guiding the next phase of the project.

3.0 FORWARD PLANS

As per the proposal, LFA and extension proposal the following activities are planned in the next quarter and beyond the pilot phase in the extension year. The table below addresses these (3.1) as well as monitoring and evaluation plans (3.2).

Time Period	Activity	By Whom
Next Quarter Jan-March 2001 Next reporting period till end of initial pilot phase	Policy Dialogue and report School teacher training Development of SHAPs Final Situational Analysis On going monitoring Infusing IEDs programmes Materials development Setting up of CtC RC Confirmation of extension monies	HAS, Hugh Hawes HAS SC (UK)
Extension Year April 2001–March 2002	Materials Development -Starter pack -Teacher workbooks -Curriculum in waiting -Video Dissemination Strategy Self-identified expansion schools Running and mobility of CtC RC External Evaluation Research on consolidating case-studies for a publication International School Health Forum M. Ed. Elective on HAS Confirmation of EC funding	HAS External Reviewer TK and HAS SC (UK)

4.0 RESOURCES

INPUTS AND BUDGET NARRATIVE WILL BE SUBMITTED SEPARATELY BY IED FINANCE SECTION.

5.0 SUPPORT AND ADVICE RECEIVED

This year no formal consultancies have been sought from outside. HAS increasingly finds itself perceived as the 'expertise' in the area of school health promotion and Child-to-Child in Pakistan and as is documented earlier in this report much work has occurred in the area of outreach and expansion already. However, the external mid term review (Gibbs 1999) has helped HAS set directions. In addition the CtC Trust (UK) continues to be a most supportive resource to HAS with one local HAS team member having attended one of their courses in this year. In particular we should like to thank Christine Scotchmer, Hugh Hawes, William Gibbs, Pat Pridmore, Rachel Carnegie, and Clare Hanbury –all working with, or friends of, the CtC Trust who have taken a keen interest in our work, offered us advice and also disseminated our work internationally. This has occurred though publications, visits, dialogue and an invitation to TK to speak at a seminar hosted by the CtC Trust (UK) at the Institute of Education, London, in January 2000.

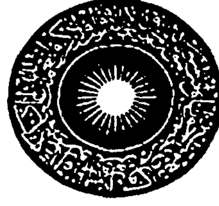
The HAS team would also to thank SC (UK) for being a most supportive and understanding partner in the process particularly Mr. Jeewan Das, Programme Officer Karachi. In addition we should like to thank the IED management who have lent their support to HAS particularly Dr. Gordon MacLeod, Acting Director, Dr. Robert Baker, former Director, Dr. Pardhan, Director Admin as well as Dr. Mohammed Memon, professional programmes co-ordinator and member of our steering committee. We are grateful to all steering committee members for their participation and advice.

6.0 ISSUES RAISED BY PARTNERS/BENEFICIARIES

No major issues have been raised by partners or beneficiaries. The main issue of sustainability is one the team and schools are grappling with. It is hoped that the extension year will enable sustainability to be tackled not only in a vertical way but also horizontally, not through replication of the pilot project but application of lessons learned for expanded activities.

The following issues need addressing with SC (UK):

- Confirmation of amount of funding for extension year
- EC Funding to 2004
- A long term partnership between IED and SC (UK) and the DSS (Development Studies School).



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THE AGA KHAN UNIVERSITY

Institute for Educational Development

Health Action Schools in Pakistan a Pilot Research Project

by Dr. Tashmin Kassam-Khamis

2nd Annual Report March 2000

Table of Contents

1.0 IDENTIFICATION 1

2.0 PROGRESS REPORT 1

2.1 CHANGES IN PROJECT CONTEXT 1

2.1.1 Staff Turnover 2

2.1.2 Teacher Training and Follow up 2

2.1.3 Materials Development 2

2.1.4 Mid Term Review 3

2.2 BENEFITS ACHIEVED AND OTHER OUTCOMES 3

2.1.1 Government Schools 3

2.2.2 School Improvement and Professional Development of Teachers 3

2.2.3 Improving children's knowledge, skills and behavior.. 4

2.2.4 Outreach 4

2.3 CONSTRAINTS 5

2.3.1 FOCUS of Attention 5

2.3.2 Developing Community Links 6

2.3.3 Sustainability 6

2.4 PROGRESS TOWARDS OBJECTIVES 7

2.5 PROGRESS TOWARDS LEARNING OBJECTIVES 9

2.6 ACTIVITIES/PROGRESS COMPLETED 10

3.0 FORWARD PLANS 10

3.1 ACTIVITIES/PROGRESS PLANNED 11

3.2 MONITORING AND EVALUATION 11

4.0 RESOURCES 11

5.0 SUPPORT AND ADVICE RECEIVED 11

6.0 ISSUES RAISED BY PARTNERS/BENEFICIARIES 12

Health Action Schools in Pakistan
Institute for Educational Development
The Aga Khan University

1.0 IDENTIFICATION

1.1 Project/programme name: Health Action Schools Pilot Research Project

1.2 Project/programme code:

1.3 Location: The Aga Khan University Institute for Educational Development, Karachi

1.4 Reporting period: From March 1999 to March 2000

1.5 Author of report: Dr. Tashmin Khamis

1.6 Date of report: March 2000

1.7 Name of partner implementing agency: The Aga Khan University, Institute for Educational Development, Karachi

1.8 Funding source(s): Save the Children Fund (UK) and The Aga Khan University, Institute for Educational Development

1.9 Project/programme duration: 3 years

2.0 PROGRESS REPORT

This report is the second annual report of the Health Action Schools (HAS) Pilot Research Project and follows the seventh quarterly report submitted to SCF (UK) in December 1999.

2.1 CHANGES IN PROJECT CONTEXT

No major changes have occurred in the project context. The initial 5 pilot HAS from different social and educational contexts continue to implement the programme to differing degrees as highlighted in the external evaluation mid term review report (Gibbs 1999). Staff changes were also mentioned in the last quarterly report and the project is on the whole following what was planned (See Proposal and LFA - March 1998). Below are highlighted the key changes or events, which have influenced progress of the project in this last year.

2.1.1 Staff Turnover

Since the start of the project human resource and staff turnover has been a constraint to the progress. This has been at both the teachers level as well as on the HAS team itself where over the last year there have been changes of five members on the team. This inevitably affects progress as new members and teachers need training and professional development. However, Gibbs states in his mid term review report (page 7) *Through positive leadership a professional and reflective team has been created with a clear knowledge of what the programme is about. Even though membership of the team has changed regularly a clear sense of purpose and direction has been maintained...The sharing and delegation of responsibilities and regular weekly meetings has created a strong sense of team responsibility, further fostered by team retreats.*

2.1.2 Teacher Training and Follow up

As has been highlighted previously the HAS team have experienced that training alone with monthly visits are not enough, and that teachers require more support in schools. It was envisaged that training's would be held initially twice a year and then only once a year. Due to the large numbers of teachers trained (due to transfers, leaving and many carrier subjects), and more individual school based training's, teacher education has continued to take up more of the HAS time than was envisaged. Eighty teachers from the HAS pilot schools have received training in 1999. Of these only 58% had been trained and were in the HAS programme in 1998 , the rest (42%) were new to the programme in 1999. The HAS team conducted 14 workshops in the last year, of which only one was held for all schools at IED. All the others have been school based that caters to the individual school's needs. Whilst this has proved to be more effective in terms of returns seen in teaching and learning in the classroom as well as in teachers attendance, this is extremely resource intensive. Topic planning sessions and school health action planning have also been conducted in the individual schools.

