SCHOOL HEALTH

A Handbook for Teachers, Administrators and Health Personnel

D. RAYANNA, Ph.D.

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for
Teachers, Administrators and Health Personnel

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We all hope and pray for our children to grow up healthy and happy. We wish them to live a productive and stimulating life. We expect them to have rights as citizens to live in peace, to live in an environment which has been preserved from contamination and exploitation.

ABOUT THE AUTHOR

Dr. D. Rayanna is on the Faculty of the Regional Center for Urban and Environmental Studies, Osmania University, Hyderabad, handling Training priorities of the Urban Community Development Projects assisted by Overseas Development Administration (ODA), U.K., UNICEF and other aid agencies.

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Earlier as Executive Secretary of Andhra Pradesh Voluntary Health Association, a position that he held for eleven years, developed and strengthened the organisation. His innovations such as the School Health Mirror in India was appreciated. He edited several school health bulletins in English and Telugu between 1984 - 1988. He had taken a lot of interest particularly in School Health Programmes, organised several training courses for teachers and assisted in formulating training syllabus for teachers for Government of Andhra Pradesh with the assistance of UNICEF and Government of A.P. He also prepared health profile of Andhra Pradesh.

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FOREWORD

In recent years there has been increasing interest in school health programmes, and rightly various states such as Andhra Pradesh have initiated them in a bigway. International bodies like UNICEF, UNESCO, WHO and others are playing active role in promoting school health. Voluntary organisations too, following their tradition of innovative approaches, have come forward to promote school health programme in a big way and with much success.

The health situation of the children in the schools in our country is nowhere near to the optimum level. There is a lot to be done in this regard to reach the goal. Success in achieving the goal will depend on many sectors in addition to health. Most important among this is education provided through schools.

School health cannot be considered as one of the activities of the school alone. It is to be seen a process and it should become a movement where every one - parents, teachers, health personnel and community have a role to play in this process.

Dr. D. Rayanna is one of the pioneers in promotion of school health in Andhra Pradesh. With his vast experience in the field, he tried to give a comprehensive view on the subject in this book. The book fills the void in the literature on school health and gives practical suggestions for strengthening school health programme.

The author has dealt with every aspect of school health in a comprehensive way and this is certainly going to be a valuable asset to teachers, parents, health care workers, administrators and to all those who are interested in involving themselves in the promotion of the health of children, who are the future of our nation.

Secunderabad,
World Health Day,
7th April 1995.

- Fr. John Vattamattam
Executive Director, CHAI

ACKNOWLEDGEMENTS

It gives me a sense of satisfaction for having completed this book on comprehensive School Health programme. At this moment, I can't but remember all my friends, well wishers, and all those individuals and institutions who helped me in bringing out this volume.

At the outset I wish to record my profound gratitude to Dr. Mira Shiva, Head of Public Health and Policy, Voluntary Health Association of India, New Delhi, who inspired me to take interest in school health programmes and activities in early eighties and sustained my interest in this area there after.

Dr. M. V. Bapi Raju Sharma, Deputy Director, State Mass Media Education Bureau, Family Welfare (Retd.) stimulated and sharpened my interest in school health. He spent several hours in discussing the manuscript and gave me several suggestions for incorporation. I am extremely grateful to him for all that he did.

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I express my thanks to the authors and publishers of various resource materials used in preparing this handbook. The list of reference materials used are given in the appendix.

I wish to record my sincere thanks to Fr. John Vattamattam, Executive Director, Catholic Health Association of India (CHAI), Secunderabad, and Mrs. D. Philomena, Secretary, Andhra Pradesh School Health Association (ASHA), Secunderabad for their encouragement in publishing this volume and OXFAM for their partial financial assistance.

April, 1995.
Secunderabad.

Dr. D. Rayanna

CHAPTER - I

INTRODUCTION

In the developing world, school-age children have survived the vulnerable years of infancy and early childhood despite the fact that they continue to be exposed to a wide range of diseases and health hazards. Childhood illnesses are relatively simple and inexpensive to prevent with appropriate knowledge. Positive influences in the school years, can have far-reaching benefits for adult life and forms the underlying rational for health education during childhood.

The WHO\UNICEF International Consultation on Health Education for the School-Age Child (1985) declared: " In the context of social justice and as an important means of achieving health for all through the primary health care strategy, the health learning of the school-age child should be enhanced in every possible way so as to promote the exercise of self-reliance and social responsibility and a better quality of life for today's children and tomorrow's adults (WHO\UNICEF, 1986:14).

School-age children, 6-14 years who attend school, as well as those who are outside the formal education system, have been viewed as both recipients and transmitters of health knowledge. If these children are socialized through scientific and systematic means into behaviour that is conducive to healthy living, they will not only grow into healthy adults but also be able to influence those around them, thereby enhancing the health status of their communities.

Incorporation of health, hygiene and nutrition education into regular school syllabi, has always been a feature of Indian education. In the last three decades several pilot projects have been undertaken in the state sector with the purpose of demonstrating the suitability of alternative approaches and the feasibility of incorporating them into the regular education and health systems. Similarly, voluntary organisations have experimented with innovative educational techniques in both the formal and non-formal systems packages which can be adopted by the state on a larger scale and a long-term basis.

Health Awareness :

Children are open to a variety of influences. The most important influence comes from their homes and communities. Health values, attitudes and behaviours are shaped from the early childhood years. Relatively few children in today's world absorb from their environment the concept that health is a high-priority asset, or that they themselves can be instrumental in affecting it. Although contact with health workers entails some amount of health education, it is difficult to improve health knowledge significantly. Furthermore, the contact tends to be more curative than preventive.

Focussed educational intervention holds the potential of changing health behaviour. In the context of poverty, malnutrition inadequate outreach system, and limited services provided at sub-centre and Primary Health centre levels, planned health education and mass media can help individuals to avoid disease and develop healthy life styles. Within the school, children's understanding of health is also affected by the health-related aspects of the school environment and the health services provided. Thus, if children's health attitudes are to be influenced positively, a comprehensive health service which rationally relate to educational inputs is essential.

The school contains the largest single captive audience for health education. At present there are 98.1 million children (50.4 million boys and 47.7 million girls) enrolled in about 5.58 lakh primary schools in India (Statistical Hand book-India 1992). In rural areas 96.4 per cent of the population is served by primary schools located within one kilometre. While the statistics are impressive, a number of deficiencies like proper school buildings and lack of basic sanitary toilet facilities and safe water supply are visible. The teacher-pupil ratio is very high and there is a large number of drop outs every year. As the universalization of primary education is a declared policy, a close interaction between the school and the village community would become a promising second front in preventing ill- health and malnutrition.