In addition to the monthly school meetings, more lesson observations are conducted. This means that every week the team visits schools with each school visited at least once a week during health education terms. This is taxing on the IED team but a very necessary part of the action research.

2.1.3 Materials Development

One of the objectives of the project was to identify and develop relevant health education materials. The Child-to-Child materials have been tried and tested out in the schools and a proposal submitted to SCF for professional translation and adaptation of these materials into Urdu was funded in July 1999 through a grant of 500,000 rupees. The first book is due to be published in the next month and should be of benefit not only to the pilot HAS schools but to all schools wishing to become health promoting, enhancing the sustainability once the project comes to an end in its present form. However, due to one of the books being revised by UNICEF and Child-to-Child, SCF (UK) is being requested to allow delay in publication of this book based on the new version of *Facts for Life* and *Children for Health* rather than publishing an out of date version.

2.1.4 Mid Term Review

William Gibbs from the Child-to-Child Trust (UK) carried out an external mid term review from 1st to 10th of December 1999 (See Report). Whilst overall he is most complimentary in his review of HAS' success and achievements, he highlights the need to reconsider the comprehensive school health promotion model as outlined in the proposal. He suggests changing the focus of attention of the less successful areas of health environment and health services and linking these to the more successful health education curriculum. The review also recommends areas that need further development in this next phase of HAS in order to help other schools and teachers develop health promoting schools through the development of curriculum, starter packs and workbooks for teachers. In addition, the reviewer makes recommendations on focusing and consolidating research not through a before and after comparison with baseline study as was initially envisaged but through writing up qualitative case studies from the rich documentation HAS has collected. The team has considered these suggestions in a team retreat in March 2000 and this will mean re-looking at the original work plans and LFA and modifying them accordingly.

2.2 BENEFITS ACHIEVED AND OTHER OUTCOMES

2.2.1 Government Schools

Currently the third situational analysis is underway to assess progress since baseline in the areas of health education, environment, health services and community links. The differing context of each school has meant that the model has evolved differently in each setting. However, this year HAS has made strides in the Government schools which are more responsive than in the first year. The reasons for this appear to be due to:

- A more individually tailored programme and particularly training.
- More follow up and lesson observations in schools directly linked to the training.
- Greater rapport with the Directorate of Primary Education provincially leading to less frequent teacher and head transfers.
- Greater involvement and hence support of the Head in the planning of the programme.
- Teachers perceiving importance being given to them by external visitors coming to look at a HAS school in action.
- Commitment and individual personalities of HAS team members that have built rapport with the teachers.

2.2.2 School Improvement and Professional Development of Teachers

At the outset this action research project aimed at school improvement with health action as a vehicle. The action research model has allowed the team to continuously monitor, reflect and modify the intervention according to the needs of the programme. This has resulted in progress in the uptake of new teaching methods to teach health education in the second year. In the lower income schools more child centred active methods have

been used for the first time in the classroom. Teachers report also using these methods in other subjects. To supplement longer training programmes (1-3 days) through requests by teachers as well as observations by team members and as a follow up to the last large training in February 1999 on active methods, FAME (Fun Active Methods Enhancement) sessions were introduced. These are 1 hour sessions held in schools at their request where any teacher (HAS or Non-HAS) may participate. Schools decide which active methods they would like training on. These include puppets, drama/role-play, surveys, stories, pictures and life skills. There is evidence that following FAME sessions teachers modify their lesson plans and Heads have reported that teachers use these methods in subject teaching. Opening up of these sessions to non-HAS teachers sees a transfer of ideas within schools but also between schools e.g. in double shift schools like SMS. The mid term reviewer states (page 5) *Some teachers involved in HAS also reported using FAME new methods in other subjects in the curriculum. This is of enormous significance and indicates that for some teachers the HAS programme ~~is~~ providing an effective school based form of "Teacher Training".*

Planning skills amongst teachers has also improved as teachers now plan topics as well as their school health action plans (SHAP) with the support of other teachers and the HAS team. The Child-to-Child Six Step Approach enables teachers to create a sequence of learning activities and teachers now do not try to teach a health topic in one lesson but promote understanding through a series of lessons that make health education personal and contextual. (See Appendix 1 for examples of Health Topic Plans and Appendix 2 for SHAPs for 2000).

2.2.3 Improving children's knowledge, skills and behaviour

Evidence from our own project documentation as well as from the mid term review report *reveal that children had gained and used a variety of health knowledge at a variety of levels.* (Gibbs, 1999, page 2). Teachers also report improved health behaviour amongst pupils particularly in the areas of personal hygiene and environmental hygiene including greater use of boiled water at school and healthy lunch boxes. Children are said to enjoy the health lessons and at one government school teachers state an *increased attendance on Friday, the day on which health lessons are taught* (Gibbs, 1999, page 4).

Due to one team member (Farah Shivji) having a background in special needs, the area of inclusive education and awareness raising on children with disabilities was integrated with HAS using the Child-to-Child approach. A study on teachers attitudes towards inclusion was also carried out amongst our HAS teachers (See 7th Quarterly Report).

2.2.4 Outreach

A national presence has been established in this second year of the pilot project. HAS' has supported the spread of health action at the school level through training, curriculum development, sharing of materials and consultancy in the following areas:

- In NWFP through the PEP-ILE (Primary Education Programme, Improving the Learning Environment) programme working through GTZ with the NWFP Primary

Education Government Department. Some 20,000 teachers have been trained on First Aid through PTR (parent-teacher relations) units developed in collaboration with HAS that enable teachers to link with parents regarding the health of their children.

- In the Northern Areas and Chitral over 40 primary schools from Government, Private, Community Based and AKES sectors now receive health and hygiene education through WASEP's (the Water and Sanitation Extension Programme) SHIP (school health intervention programme). HAS helped develop their curriculum and trained 30 health and hygiene promoters on the Child-to-Child approach.
- In rural Sind HAS is supporting the expansion and modification of the model to 10 community based fellowship schools through the large and established NGO, HANDS (health and nutrition development society).
- In Peshawar, Quetta, Islamabad and Afghanistan through training of SCF (UK) partner NGOs working with Afghan children in camps in Pakistan or in Afghanistan on child focused health education activities (See Appendix 3).
- In addition, HAS is now becoming a resource base for others who are developing health education programmes in Pakistan or in the region. Referrals to HAS come from TRC, the AKDN as well as SCF Alliance. Recent visitors to HAS have included schools and NGOs from Karachi, IED evaluators from the European Commission, SCF (US) in Quetta and AKF working on health education Government schools in Tajikistan (See Appendix 4).