Addressing the Out-of-School Child:

Though a vast number of children are enrolled in schools, large numbers attend irregularly, and many children also drop out from school before they complete primary education. While enrolled children in schools are accessible to school health services, those who are out of school are rather more difficult to reach. Not only are they scattered in the adult world of economic pursuits, but little objective data are available on who they

are, where they are, through what channels they receive information and how they process it. In India these children have remained outside the purview of state-sponsored health education efforts. Efforts have perhaps not been made to provide them with health information on the ground that the achievement of universal primary school enrollment would automatically bring them in contact with such a service. In order to systematize such efforts, a first step is to identify these children. The WHO\UNICEF International Consultation (1986) identified six sub-groups for out-of-school children:

a. those who stay at home and are involved in aspects of the home economy;

b. those who live at home and are involved in some form of organised labour;

c. children who are not permitted or encouraged to attend school (particularly girls);

d. children who are isolated on account of geographic inaccessibility or physical handicap;

e. "street children" who have lost or severed contacts with their families; and,

f. "refugee children" who come from societies disrupted by natural ors man-made disasters.

There are large numbers of these children in both rural and urban areas in India. While some are covered by non-governmental programmes, others are reached by non-formal primary education, and still others are found at employment sites with their parents. The majority, however, are dispersed.

Unlike school children who are familiar with "organised learning," out-of-school children pose the greatest challenge to health education. They are exposed to unhygenic condition makes them vulnerable. Not only do they have to be located, but approaches which are innovative, flexible and captivating must be devised for them, particularly as the educational content must also be meaningful to the children's lives.

Because the children are a vulnerable group and become easy victims to many childhood diseases provision of comprehensive health care services in schools as part of community health care system is important in the largest interests of the society. It should be recognised that school health programme is a specialised service to a specific age-group.

The National Health Policy of India, 1983 has included school health programme in the list of problems requiring urgent attention and reiterated the need to organise school health services, linked with the general preventive and curative services, as a time bound programme. The National Policy of Education (1986) has emphasised the need for the overall development of the young child. It states that recognising the holistic nature of child development i.e. health, nutrition, social mental, physical, moral and emotional development, early childhood education will receive high priority and be suitably integrated with other services where ever possible.

Hence an attempt is made in the following chapters to identify and plan out strategies to universalise the concept of school health. This book titled - School Health, a hand book for teachers and health personnel- will assist teachers, principals / headmasters, administrators and health personnel in organising school health programme in a systematic way. It is also a good reading material for teacher trainees in B.Ed, and their teachers. It contains innovative ideas for promoting health awareness among school-age-children. The teachers should use the ideas to suit their own circumstances. The book should guide its user in combating theory and practice into a dynamic and relevant school health programme.

CHAPTER - II

AN OVERVIEW OF SCHOOL HEALTH PROGRAMME

It offers a possible starting point, particularly for teachers in understanding the basic issues concerning school health programmes. The chapter gives an overview of the development of the school health programmes in India and evaluates the efforts made towards promotion of school health.

Historically speaking, the introduction of Medical Inspection of school going children in the city of Baroda in 1909 was a landmark in the development of school Health Services in India. Between 1909 and 1937 Bengal, Bombay, Punjab, Uttar Pradesh, Bihar, Madras and Delhi also introduced the medical inspection of school children. In 1941 the Joint Committee of the Central Advisory Board of Health & Education emphasized the need for satisfactory medical inspection, treatment and school-feeding in any system of Public Education. In 1946 Bhore Committee put stress on the provision of the physical and nutritional programme for school going children and stated that the functions of school Health Services should be under the Health Department and not that of Education Department. The Committee strongly recommended the inclusion of school health services as one of the important component of Primary Health Centre for the school children of rural areas. The Committee had also recommended that the instruction of school children in hygiene should begin at the earliest possible stage

In the Indian context, two reports of Bhore Committee and Mudaliar Committee offer valuable information and suggestions for health planners. These reports have dealt with all the dimensions of health care delivery system and strongly recommended the need for the establishment of primary health centres in the rural areas to provide integrated curative and preventive services under the supervision of a single medical officer who is also the leader of the PHC team. Among the accepted functions of the primary health centres, are school health services and health education.

The main recommendations of the Bhore committee (1946) deserves to be recalled because of its importance and the main recommendations of the Committee

1. PHCs should be the base for the school health services.
2. One Medical Officer for 5000 children.
3. Strengthening of PHCs with ancillary staff.
4. Establishment of school health bureau and coordination committees in all other departments especially education department.
5. School teachers should receive adequate instructions in health education during the period of training.
6. Thorough medical examination for all pupils at the time of their entry into primary schools.
7. Provision for the treatment of defects detected, follow up and referrals.
8. Immunisation services.
9. Provision of sanitary facilities in each school.
10. Health education to be made an essential part of the school curriculum.
11. Provision of midday meals at least 1\3 of the daily calorie requirement.
12. Raising up of kitchen gardens.
13. Involvement of private medical practitioners in school health.

In 1953 Secondary Education Committee reiterated the need for medical inspection of students and the introduction of School Feeding Programme. In 1955 the Central Health Council viewed with concern the lack of adequate student health services through out the country and directed the state governments to take immediate steps to establish a student Health Service under their Health Department.

In 1957, the Ministry of Education set up the Health Education - Nutrition Education Committee to initiate the preparation of syllabi on health education for schools and teacher training institutions. The Central Health Education Bureau set up the School Health Education Division in 1958 to serve as a technical resource agency to the Ministry of Health and the Ministry of Education and coordinated the preparation of syllabi and conducted national workshops and state-level joint workshops of health and educational personnel as an orientation for implementing the syllabus.

During 1958, a school health education project for strengthening health education in schools was started and was completed in 1961. A draft syllabus for health education in teacher training (Secondary Schools) was developed and circulated for comments. A conference was also organised to encourage inclusion of Health Education in the

pre-service training of teachers. Based on the findings of the survey to determine the health education component in various school curricula, syllabi on health education for age groups 6-11, 11-14, and 14-17, teacher training B.Ed\L.T\B.T and teacher training at elementary level (one year and two year courses) were developed and circulated to State Ministries of Health and Education. Use of newer methods of education were demonstrated. Suggested lessons were written in the light of actual experiences in the use of newer methods.

These syllabi were recommended for implementation to the states by the Union Ministry of Education. This major development was an important landmark in strengthening of health education component of the school and teacher training curricula in various states.