2.2.4.1 Publications and Presentations

Publications have also helped to spread and share ideas on health through schools through newspapers, newsletters and internationally e.g. through the Child-to-Child newsletter (See past quarterly reports and Appendix 5). In addition presentations have been made on HAS both nationally (at IED, AKU and to the Education Working Group) and internationally in Brazil at an SCF Alliance meeting as well as in London at the Institute of Education, London University. In May 2000 a presentation on HAS will be held at a conference on teacher Education at the University of British Columbia, Canada (See past quarterly reports and Appendix 6).

2.3 CONSTRAINTS

Some of the constraints have already been alluded to previously in this document and previous quarterly reports. Below are discussed some of the major challenges the project has faced this last year.

2.3.1 Focus of Attention

Lack of human resource, differing needs of individual schools, high teacher turnover and limited teaching/learning days particularly in Government schools (approx. 100 days in a year) has meant that the programme has focused on health education and teacher development. As Gibbs (1999, page 8) states *The programme so far has focused essentially, and in my opinion quite rightly and realistically, on the first of the three areas of action, the health curriculum.* The benefits of this have already been

highlighted in section 2.2. However, there is therefore less evidence of HAS' success in the other two areas of the model namely health environment and health services. Whilst the triangular model assumes equal importance and influence of the three areas experience suggests otherwise and that perhaps the curriculum needs to be the carrier to enhance the other two areas. In this final year of the pilot an attempt is being made to define health services and environment in a broader way and look for avenues to link these with health education.

2.3.2 Developing Community Links

HAS defined community in such an urban setting as the families of children attending the HAS schools. Whilst there is evidence of children relating health knowledge to their homes and taking messages and action home through the six step approach, there is little evidence of actually *developing community to school links which develop health (Project Proposal, Hawes and Khamis, December 1997)*. It was envisaged that school health committees may be established but even the community school has been reluctant to do so. Reasons ascertained are lack of policy on parental involvement and parental pressure and judgement of teachers. Capacity has not existed amongst team members to mobilise communities and whilst ownership of the programme does lie with the school lack of more direct community involvement jeopardises sustainability of the programme beyond the life of the pilot.

2.3.3 Sustainability

The pilot has been human resource intensive due to the difference in evolution of the model according to the different contexts. In addition, finding the skilled local manpower to run the programme has been a challenge. However, the majority of team members are now local with one M Ed. Graduate (Professional Development Teacher –PDT) having joined the project team from the Government sector. Capacity development of these team members has been an integral part of the process and training of HAS teachers as well as others means that a critical mass of Child-to-Child practitioners are now available in the country. A proposal has been sent to SCF for the funding of a Child-to-Child resource centre at IED in order to support teachers, develop materials and provide training beyond the pilot.
AKU-IED has also been supportive seeing HAS as an integral part of it's upcoming programmes and Phase II proposal. It has been suggested that an elective module on Health Action as well as health education units in the primary module of the new M Ed. programme be established in the upcoming year. Other areas of consideration of sustainability at IED and AKU include through the Visiting Teacher programmes and the work of the Professional Development Centres as well as the proposed Institute of Human Development of AKU (Gibbs, 1999). The Principal Investigator (TK) also teaches units on school health to nurses at AKUSON.

In order to address the issue of sustainability beyond the pilot SCF (UK) and the HAS team need to develop a **dissemination and expansion strategy.**

2.4 PROGRESS TOWARDS OBJECTIVES

2.4.1 Obj 1: To develop prototypes of health promoting schools

2.4.1.1 - Based on the comprehensive school health promotion model ...

Each school has now developed their third School Health Action Plan (SHAP) (App. 2) that prioritises what health themes per term, health topics each target class will work on using the 6 step approach, number of lessons for health (n=20 to 30 per year), carrier subjects, co-curricular activities relating to the environment and linking the home with the school. Each school has also appointed a health co-ordinator to manage the project in the school.
As previously mentioned, the comprehensive school health action is being reconsidered with the curriculum as the fulcrum. Work is currently underway to link the other areas of the model to health education.

2.4.1.2 - To monitor the progress to test the hypothesis that there will be an increase in health knowledge and health behaviour; improvement in children's life skills, self esteem and participation in learning; improvement in teaching methodology; evidence of positive educational results

Evidence from research documentation and the mid term review suggest that to differing extents in each school there has been an increase in health knowledge and behaviour as well as improvement in teaching methodology through the school based training's, FAME sessions, regular school follow up, topic planning and use of Child-to-Child. The teaching learning and use of Child-to-Child methodology is being monitored through the action research by way of lesson observations and topic plans.

The third situational analysis will provide further evidence of progress with the final evaluation and case study research supplementing this.

2.4.1.3 - Inservice training for project organisers, heads and teachers

The regular weekly team meetings and team retreats (May 1999, March 2000) allow for the ongoing development of HAS staff. In addition organising workshops, presenting at conferences, research studies and writing these up as well as working with consultants such as Hugh Hawes has been a part of the professional development process. Two previous team members are now pursing Masters studies in this area and two other team members are now co-ordinating programmes in the health promotion field in other countries in development. It is hoped the Education Co-ordinator may also attend a course on Child-to-Child in the UK this year.

As has already been mentioned in this last year 14 workshops, mostly school based, have been held at which over 80 teachers have obtained training on Child-to-Child and active methods. In addition in the last year some 75 other participants (SCF partner NGOs (n=40), WASEP (n=32), PEP-ILE (n=3)) were also trained on Child-to-Child.

2.4.1.4 - Internal monitoring mechanisms

It was proposed that simple and effective internal mechanisms of monitoring would be developed with the schools. Initial attempts through the Environmental Checklists failed. In addition in the six step approach teachers and students appear to get to step for of Action but not beyond to steps 5 and 6 on Evaluation.

The mid-term reviewer has suggested that schools perhaps assess health education as part of their curriculum giving the subject a seriousness on the timetable. In one school (SMS) this is already occurring. The challenge is to ensure that the appeal of health education, currently being taught in a more interactive way without a textbook or set syllabus unlike other subjects, is not lost if it is assessed.

2.4.1.5 - Develop and identify teaching materials

Much progress has been made in this area with the first professionally translated Child-to-Child Urdu activity sheets currently being printed and due out in April 2000. A second CtC resource book based on *Children for Health* and *Small is Healthy part I*, taken from *Health Promotion in our Schools* (Hawes, 1997) is delayed (See section 2.1.4) until the revised edition is published.

2.4.1.6 - Management structures

Some progress has been made in the way the school manages the project through committed health lessons, enhanced and reinforced through carrier subjects. Each school has an appointed health co-ordinator that manages the health programme in the school. Challenges have occurred in trying to involve parents and children in the management of the project.