School Health Committee:

The Ministry of Education appointed a School Health Committee under the Chairmanship of Smt. Renuka Ray in 1960 to assess the present standard of health and nutrition of school children and suggest ways and means of improving them. The Committee submitted its report in 1961 and considering the prevailing conditions and the available resources, made important recommendations for drawing up school health programme and referred to other areas like school meal, pre-school child, school health education, training, studies, research, school environment and school health administration.

The committee recommended that School Health Services should form part and parcel of the general health services for the community. It further said that with adequate training in health education and school health services, it should be possible for the teacher to undertake certain functions related to school health services such as:

a. observation of students for defects and deviations from normal health,

b. screening them for height, weight, vision and hearing,

c. providing first aid,

d. maintaining cumulative health cards and filling in relevant portions of the same,

e. giving health education for prevention of preventable problems and development of healthful living practices among students.

The Committee observed that atleast in case of children in elementary classes parents should also be present at the time of medical examination of children. The committee also urged the development of student Health Education Units in the State Health Education Bureau to provide leadership in this field. One of the recommendations of the Committee was that at state level there should be a State School Health Council to facilitate cooperation and coordination of many individuals and groups concerned with the health of the children.

Accordingly a National Council on School Health was appointed in 1963. Some of the States also set up State Health Councils. So far as health education was concerned, an important recommendation was that the Council commends the training programme for teachers formulated by the Union Health and Education Ministries to prepare teachers to undertake their share of responsibility for school health effectively and urges the Central and State Governments to start such training programmes jointly, if necessary, in as many places as necessary.

Efforts by Central Government:

In 1963 Government of India constituted the National School Health Council, it was reconstituted in 1966 to carry out the recommendations of Renuka Ray Committee. In 1962-63 as part of the minimum needs programme, Mid-day meals programme for the age group 6-11 was introduced to school children for 200 days in a year. Top priority was accorded to comprehensive health service scheme during the third five year plan and the States were to ensure care of health in schools by arranging

a. clean drinking water and sanitary facilities,
b. medical inspection,
c. follow-up services in association with primary health units and
d. instruction of teachers in Health Education.

The Fourth Plan envisaged:

a. immunisation against preventable diseases,
b. scientific health education for students and teachers,
c. protected water supply,

d. sanitary latrines,

e. hygienic surroundings,

f. medical check up, and

g. attention to remedial defects like errors of refraction, dental caries, skin diseases, emotional problems, etc.

National School Health Scheme:

The Fifth Five Year Plan noted the serious deficiencies in the system of medical inspection of school children and emphasized the detection and treatment of defects of school children as part of general health services. It was in 1977 that a modest beginning was made to reach the benefit of school health service programme to the children in primary classes. A centrally sponsored National School Health Scheme was operated to provide health services supported by health education to the children in primary classes in giving priority to tribal, backward and hilly areas in rural India through a network of selected Primary Health Centres having two doctors, in a phased manner. The Central Government provided recurring and non-recurring grant in aid to the states and Union Territories. In the first year it was envisaged to cover 377 PHCs distributed over all the states and U.Ts. During the second year i.e. 1978-79 a provision for additional 409 PHCs was made. Comprehensive guidelines were drawn up indicating independent and joint responsibilities of Central and State governments and also of State Health and Education Departments.

The prototype health education materials based on the feed-back from the states\U.Ts regarding common health problems of the students was supplied by the Central Health Education Bureau, New Delhi. However, the states\U.Ts could also develop need based supportive health education materials. The cost of medicines, training of personnel including teachers, printing of school health records and returns, and transport was to be borne by the State\U.Ts. The expenditure was to be shared both by health and education departments.

In 1979 the National School Health Scheme was transferred along with few other centrally sponsored schemes to the State Sector leaving only Union territories with the Central Government. The Scheme continued in operation in 8 U.Ts. except Delhi which had its own comprehensive school health scheme. The scheme in U.Ts continued upto 1984-85.

Operational Problems:

The development of school health services in India have been sporadic and uneven. Though the school health service programmes are going on in the various states \ union territories but there is no uniform pattern. Out of 22 states only 14 states (Madhya Pradesh, Gujarat, Rajasthan, Punjab, West Bengal, Tamilnadu, Himachal Pradesh, Haryana, U.P., Orissa, Andhra Pradesh, Karnataka, Kerala and Sikkim) have established a School Health Programme out of their health budget. The coverage has not been very encouraging since the scheme is in operation in only 1337 P.H.Cs. Although School Health has been a prescribed function of PHCs, it has not been done by medical and non-medical staff effectively because of the following reasons:

a. No separate vehicle has been provided. There is inadequate supply of fuel and School Health Programme is not given priority for vehicle utilisation.

b. One medical check up of School children without proper follow up is not enough.

c. There is no financial provision for printing of health cards.

d. Training of teachers, multi purpose health workers (MPWS)and other health and educational personnel for school health programme is ignored.

e. There is no coordination and supervision between different health schemes.

f. There is no effort made to involve the voluntary agencies.

g. There is no proper documentation and reporting system for the School Health Programme.

There are also other reasons for limited efforts on emphasis on school health services during the last 20 years. Relatively the children of school age have been neglected in our concentrated efforts to attend to the pre-school age groups (3-5) years as they are the most crucial and most vulnerable from the point of view of nutrition and development. Impression has also grown that the results of school health programmes do not commensurate with the efforts and resources expended on them.

The school health programme has largely focussed on medical inspection of students for diseases and deficiencies. The review carried out by the World Health Organisation of the School Health Education in India has descried the narrow focus of these services on physical examination and recommended a comprehensive programme with emphasis on personal hygiene, health education and healthful living.

Morbidity Studies:

Numerous Morbidity studies among school children have been carried out by individual researchers mostly in urban areas of India. The incidence of various diseases is as follows :

a. Dental Infection 70-90%

b. Malnutrition including anemia 40-75%

c. Worm infestation 20-40%

d. Skin diseases (some leprosy) 10%

e. Visual defects and diseases of the eye 4-8%

f. Pulmonary TB 4-5%

g. Congenital anomalies of the hear 1-10%

h. Diseases of respiratory, gastro-intestinal and uro- genital systems 1-10%

i. Clinical ocular signs of Vitamin A deficiency 15-20%

j. Other infections of various kinds 2%

The relationship between scholastic performance and nutritional status of the children has also been established in some studies. The great majority of even malnourished children of the school age will live to grow into adulthood, and will eventually become our future adult citizens possibly with poor physical stamina and varying degrees of functional incompetence.

Intensive Pilot Project:

In view of the experiences gained and problems faced so far, a Task Force on the School Health services was appointed in 1981 by the Ministry of Health & Family Welfare. Based on the recommendations of the Task Force, an Intensive Pilot Project on School Health Service Programme has was launched in 1982 to cover 2.5 lakh primary school children in rural areas. The Project worked in 25 Blocks of seventeen states and three Union Territories. The specific objectives of the project were:

a. determine the type and extent of morbidity prevailing in primary school children in the project area.

b. estimate the amount of referral services \ required for primary school children,

c. see the feasibility of preventive and promotive health of primary school children,

d. identify opportunities for strengthening health education in school programme,

e. determine the most feasible and effective organisational models for school health programmes in various types of districts (eg: ICDS Districts, Family Welfare Area Project Districts, Integrated Tribal Development Project Districts, Leprosy Hyper-Endemic Districts) and

f. estimate the possible effect of the project on morbidity and nutritional status of children.

An important feature of the project was to treat the teachers as part of the School Health Programme. The teachers were exposed to a seven day orientation training and were given a medical check up and treatment for the ailments detected. This was to ensure good health of the teachers and to generate interest in them to promote the health of students.

The project was funded by SIDA (Swedish International Development Agency) for a period of 2 years. The funds were provided for printing of cumulative Health Cards, printing of health education material, training of teachers, records and reports medicines and correcting aids, school medical examination kits for P.H.C. doctors and for supply of fuel.

Expansion of the Project:

The Intensive Pilot Project was extended to another 75 PHCs of four new states in 1984-85 by the Ministry of Health and Family Welfare. Financial assistance was provided to this centrally sponsored National Health Service Scheme for 5 years by the Government of India.

Under the Extended Programme 10 lakh primary school children and 29,000 teachers from 10,000 schools have been covered. The objectives of the extended programme are:

a. to prepare younger generation for adopting healthy practices through health education.

b. to reduce morbidity and mortality among primary school children.

The major components of the programme are:

i) observations and screening of students for defects and deviations from normal health, height, weight, vision screening and treatment of minor ailments by teachers.

ii) regular annual medical examination of students and protection against preventable diseases by immunisation.

iii) identification of sick children and referral to specialist for specialised medical care.

iv) maintenance of Cumulative Health Card for each child in the school.

v) Training of teachers.

vi) Health Education of the students to imbibe health and desirable health practices.

To facilitate the teachers involvement in an affective manner the schools were provided with:

1. Weighing machines and measuring scales.
2. Elementary Medicines for the treatment of minor ailments.
3. Manuals for teachers and health education materials.

Evaluation of the Project:

The National Institute of Health & Family Welfare, New Delhi carried out an All India evaluation of the School Health Intensive Pilot Project and the Extended Programme and submitted its report to the Ministry of Health and Family Welfare, Government of India in January 1988. It was found that despite various constraints faced by the State Governments, the coverage of medical examination of students varied from 45 to 100 %. In the smaller states the coverage was as high as 100% while in the big cities (where student enrollment was high) the coverage was 40 to 60%. An important recommendation of the evaluation study was that a comprehensive school health service

programme with intensive health education component and sound referral system be undertaken in the country.

The Intensive School Health Education Project:

The Intensive School Health Education project was launched by the Central Health Education Bureau, Directorate General of Health Services, Government of India from January, 1989. The project is envisaged to benefit about 15,00,000 primary school children through 10,000 primary schools in 100 blocks of ten States i.e. Bihar Haryana, Himachal Pradesh, Madhya Pradesh, Maharastra, Orissa, Rajasthan, Uttar Pradesh, West Bengal and Delhi.

The main purpose of the project was to help in improving the health and nutrition status of primary school children in rural areas. This will be part of the comprehensive school health programme in the country.

Specific Objectives:

1. To reduce the incidence of diseases among the children by imparting health and nutrition education.
2. To inculcate healthy practices among the students for self-health care.
3. To promote healthy life styles of the community by utilising school children as effective channels of communication, and as practitioners of desirable health practices.
4. To equip teachers and National Service Scheme volunteers with health knowledge to help them impart effective health education to primary school children.

The project is to utilise some innovative measures so that the health messages reach the children and through them to family members and community at large. Through the school children, the younger children and siblings at home will be helped. The youth force in the country such as National Service Scheme volunteers and members of Nehru Yuvak Kendra were also brought into the programme to carry health messages to the school children.

CHAPTER - III

WHY SCHOOL HEALTH

Children are the wealth of a nation. Education of children in the formative years of life towards a healthy living is the key to the promotion of a healthy nation. In this chapter, we discuss, why school health programme should be initiated in every school.

Why is School Health important?

1. School children (6-14) form a large group, nearly 25% of the population in our country. Since it is a sizable population, they deserve good health services.

2. It is easy to look after the health of the school children because they are all together in one place. It is easy for the delivery of different components of health care. Children learn many new things at school. Hence trained teachers can easily put across correct and healthy habits.

3. This age-group (6-14) comprises the formative stage in the growth and development of the children physically, mentally, emotionally and socially. The children and youth respond better to health education and develop favourable attitudes. Thus they formulate desirable health practices.

4. One of the reasons for absenteeism among school children and, to some extent, low enrollment in schools is their low health status and sickness. Further, performance of sick children in School will be generally lower than healthy children. So, a school health programme which aims to improve children's health is necessary. Health is both a requisite for and a goal of formal education because the student can hardly achieve any other goal without health.

5. Children and youth can receive correct instruction from qualified teachers instead of relying only on information obtained from peers, neighbours and family members which may be based on ignorance or superstition. School is geared to handle these matters from the educational point of view. It reaches to a large percent of individuals of the community face to face. Teaching this way has more impact than mass media or any other mode of imparting health education.

6. Children are a vulnerable group and become easy victims of many diseases of childhood. Every third child has some sign of ill health . Many of such illnesses are simple and easily treated if detected in early stages. Periodical health check up of school children helps us to detect defects early. For example a child with ear infection may develop deafness if he is not treated promptly. Defective vision is another handicap.

The possibility of using behaviour patterns and responses of children, as illustrated below, to aid in identification of impairment of vision and hearing is under investigation:

Class room behaviour of children :

(i) With visual impairment

- The child who has defective vision may look at neighbour 's book when the teacher writes on the board
- He may some times go near the board
- While reading, hold the book very close to his eyes
- Take more time to copy form the board
- May complain that the teacher is too fast

(ii) With hearing defects

- Often appears inactive and board
- Some times appears over-attentive, and staring at the teacher's face (lip reading)
- Turns the head to either side, holding the hand behind the ear
- Shows alertness and anticipation for sounds

Scholastic backwardness and recurrent absenteeism were found to be indicators of disabilities and chronic illness.