2.4.2 Obj 2: To encourage policy makers to support the project

On an ongoing basis steering committee members have met regularly, once in two months, and lent their support from the different Government and INGO sectors (Appendix 7 for TOR). It is planned that with the facilitation of Hugh Hawes in November 2000 another policy seminar be held to disseminate HAS' suggestions and experience on development of a school health curriculum.

In addition with HAS and IED represented on the Education Working Group though Dr. Khamis, as well as involvement with SCF's Regional Strategy on Education through the OSCAR office, dissemination of HAS' experience to policy makers is occurring.

2.4.3 Obj 3: To share lessons with other systems

This has been a major activity in the second year.
(See 2.2.4 Outreach)

2.4.4 Obj 4: To introduce school health education into IED's programmes

One important way to ensure sustainability of health education in schools is through teacher education institutions e.g. IED. The IED Director and management have continued to lend support to the project, the Director himself and other visitors to IED having visited HAS schools. Recommendations have been made that each VTP cover two days minimum of health education (See Appendix 8). Plans are underway to develop a Health Education in Action Elective for the upcoming M ED. programme.

2.5 PROGRESS TOWARDS LEARNING OBJECTIVES

2.5.1 Child Centred Participatory Approaches; Sharing Information

Before the initiation of this pilot very little work existed in Pakistan on the use of Child-to-Child approaches particularly in schools. The large number of requests for help and training as part of HAS' outreach activities show that there is a need and scope for such approaches in the country and indeed the region. Lessons have been learned on how to relate the activities to children's rights programmes and SCF partner NGOs have gained from HAS' experience of monitoring Child-to-Child. In addition sharing of relevant materials has occurred.

2.5.2 Multi-sectoral work

We believe that health and education are inseparable. In this second year the lessons have been adapted and gone to scale through both the health and education sectors in the Northern Areas (WASEP) and NWFP (PEP-ILE). In addition the steering committee provides a forum at which health and education sectors come together for the first time with those advocating children's rights. Learning has also occurred on the integration of Child-to-Child and inclusive education. Currently work is being done to assess the usefulness of the Child-to-Child approach on pre-school age children for whom materials or the approach were not designed.

2.5.2 Sharing Information

Sharing of information has occurred in various ways as outlined above - through workshops to SCF partner NGOs including the Aids Awareness Programme (AAP), materials, sharing meetings and publications. The Urdu publication will enable further sharing amongst Government and lower SES schools. This publication is the first major publication of IED and IED has thus learned lessons on publication development through this process.

2.6 ACTIVITIES/PROCESSES COMPLETED

As per the project proposal and LFA the following activities have occurred as planned:

- Schools have made their third school health action plans based on school health themes and 30 lessons per year.
- On the job monitoring, advice and encouragement of teachers by the team members through monthly meetings, topic planning days and lesson observations. Monitoring through the situational analysis and regular documentation is ongoing.
- Development and sharing of materials through the Urdu publications, testing out existing Child-to-Child materials in the classroom and teacher support through FAME sessions.
- Teacher training either grouping schools together or individually school-based trainings have occurred on a regular and needs basis as and when the school can mange it.
- 'Dissemination days have occurred during the mid term review and then between a couple of schools on the SHAP planning day.
- A mid term review was externally carried out in December 1999. (See report attached).

3.0 FORWARD PLANS

As per the proposal and LFA the following activities are planned in the coming year as part of the final phase (III) of the pilot project:

- Ongoing intervention in the final year of the pilot.
- A policy seminar on the dissemination of a Health Action School Programme is planned for later this year with work on a curriculum statement for health education.
- Consolidation of materials (starter pack; teachers workbook) and curriculum as per the suggestions of the Mid Term Review.
- Encouraging self identified expansion schools to come forward based on a dissemination strategy that will be drawn up with the help of SCF (UK) and the Research Support Unit of IED.
- Begin work on the writing up and publication of case studies from the research with help from experienced researchers at IED (Dr. Iffat Farah).
- Begin Development of an M Ed elective module on Health Education in Action.
- Final Report reviewing the project and making recommendations to be compiled.
- Visit of an External Review team to evaluate the project at completion of the pilot.

3.1 ACTIVITIES/PROCESS PLANNED

Quarter	Activities	By Whom
April, May, June 2000	Retreat Report Finalise Situational Analysis 3 Materials Development and dialogue on 2nd publication Dissemination Strategy	HAS team HAS team SCF and HAS team HAS team, RSU, SCF
July, August, September 2000	Training / Sharing experiences Curriculum Development Resource Centre Dialogue Research case studies	HAS team HAS team SCF and IED TK/IF
Oct., Nov., December 2000	Policy Seminar Curriculum Development Expansion school criteria Development of M Ed. elective	HAS team, SCF, HH HAS team HAS team TK and HH
Jan., Feb., March 2001	External review Complete Materials Development Final Situational Analysis Final Report A way forward	External, SCF, CtC HAS team HAS team HAS team SCF, IED,HAS team

3.2 MONITORING AND EVALUATION

Monitoring and Evaluation will occur as planned (See LFA, proposal and 1st Annual Report). However, it is proposed as per the suggestions of the mid term review (p.15, 16, 21) that a more qualitative evaluation through case studies of processes involved in developing HAS be conducted rather than a replication of the base line study in a before and after study.

4.0 RESOURCES

INPUTS AND BUDGET NARRATIVE WILL BE SUBMITTED SEPARATELY BY IED FINANCE SECTION.

5.0 SUPPORT AND ADVICE RECEIVED

5.1 Save the Children (UK)

The HAS team would like to acknowledge the support given by SCF, particularly Sadia Ahmed and Jeewan Das. They have proved to be real partners in the process. In addition SCF have helped with dissemination of the project through involvement of the Principal Investigator at SCF country and regional meetings, the Education Working Group and workshops with partner NGOs.

5.2 Child-to-Child

Although in this second year the only formal consultant to the project has been the mid term reviewer, William Gibbs, who worked in a most participatory manner with the team professionally developing as part of the process, we should like to acknowledge the support given to us by the Child-to-Child Trust, especially Hugh Hawes, who we have the privilege of having as a 'Mentor', and Christine Scotchmer, Executive Secretary, who has disseminated our work widely and supported us with materials, reports and continuous advice.

5.3 Materials Development

The Child-to-Child materials development project was co-ordinated by Mr. Yassir Hussain, heading the publication's department in collaboration with HAS. We are grateful to him and those who worked on the project particularly Ms. Fatima Imam the reviewer and Spiral Communication's who are printing the book.

5.4 IED

I should like to acknowledge the support lent to the HAS project by the IED and in particular the Directors, Drs. Robert Baker, Sadruddin Pardhan and Alan Wheeler. The support and interest in the project have ensured that lessons learnt from the project inform IED programmes, which in turn support sustainability of health promotion in our schools. In addition the commitment to professionally develop team members will ensure that an expertise in this area be built at the IED to carry on work on health promoting schools in Pakistan.