7. Health knowledge and principles are taken home to siblings and parents by the child. A major thrust at school going section of the community is that it shares its effects with the community as a whole. Those children who are not attending the school, due to poverty or ignorance, can also be reached this way indirectly. A good school health programme should be community's programme based in school but spreading out. Early detection of problems and prevention of chronic and serious defects nutritional deficiencies and provision of basic health care is possible through this programme.

8. Health education is an integral part of general education and should therefore find a place in the school curriculum. Within individual classrooms, the teachers can lay broad and flexible plans for health teaching and make it more meaningful and experience oriented to the students. The teacher can also select a few timely problems and work on them to the point of accomplishment.

9. A child who spends 6-8 hours in the school has a lot of time to acquire good health knowledge which can be taken back home. It is therefore felt that none of it should go a waste and this resource must be utilized in primary health care programmes. With a little training children can be made use of as health guides, health promoters or change agents for the villages, slums and other communities.

It is therefore important that teachers and health personnel should be aware of community health programme and services rendered so that duplication can be avoided. In planning a programme of school health, it is important to ensure that school it self is a

place of safe and healthy environment for young people. Health aspects (health, nutrition and environmental sanitation) must be incorporated in the school curriculum. Finally what is being taught to children need to be more relevant and with lots of fun and activities. In addition early detection and treatment might undoubtedly lower the need for costly rehabilitation efforts and improve scholastic performance. Some of the common health problems of school children can be prevented and others can be detected and treated early which becomes part of school health programme.

Children enjoy activity based learning. The teachers must involve children in developing songs, role plays, rhymes, puppet shows, check lists etc., in 'work experience' period. The children can be encouraged to use them with younger children. Activities not only appeal to children but also foster concept formation. The results of some activities of school children may be properly displayed and the parents may be invited to look at them. It pleases them, and they can see and learn from the experiments, demonstrations and other activities being taken up in school.

Evaluation

A nominee of the voluntary Health association of India who participated in the evaluation of the Kangazha school health project found that several thousand school days have been saved in addition to improvement of health habits and hygiene of the school. The improvement in attendance is attributed to an overall reduction in morbidity and correct application of quarantine regulation. The programme was found to be inexpensive, costing less than one rupee per student per year. The evaluator found the programme ' simple and replicable '.

CHAPTER - IV

SCHOOL HEALTH AND ITS COMPONENTS

In this chapter an attempt is made to understand the concept of school health. It identifies the objectives and main components of the school health programme. The three main components, namely health education, health services and health school living were discussed, and the strategies for their improvement highlighted.

- School health is not just medical check up of students
- School health is not merely mid-day meals
- School health is not merely physical education
- School health is not just vaccination in the school campus
- School health is not an intellectual exercise and wishful thinking in health planning.

What is School Health?

It is a part of community health programme through which comprehensive care of the health and well being of children throughout the school years is taken care of. It is a part of educational programme through which changes are brought about in knowledge, skills and behaviour for a healthy living. The school health service is an economical and powerful means of raising the health of the communities. It is a personal health service. It has grown from the narrow concept of medical examination of children to the more comprehensive care of health and well being of school-going children. Today, school health programme stresses the role of the child as a 'change-agent' for the community. A child has greater capacity to observe, learn, experiment and then transfer knowledge to others. It is more prone to a new way of life, and changes come to it more naturally. A physically, socially and mentally healthy child can best learn whatever is taught in the school.

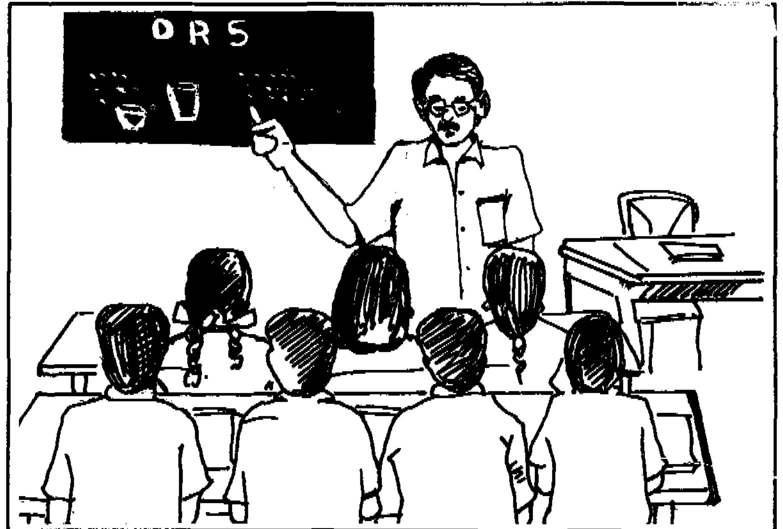
Objectives of School Health Programme

1. To inculcate healthy practices and positive health among students for self-health care
2. To develop the knowledge and attitudes which will enable the students to make intelligent decisions for better health
3. To make the students aware of common health problems and the ways to prevent them and cure the simple diseases
4. To encourage and recognise students as 'change agents' in health promotion
5. To equip the teachers with health knowledge and skills to impart effective health education in a healthy environment
6. To ensure proper environmental sanitation at school including attention to protected water supply, and disposal of wastes
7. To promote appropriate social and emotional behaviour and
8. To develop school, home and community cooperation in health promotion.

Three main components:

A comprehensive School Health Programme has three components: Health Education, Health Services and Health Environment (Healthful living).

Health Education:



School Health Education is that part of health education which takes place in and through the schools. The objective of health education is the translation of what is known about the maintenance and promotion of personal and community health into patterns of desirable behaviour. Health education seeks to help the student to receive health information and to provide experiences for practicing what he has learnt. Health education should influence children's behaviour about, for example, use of toilet facilities, personal hygiene choice of diet, road safety and personal relationships.

A school's regard for health education should be expressed not only through its normal academic arrangements, but also through the whole school environment, the pattern of relationships established, the values transmitted by the personal example of teachers and other adults working in the school.

With children between 6-14 years old there should be a steady progression towards more detailed knowledge and understanding of the working of their bodies and the ways in which they can take responsibility for their own health and well being. Where they have opportunities to observe, measure, experiment, predict, debate and record their findings in many different ways, health education becomes a lively part of topic or thematic work. Because of its immediate relevance to the children themselves-their bodies, emotions, environment and families-health education is a valuable source of learning experiences. Therefore careful planning in health education and integration with other subjects is of utmost importance.

Steps in preparation of Health Education out lines:

1. Determination of the specific habits, attitudes, and knowledge objectives sought in the health education of pupils before they leave school.