6.0 ISSUES RAISED BY PARTNERS/BENEFICIARIES

Whilst no major issues (other than what has already been mentioned in the progress reports) have been raised in the last year by partners or beneficiaries the following issues need addressing with SCF (UK):

- Follow up on suggestions made in the Mid Term Review Report (herewith attached)
- Dialogue on the Second Urdu CtC Publication
- Funding of the CtC Resource Centre
- A way forward beyond the pilot phase

THE AGA KHAN UNIVERSITY
Institute for Educational Development

Health Action Schools in Pakistan

Annual Report

April 1998 - March 1999

For Save the Children (UK)

018

Table of Contents

		Page Number
1.0	IDENTIFICATION	1
2.0	PROGRESS REPORT	1
2.1	CHANGES IN PROJECT CONTEXT	1
	2.1.1 Situational Analysis	1
	2.1.2 Steering Committee	2
	2.1.3 Teacher Training and Follow up	2
	2.1.4 Material Development	2
	2.1.5 Schools	2
	2.1.6 Mid Term Review	3
2.2	BENEFITS ACHIEVED AND OTHER OUTCOMES	3
	2.2.1 Five Pilot Schools	3
	2.2.2 Toy Making Workshop	5
	2.2.3 SCF Partner NGO's Child-to-Child Workshop	5
	2.2.4 Outreach	5
2.3	CONSTRAINTS	6
	2.3.1 Government Schools	6
	2.3.2 Teacher Turnover	7
	2.3.3 Human Resource	7
2.4	PROGRESS TOWARDS OBJECTIVES	7
2.5	PROGRESS TOWARDS LEARNING OBJECTIVES	9
2.6	ACTIVITIES/PROCESSES COMPLETED	9
3.0	FORWARD PLANS	10
3.1	ACTIVITIES/PROCESSES PLANNED	10
3.2	MONITORING AND EVALUATION	11
4.0	RESOURCES	11
5.0	SUPPORT AND ADVICE RECEIVED	11
6.0	ISSUES RAISED BY PARTNERS/BENEFICIARIES	12
	APPENDICES	

Health Action Schools in Pakistan
Institute for Educational Development
The Aga Khan University

1.0 IDENTIFICATION

1.1 Project/programme name: Health Action Schools Pilot Research Project

1.2 Project/programme code:

1.3 Location: The Aga Khan University Institute for Educational Development, Karachi

1.4 Reporting period: From April 1998 to March 1999

1.5 Author of report: Dr. Tashmin Khamis

1.6 Date of report: April 1999

1.7 Name of partner implementing agency: The Aga Khan University Institute for Educational Development, Karachi

1.8 Funding source(s): Save the Children Fund (UK) and The Aga Khan University, Institute for Educational Development

1.9 Project/programme duration: 3 years

2.0 PROGRESS REPORT

This report is the first annual report of the Health Action Schools (HAS) project and follows the six monthly and third quarterly report submitted to SCF.

2.1 CHANGES IN PROJECT CONTEXT

No major changes have occurred in the project context. The initial 5 pilot HAS from different social and educational contexts continue to implement the programme to differing degrees as highlighted later in this report. Staff changes were also mentioned in the third quarterly report and the project is on the whole following what was planned (See Proposal and LFA - March 1998). Below are highlighted the key changes from the LFA/Proposal.

2.1.1 Situational Analysis

Although the project has come to the end of it's first year of implementation in most schools a full year of implementation has not occurred. When taking into account holidays, examination and registration time and strike days most schools have had only half that time (6-8 months) actually engaged in teaching-learning. Originally it was proposed that the situational analysis tool be administered on a six monthly basis in each school, in order to monitor change in a more formal way on the various components of the comprehensive school health promotion model. The tool is largely a qualitative one that takes time to administer, relying on observation and interviews with the Head, teachers, pupils and their parents. It has therefore been decided that this tool now be administered on a yearly basis - the next one planned for October 1999. However other mechanisms for ongoing and internal monitoring will occur on a continuous basis.

2.1.2 Steering Committee

Pre-intervention, the steering committee, made up of health and education representatives from both the Government and AKDN sectors met on a fortnightly basis. In this first year we have held monthly meetings. However, turn out has been poor recently and it is felt that the momentum of the project is now sufficiently underway to merit less frequent meetings. It is proposed that meetings be held every 2 months, unless an urgent need arises in between.

2.1.3 Teacher Training and Follow up

As has been highlighted previously (Six monthly report) the HAS team felt that training alone with monthly visits are not enough, and that teachers require more support in schools. It was envisaged that training's would be held initially twice a year and then only once a year. Due to the large numbers of teachers trained (due to transfers, leaving and many carrier subjects), and more individual school based training's, teacher education has taken up more of the HAS time than was envisaged. Some 85 teachers from the HAS pilot schools have received some training but of these just under half (n=40) having only attended one training. Some 45 HAS teachers have attended more than one training of the possible 4 conducted so far (January 1998 - Introduction, March 1998 -Pre-launch, July 1998 Refresher, February 1999 - Active Methods). Topic planning sessions have also been conducted in the individual schools.
In addition to the monthly school meetings, more lesson observations are conducted. This means that every week the team visits schools with each school visited at least twice a month during health education terms. This is taxing on the IED team but a very necessary part of the action research.

2.1.4 Materials Development

One of the objectives of the project was to identify and develop relevant health education materials. The Child-to-Child materials have been tried and tested out in the schools and a proposal submitted to SCF for professional translation and adaptation of these materials into Urdu (See Materials Development Proposal). This would be of benefit not only to the pilot HAS schools but to all schools wishing to become health promoting, enhancing the sustainability once the project comes to an end in its present form.

2.1.5 Schools

Two of the schools (Pir Mehfooz Government school and Metroville Community Based school) have changed location to a new site, but within the original locality. Baseline situational analysis was conducted in the original site with the second situational analysis in the new location.

In addition it appears that although we have 5 pilot research schools a sixth HAS school has begun. Due to joint planning sessions between the SMS boys school with the girls school, teachers have attended training and are teaching health lessons. We hope in the coming months to do a case study on this first expansion school, despite it not being one of our research schools.

Whilst the research aimed to focus on primary classes, flexibility was given to the school as to which classes should be involved. Some schools chose to involve the whole primary section (Metroville, Pir Mehfooz) whilst others decided to start with certain sections (Generation's, Atiya Bai, SMS). However, two of the schools have also involved their pre-primary sections (Generation's and Metroville). These appear to be pioneers of health promoting pre schools perhaps globally, and whilst the Child-to-Child approach has not been geared for these very young age groups, the experiment is being watched and documented closely.

2.1.6 Mid Term Review

The proposal states that SCF will conduct an external mid term review in April 1999. As far as I am aware a team has not been identified by SCF to conducted this yet. As stated previously the intervention has only occurred for 6-8 months in most schools. It is therefore proposed that if a mid term review exercise is conducted this should occur 'mid term' between December 1999 and March 2000.

2.2 BENEFITS ACHIEVED AND OTHER OUTCOMES

2.2.1 Five Pilot Schools

Appendix 1 gives a thorough status of each of the five pilot HAS (*complied by team members, Dr. Omer and Ms. Shivji*). Below is a summary of benefits achieved as shown from a comparison of the situational analysis II with that conducted at baseline.

2.2.1.1 Atiya Bai Girls Government School

Some changes were seen in the environment of the school. There was visibly less litter with dustbins filled in the classrooms. In terms of safety and the surrounding there was less of a visible difference. However, whilst the latrines were still in an undesirable state, soap for washing hands was now being brought in by children themselves and more children were bringing clean water from home to drink. Teachers also noted the better appearance of children and their willingness to take care of and clean their school and greater awareness about healthy habits such as washing hands. This school had a poor start with only one health teacher and the health co-ordinator (now 'promoted' to a secondary school) interested and attending training. However, at least in health lessons the participating teachers show some change from the usual rote learning to more discussion and question/answers from the students. The general impression is that students appeared to be more confident when interacting with the team and appeared less frightened during interviews - though this could be due to being more familiar and comfortable with the team members. So whilst some headway has been made with the environment and health lessons, there has been none or little impact on involving parents, in the area of health services or co-curricular activities, though the toy making workshop using junk material went down well (App. 2).

2.2.1.2 Generation's Private School

This school, despite it's privileged environment has also noted change since the project intervention. For the first time in eight years it boasts it is 'Lice Free' with teachers convinced this is due to the Child-to-Child six step approach used on the topic of Lice. The assembly spots and displays around the school show it is clearly a health promoting school. Teachers, although burdened with a rigid curriculum and many other school interventions, report their enjoyment with the project and a real focus on health in 'an organised manner'. Their enthusiasm at our monthly meetings is evident from their eager stories of what happened in their classes. Although active methods were previously used in the school those who at least attended part of the February active methods workshop are trying out new methods in their classrooms such as surveys and puppets. It is hoped in the next phase more involvement of health services and the parents would occur.

2.2.1.3 Metroville Community Based School

The school site has changed since the baseline survey. Whilst no major changes have been noticed in the environment, children appear to take more responsibility of health issues e.g. Displaying health signs around the school and bringing clean drinking water from home. Work however still needs to occur on use of active methods with 'activity' and 'practicals' seen as active learning. The school has had two health co-ordinators and although the head is very supportive of the programme, more ownership needs to be taken by the teachers. There is much scope for more community involvement in this school as well as co-curricular activities.
Another benefit through this school being a HAS is the link this school has now made as a co-operating school with IED. This has enabled the head and teachers to attend Visiting Teachers (VTP) courses and ADISM (advanced diploma in school management).
The lower secondary classes (6 and 7) are also being involved in the project.

2.2.1.4 Pir Mehfooz Government School

This school too has changed location. Compared to baseline dustbins are now present in classrooms and although the general water and sanitation situation has not improved, more children are bring clean drinking water from home. The school initially was a multi grade school due to lack of teachers (only 2 in the school). However due to HAS links with the Government hierarchy there are now 5 teachers in the school. In health classes where teachers have had training, there is a small move away from pure rote learning with more discussion and question and answers being used, with the health co-ordinator using active methods such as surveys and stories. In general it was felt that at least some children appeared more confident than compared to our initial interactions with them. There was a lot of resistance to training initially by teachers from this school. However with the support of the Directorate of Education and the DEO's office, teachers having been made to attend training at IED actually expressed a desire for more training. It was unprecedented when the last head actually came to seek permission from the HAS team to transfer to a local school due to personal problems, with that head having attended all our teacher training's. It also appears that whilst change is still slow in the components of comprehensive school health promotion there is less teacher absenteeism.
A very successful toy making workshop was also held in this school.

2.2.1.5 SMS Boys AKES school

The first visible change since baseline around the school is that children's work is being displayed around the school, including on health topics such as malaria. Whilst there is much room for improvement in the school environment, that water and sanitation situation has improved with better state of latrines and more children bringing boiled water from home to drink. Teachers have also begun to use more active methods in their teaching since the intervention such as surveys, stories, role plays but there is scope to further challenge thinking. Assembly health spots are also being held with parental participation in preparing these evident. As mentioned previously the health programme has spread to the girls school due to their joint planning sessions. The status of health education has also been raised, as questions on health topics are part of the examination system in these two schools.
There is scope to involve the nurse more in this school other than in health services which is meeting some resistance, although she reports that the level of health awareness has been raised in the last year amongst pupils and staff alike.

2.2.2 Toy Making Workshops

Two toy making workshops were held in the poorly resourced Government schools using junk and scrap readily available materials, which were also attended by members of the SCF partner NGOs (App. 2). The message of older children stimulating younger siblings with toys and play was part of the exercise. An article on ***Toys R Healthy*** was published in the Children's magazine of the Dawn English daily newspaper on March 13th 1999 (App.3).

2.2.3 Child-to-Child Introductory Workshop for SCF Partner NGOs

In January 1999 at the request of SCF a two day introductory workshop on Child-to-Child approaches was conducted by Dr. Khamis with the help of the HAS team. Participants included those working with working children and the Aids Awareness programme. In addition two persons working with the USAID funded AKES community based schools in Sind also attended. A sharing experiences follow up is planned in the next quarter. (See Workshop Report).

In addition, Dr. Khamis is a member of the **Education Working Group** set up by SCF after the regional education meeting in Nepal last year, which aims to promote quality education in Pakistan. Through this forum the work of HAS may be disseminated and learnt from.

2.2.4 Outreach

The six monthly report highlighted outreach activities and publications on HAS in the media and elsewhere. Since that report other outreach activities included the following:

2.2.4.1 Publications

- *IED, Pakistan translates Child-to-Child materials.* CtC Newsletter '98
- *Linking health and education.* AKHS international newsletter, Oct. '98
- *Nutrition Education and Child-to-Child.* UN-SCN News, Dec. '98
- Media articles; The Jang, 13/2/99; The News 13/2/99; Star 13/2/99; Urdu Press 13/2/99; Young World Dawn, 15/3/99, Star 3/12/98, The News 14/10/98.

(App. 4)

2.2.4.2 Meetings

- AKU Task Force on Human Development -presentation to Dr. J. last on 22/3/99.
- World Bank, Water and Sanitation Programme - 29/1/99.
- Child-to-Child and Inclusive Education - March 1999, London.
- Provincial Education Director, Primary Schools - April 1999.

2.2.4.3 Materials

Materials have been requested and shared with the following:

- SCF Partner NGOs
- AKHS,P, CHS and AKHB -WASIP.
- AKES, Community Based Urban and Rural schools projects
- Rah-e-Nagat, Community development NGO
- Punjab middle schooling project
- Pattan- non formal school programme
- Health Education Officer, Kohat

2.2.4.4 Training

Although 85 teachers from participating HAS pilot schools have received some training, a further 13 people have benefited from the training courses from other organisations and schools e.g. SCF partner NGOs, AKES teachers, community based school teachers - Afghan Academy, Government officials from PEP-ILE in NWFP and nurses. Thus in total 98 persons have had exposure to Child-to-Child and comprehensive school health promotion training through HAS training workshops. In addition through workshops for SCF partner NGOs Child-to-Child approaches have been explored. Awareness on the approach has also been raised through IED programmes at the VT and M Ed. courses and teaching that the Principal Investigator (TKK) conducts on school health for nursing students at AKUSON.