2. Determination of the specific learning experiences in health which the school seeks to provide.

3. Selection and preparation of such introductory orientation and background material which may be needed for training.

4. Gradation of health education programme suitable to different grades and age groups.

Principles related to effective School Health Education:

a. Health education should focus upon the whole individual and should emphasize development of physical, mental and social well being.

b. Health instruction is useful only if the individual applies his understanding of health to every day experience in a personally meaningful way in the daily living.

c. It should attempt to foster in an individual a greater value of health.

d. Health instruction programme, to be effective and meaningful, should be based upon individual and societal health needs, health interests of the learner and the level of the learner's health knowledge.

e. It must be in keeping with the general aim and objectives of education.

f. In health teaching full consideration should be given to the social, cultural and economic factors which have a bearing upon health behaviour.

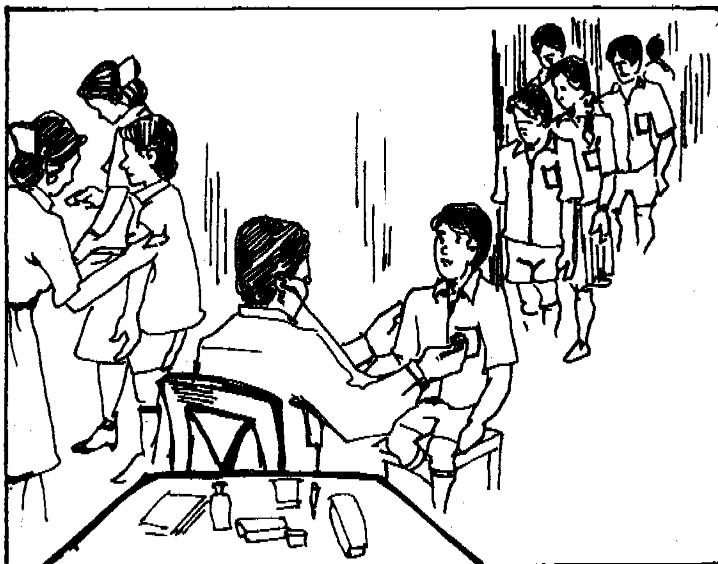
g. Health teaching should be an integral part of the school curriculum and should be guided by sound principles of learning.

h. Health teaching should be an integral part of the total school-community health programmes and other efforts which contribute to the well-being of the individual and society.

Health instruction is dynamically related with health services and healthful school environment. Continual communication between home, community and school is indicated to enrich the effects of health education programme on the health of the community.

School Health Services:

The second component of a comprehensive school health programme is health services. The main objective of school health services is to appraise the health of children, prevent and control of common diseases, provide first aid in emergency and refer those who need specialised treatment.



1. Health appraisal : This includes an assessment of the present health and health needs of students as well as teachers. Both health personnel and teachers participate in this activity. Observation, identification and encouragement in the correction of remedial defects are important steps in health appraisal.

   At the time of the health check up of children the parents should preferably be present to give the full history of the child and the present illness if there is any. All possible measures should be taken to promote normal health and development of the child. Health counseling of pupils and parents is also part of health appraisal. School Health Services assist in the identification and education of scholastically backward or handicapped (physically, mentally and psychologically) or sick children and their follow up.

2. Remedial measures: These include curative, corrective and rehabilitative aspects (For example providing spectacles, hearing aids or orthopedic aids). The doctors, teachers and parents should plan for the follow up treatment of children after the diagnosis is made.

3. Provision of First-Aid and Emergency Care: Every school should be equipped with the first-aid amenities. All teachers should be trained in first-aid and kits should be provided according to the strength of the children and the list of the drugs as

advised by the Medical Officer which are very essential for certain emergencies. (See appendix for a list of medicines and first aid kit).

4. Promotive and preventive services: These include control of communicable diseases, immunization, isolation, supplementary nutrition. Health education and healthful school living are certainly a part of promotive services. Maintenance of health records is also part of school health services.

Healthful School Living:

The third component of a comprehensive school health programme is healthful school living. The school is like a second home for the child. He spends 6-8 hours a day in the school premises throughout his childhood.

The concept of healthful school living implies:

a) Provision of safe and healthful environment:

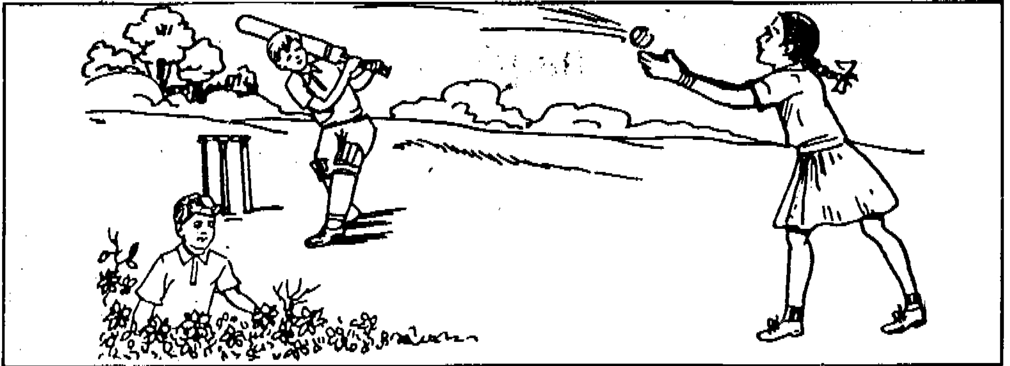
Inspite of recommendation by Ministry of Health and Education very few school authorities make a willful effort to comply with the standards set providing healthy school environment even if financial restraints are not a major problem.

Following health related factors have to be kept in mind:

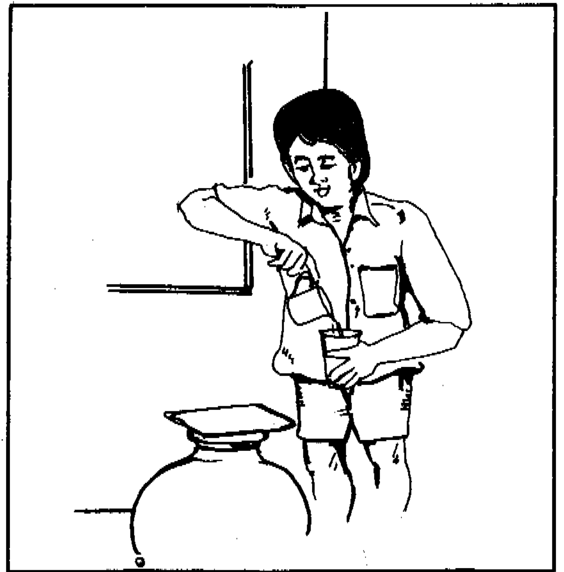
- Choice of site for school building away from dust, smoke fumes, heavy traffic, noisy places.
- Good construction of buildings with a non leaking roof, walls free from dampness, structure being stable.
- Adequate numbers of class rooms and class room size suitable for the number of children.
- Ventilation in the class rooms - there must be cross ventilation with windows and / or ventilators.
- Light in the class rooms - to protect the eyes of children proper lighting is necessary. The blackboard and visual aids should not be a strain on the eyes. The teachers should supervise reading, writing and handwork to avoid strain on the eyes.

- Seating and desk: Standard manufacture of chairs and \ available) need to be arranged in the classroom. Children sh\ per their average heights and periodical reseating will be . ...ovide clean mat on a dry floor if other facilities are not available.

- Playgrounds: Provision ought to be made for games facilities. The physical instructor should help to maintain the playgrounds and take precautions against accidents. The ground must be cleared regularly by removing unnecessary dangerous bushes, plants etc.

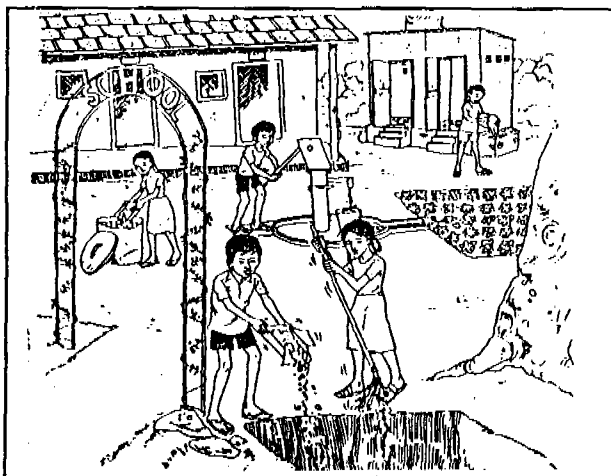


- Safe drinking water: The most important aspect is to provide safe drinking water stored in clean vessels, ideal being provision of taps with free flowing water. Children must avoid repeated dipping of a glass into water container or pot. A ladle should be available with the water pot. Water pot or vessel must be cleaned daily, water filtered and covered. Chlorine must be added proportionately if water source is not clean. The area around the tap should be kept clean and dry by proper drainage.



In planning schools for India, one water tap is recommended for every 50 students or one pot for 30 students. One urinal for 40 members and one toilet for 60 will be the optimum. However there must be separate urinals and toilets for boys and girls. Availability of water close to the toilets (preferably in the toilets) is important. The students should be trained in the use of latrines. As part of the activity for children, they can be involved by turns to check cleanliness of toilets and absence of flies around them.

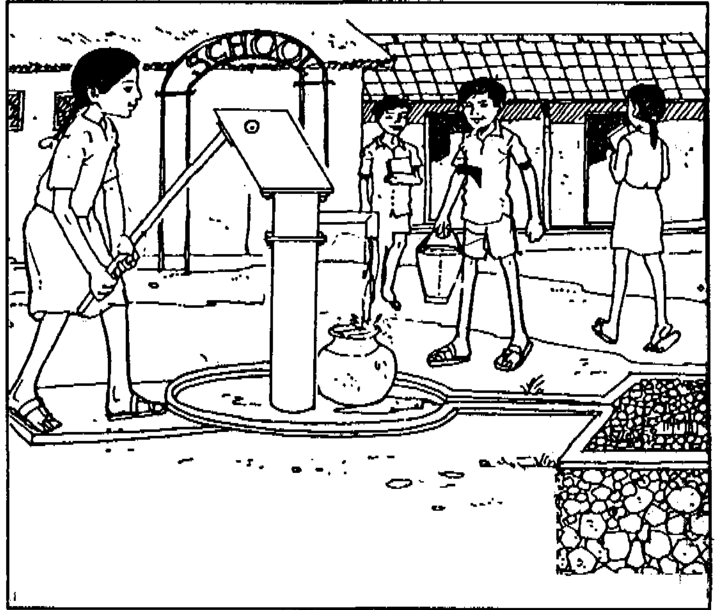
Use and upkeep of toilets and beautification around toilets will be related to cleanliness, limiting of and preventing communicable, gastro enteric diseases, etc.



Refuse Disposal: Pieces of paper, polythene bags, fruit skins, leaves, twigs may be the kind of refuse that may be lying around in classrooms or school compound. This not only creates nuisance but the heap of refuse may become a breeding ground for flies. This may result in many of the diseases.

A proper place for collecting rubbish should be planned within the school compound. Each class must have a simple waste paper basket which must be emptied daily. It is preferable that there should be a compost pit dug in which the rubbish can be dumped and composted or burned. The compost from this pit is an excellent manure for the school garden. Children can take this idea to their homes.

Disposal of waste water: A certain amount of waste water always collects around taps, handpumps, wells and washing places. If this water is allowed to remain stagnant, it causes foul smell and becomes a breeding place for mosquitoes which cause malaria or filariasis (Mosquito borne diseases).



The water collection points inside the school compound must be filled with earth. Waste water from taps, washing places should be let into a soakage pit or school garden.

Other Safety measures:

- The school authorities must check electrical installations, condition of wiring and carry out necessary repairs and prevent unwanted accidents.
- Other precautions are connected with lakes, ponds, rivers and wells.
- Particular attention has to be given to prevent stray animals especially stray dogs entering into the school compound.

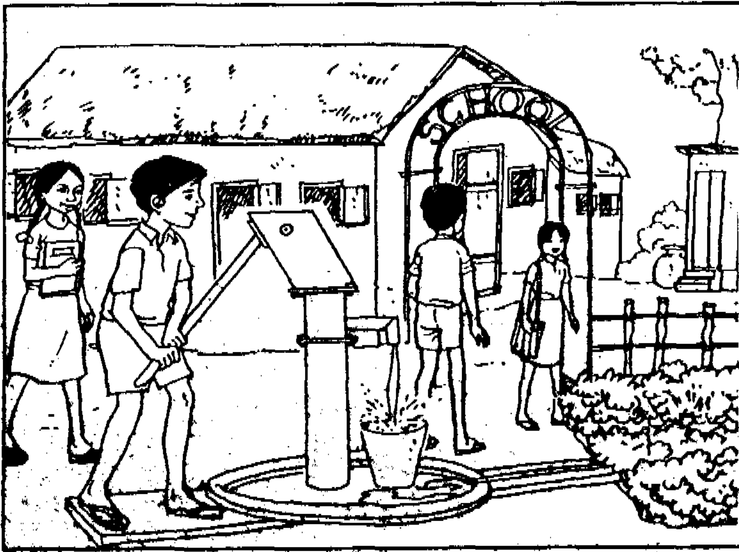
Food Sanitation:

Sufficient and clean place must be made available for children to eat their lunch. Arrangements for food wastes should be made and that should be disposed off safely. Hand washing and dish washing facilities must be ensured near food eating places.