2.3 CONSTRAINTS

Some of the constraints have already been alluded to previously in this document and the six monthly report. Below are discussed some of the major challenges the project has faced.

2.3.1 Government Schools

Working with the Government sector continues to be our major challenge. In both the Government pilot HAS schools, we are working with different Heads than at the beginning of the intervention, with 4 heads being transferred in one school. This of course has a major impact on the continuity of the implementation and requires much effort on the part of the HAS team to orient the new Head to the ideas underpinning the project.
Teacher transfers are another issue, with several teachers, including health co-ordinators, having been transferred after receiving training. With most teachers in the school not being part of the initial decision to become a HAS, a lack of ownership over the programme is an outcome. This translates into lethargy on the part of the teachers which affects their commitment to attend training or conduct health lessons.

The HAS team has worked hard on the inclusion of the Government sector with more hours and days spent on average per Government school as opposed to our other Private schools, with individual school based training's and follow up. This is because we are aware that sustainability is contingent on showing that the model can work in the Government sector. However this requires support from the Government Authorities e.g. from the Education Directorate. Mr. M. Sufi, Provincial Deputy Education Director for Primary Schools is a member of the steering committee and has lent his support to prevent transfers and enable teacher training. A meeting was also organised with the Provincial Education Director for Primary Schools, Mrs. M Essani, at which some of these constraints were highlighted and discussed, with her support extended to the project. The funders and partners (SCF) need, however, to be realistic as to what is possible in the Government sector and what they mean by 'sustainability', with expectations having to be different in the different contexts according to the starting points and constraints faced.

2.3.2 Teacher Turnover

As mentioned previously, teacher turnover in all our pilot HAS schools has hampered the progress of the project. High teacher turnover means that more teacher training is needed to train new teachers which requires more of the IED team's time. In some of the schools a system of information sharing through internal training is encouraged but this has only been successful in a couple of the Private schools.

The differences in training inputs has manifested in different levels of health action and health education lessons in the schools. This has required the team to organise more needs based training and more school specific training.

2.3.3 Human Resource

The IED HAS organisers/researchers work as a team (n=5). However, most team members are relatively inexperienced and development especially of the more junior members takes up much time of the more senior team members, whose longevity on the project is also limited either because they aspire to higher education or are not Pakistani nationals. Thus the fragility of the project is a concern, also voiced by Hugh Hawes - consultant to the project, despite the evidence of the project growing in strength month by month and the enormous potential it has as a model for school improvement. (App. 5)

2.4 PROGRESS TOWARDS OBJECTIVES

2.4.1 Obj 1: To develop prototypes of health promoting schools

2.4.1.1 - Based on the comprehensive school health promotion model ...

Each school has now developed their second School Health Action Plan (SHAP) (App. 6) that prioritises what health themes per term, health topics each target class will work on using the 6 step approach, number of lessons for health (n=20 to 30 per year), carrier subjects, co-curricular activities relating to the environment and linking the home with the school. Each school has also appointed a health co-ordinator to manage the project in the school.

2.4.1.2 - To monitor the progress to test the hypothesis that there will be an increase in health knowledge and health behaviour; improves children's life skills, self esteem and participation in learning; improves teaching methodology; shows positive educational results

The six monthly report described the research tools being employed to monitor the above. The baseline analysis report has now been compiled (See Baseline Report attached) and will allow for comparison at the end of the project. In addition two situational analyses have been conducted which will be repeated on an annual basis.
The teaching learning and use of Child-to-Child methodology is being monitored through the action research by way of lesson observations and follow up.

2.4.1.3 - Inservice training

Since the six monthly report a training workshop was held in February 1999 on the use of active methods in health teaching and designing the SHAP for the second year of intervention, with the help of Hugh Hawes, co-founder of Child-to-Child and co-author of the original HAS proposal. (See Training Report attached). In addition, the principal investigator attended a three week training course at the Institute of Education, London University, on Inclusive Education and Child-to-Child: including children with disabilities into regular classrooms. Inclusion, as part of HAS is now being looked, to enhance all the components of the comprehensive school health promotion model.

2.4.1.4 - Internal monitoring mechanisms

Some progress has been made in this area in terms of the Environmental Checklists, but unsatisfactorily. More work is needed in this area and it is hoped a retreat to be held in May for the project organisers will look at a strategy to develop better internal monitoring mechanisms.

2.4.1.5 - Develop and identify teaching materials

Progress has been made in this area with SCF being approached with a proposal to professionally translate and adapt Child-to-Child materials in Urdu. As a follow up to the February workshop it is hoped that more locally school produced materials could be collected and shared.

2.4.1.6 - Management structures

Some progress has been made in the way the school manages the project through committed health lessons, enhanced and reinforced through carrier subjects. Each school has an appointed health co-ordinator that manages the health programme in the school. It is hoped in the next phase that parents and children may be involved more in the management of the health programme.

\2.4.2 To encourage policy makers to support the project

In November 1997 a policy seminar was organised to raise awareness amongst policy makers about HAS. The steering committee is made up of members from Government, AKDN and NGO sectors from both Health and Education fields. The relevant Provincial Government sector are involved in continuous dialogue on the progress of HAS and have lent their support also. More work on this area will be necessary in the next phase to ensure sustainability and expansion of the project.

2.4.3 To share lessons with other systems

(See 2.2.4 Outreach)

2.4.4 To introduce school health education into IED's programmes

One important way to ensure sustainability is to involve those teacher education institutions e.g. IED. The IED Director and hierarchy have lent much support and taken interest in the project as it fit the Phase II mandate and vision of IED. However, already health education is an integral part of most VT courses (Primary, Maths, Science, Social Studies) as well as the Primary M Ed. module and the Primary subject specialisation with at least a day devoted on all these courses to health promotion. (App. 7)

2.5 PROGRESS TOWARDS LEARNING OBJECTIVES

2.5.1 Interdisciplinary research

In this first year of intervention lessons have been learnt in research terms on multi-sectoral work as health and education sectors come together with their differing quantitative and qualitative paradigm. We believe that the two paradigms can compliment each other and our research tools are designed in that way (See Baseline Report attached).

2.5.2 Sharing Information

Sharing of information has occurred in various ways as outline above - through workshops to SCF partner NGOs including the Aids awareness programme, materials sharing, meetings and publications.

2.5.3 School Health Action Plans

Through the work of planning the programme lessons have been learnt as to how to set up School Health Action Plans (SHAPs) in primary schools (See Training Report, Feb. 1999). Dissemination of this through publication would be an important contribution to expansion of health promoting schools in Pakistan.

2.5.4 Integration

As schools chose carrier subjects for health lessons, teachers often pushed integration where it would not fit. Their narrow view of integration meant that health topics of priority would get left out. Through the Active Methods workshop (See Training Report, Feb. 1999) the idea of health topics enhancing teaching of other subjects was explored and teachers felt more comfortable using this idea and in turn not losing the focus on prioritised health themes. Lessons from this have informed the way health education is introduced into IED's VT subject areas also.

2.6 ACTIVITIES/PROCESSES COMPLETED

As per the project proposal and LFA the following activities have occurred as planned:

- Completion of baseline and second situational analysis, as reported earlier. Situational Analysis will now occur annually, to monitor change and progress in all the components of comprehensive school health promotion.
- Materials development - professional translation and adaptation of relevant Child-to-Child materials into Urdu.
- Teacher training and toy making workshops, including facilitation by Hugh Hawes, consultant to the project.
- School health action planning and topic planning of health lessons.
- School lesson observations and follow up.
- Monthly meetings to share experiences of teachers in a school.
- Steering committee meetings.

3.0 FORWARD PLANS

As per the proposal and LFA the following activities are planned in the coming year:

- A retreat with the HAS team at IED to take stock after one year of intervention and look at future directions for the project in the coming year. This will include analysis of the consultancy report (App. 8) and suggested directions provided by Hugh Hawes (App. 5); suggestions on improving lesson observation tools and methods; training needs; health environment; health services; health management and internal mechanisms of monitoring; involving children and parents.
- A sharing experience day with SCF partner NGOs that attended the Child-to-Child introductory workshop.
- Finalising the agreement with SCF for Materials development and starting the materials development project. We also hope to dialogue with the Sindh Text Book Board on the materials project.
- Training of teachers, follow up in schools and sharing of experiences between schools.
- Dialogue with SCF and IED about the potential Child-to-Child Resource Centre in Pakistan, as the HAS team have developed substantial expertise in Child-to-Child approaches, training and materials development.
- On going research, documentation and monitoring.
- Steering committee meetings.
- Dialogue with policy makers.

3.1 ACTIVITIES/PROCESS PLANNED

Quarter	Activities	By Whom
April, May, June 1999	HAS retreat SCF Sharing experiences Begin materials development	HAS team SCF SCF and HAS team
July, August, September 1999	Training / Sharing experiences Materials development Follow up / Monitoring Resource Centre dialogue	HAS team Spiral communications HAS team SCF and IED
Oct., Nov., December 1999	Inter school visits Third Situational Analysis Follow up / Monitoring	HAS team HAS team HAS team
Jan., Feb., March 2000	Dissemination day with policy makers - minimum entitlement External review Teacher Training Complete Materials development Expansion school criteria	HAS team, SCF, policy makers SCF HAS team Spiral Communications HAS team

3.2 MONITORING AND EVALUATION

Monitoring and Evaluation will occur as planned (See LFA). However the following changes are proposed:

- Situational Analysis annually rather than six monthly.
- Mid Term review in the final quarter of this year - formal external evaluation.
- Use of new internal mechanism of monitoring the school environment - to be devised with the school and hopefully to include children's participation.
- Use of a new lesson observation checklist to help gauge progress but also aid teachers in their teaching of health lessons.

4.0 RESOURCES

INPUTS AND BUDGET NARRATIVE HAVE BEEN SUBMITTED SEPARATELY BY IED FINANCE SECTION.

5.0 SUPPORT AND ADVICE RECEIVED

5.1 Save the Children (UK)

The HAS team would like to acknowledge the support given by SCF. They have proved to be true partners in the process with Sadia Ahmed, Programme Co-ordinator SCF, one of the facilitating team at the recent workshop on Active Methods in February 1999. In addition SCF have helped with dissemination of the project through involvement of the Principal Investigator at SCF country and regional meetings, the Education Working Group and workshops with partner NGOs.

5.2 Consultancy

The workshop in February was conducted with the help of Hugh Hawes, co-founder of Child-to-Child, who is well versed with the HAS project, initially as co-author of the proposal and subsequently both visiting schools and facilitating training. The potential for a Child-to-Child resource centre was discussed with Hugh and SCF during his visit. (App. 5)

In addition Clare Hanbury from Child-to-Child trust (UK) provided a two day consultancy on future directions for the project in March 1999 (App. 8).

We should like to acknowledge the support given to us by the Child-to-Child Trust, especially Hugh Hawes, who we have the priviledge of having as a 'Mentor', and Chrisitine Scotchmer, Executive Secretary, who has disseminated our work widely and supported us with materials, reports and continuous advice.

5.3 Materials Development

Although the HAS team will over see the Child-to-Child materials development project the bulk of the work has been contracted out to Spiral communications. I should like to acknowledge the work put in to develop the proposal by Dr. Saad bin Omer, HAS team member and Yassir Hussain, IED Communication's Co-ordinator.

5.4 IED

I should like to acknowledge the support lent to the HAS project by the IED and in particular the Director, Dr. Robert Baker. The support and interest in the project have ensured that lessons learnt from the project inform IED programmes, which in turn support sustainability of health promotion in our schools. In addition the commitment to professionally develop team members will ensure that an expertise in this area be built at the IED to carry on work on health promoting schools in Pakistan.

6.0 ISSUES RAISED BY PARTNERS/BENEFICIARIES

6.1 Government Involvement

The challenge faced with Government schools has been discussed in this report, and previously. An issue was raised by SCF at the February 1999 training at the fewer numbers of Government teachers as compared to those from other systems. It was highlighted by the HAS team that although in numbers the teachers from our Government schools were less, in terms of percentage of total teachers per school the ratio was higher from the Government sector.
As stated elsewhere teacher transfers and lack of commitment plague the Government system. In fact, the training in February 1999 was the first at which teachers were present from both the Government pilot schools with a 100% attendance from the rural school.

The issue of sustainability and realistic Government involvement is one that SCF needs to debate internally. Whilst the HAS team is committed to working with the Government schools it must be stressed that much more of our time is spent on inclusion of this sector, which would not be possible without constant dialogue with the authorities. Once the project is over who will continue this dialogue and put pressure for the need for change? Trying to change individual schools for improvement without changing the system is an impossible task.

The team is also cognisant of the fact that progress will differ in the different school systems depending on their starting points.

6.2 Resource Centre

As has been mentioned earlier, dialogue has begun with Child-to-Child and SCF on the establishment of a Resource Centre. Whilst Child-to-Child and the HAS team feel that their strengths and expertise on materials and training lie in the area of 'Health', defined in a very broad and all encompassing way (with child rights and children participation the approach used to promote this), SCF has felt that the term 'health' in the title of the resource centre would narrow people's view of what it contains. As dialogue progresses and details are discussed on the establishment of a resource centre, this issue needs to be debated further to reach a consensus that meets the mandate of both the IED and SCF.