Food vendors around the school premises especially those with uncovered food should be discouraged.

Beautification of the school:

The school must present a good appearance. This is desirable because beauty in surroundings is a must for growing individuals. White washing and colouring of the building should be done annually. Students should be encouraged to keep the building and surroundings clean. There should be cleanliness campaigns periodically.



School garden:

As part of environmental protection, every school must take up plantation of trees, develop a simple garden. The waste water can be effectively used for the garden and the trees.

b) Healthful School Day:

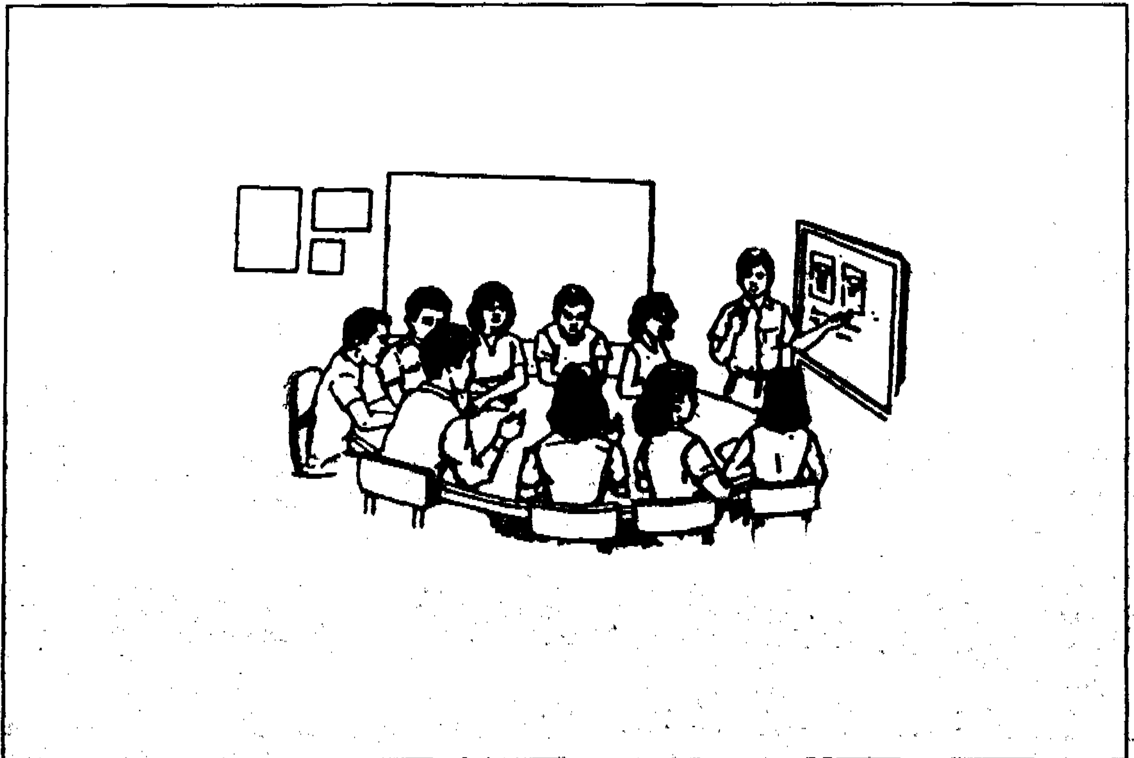
The hours and length of the school day should be based on the distance traveled by most children, the average age of the children in various classes. Generally smaller children need a shorter school day.

The sequence of subjects and arrangement of school work should have a variety, relieving tension and boredom. Health factors are to be considered in planning homework and other after - school activities. Exercise and activity including physical training, games d sports are to be planned as part of school hours. Opportunity should be given to ιdents for their involvement in planning School health activities.

It would be a good tradition to have a health review daily this strengthens health ıits and standards of personal cleanliness. This can be done formally at assembly time n a class or informally while teaching.

Iealthful Inter-personal relationship:

One of the important aspects for school environment is good pupil-teacher relationship. This should have a positive influence on the child. The child should find a classroom, a friendly enjoyable and interacting place to be in.



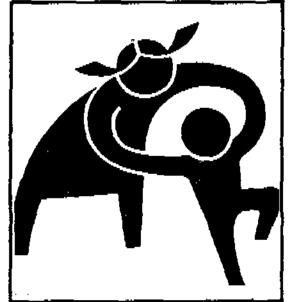
To develop and promote good interpersonal relationship, the teacher must consciously develop two way communication. The teacher has to understand the children and their background. (eg: Children who are shy, aggressive, have withdrawal tendencies, children who come from families with tensions and problems, etc.)

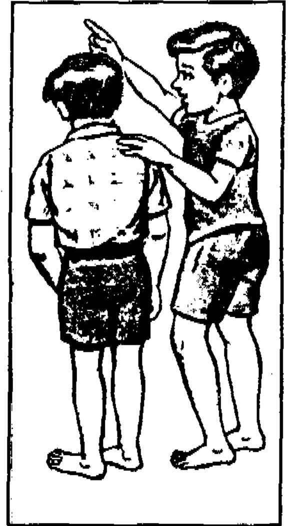
The teacher should attempt to meet child's need for security, achievement, self-expression, acceptance recognition, affection and self respect. The teacher, through the activities of the school should develop respect, courtesy, truthfulness, friendliness, cheerfulness, unselfishness, sense of humour among children. The teacher must maintain impartial behaviour with all children. He \ she must help in the development of kindliness towards younger children, habit of cooperation, fairplay, willingness to share and respect for others' belongings, the ability to forget a grudge and group participation.

CHAPTER -V

CHILD TO CHILD APPROACH

The chapter child to child describes the concept and objectives and it examines how this programme can be taken to different schools or other non-institutional set-ups or groups. The child to child programme centers around innovative activity oriented approach and creates awareness among 6 - 14 year old children on aspects of health, nutrition and childcare and making an effort in tapping the resource of children to disseminate important health care messages, making them more equipped to take care of their siblings and spread the messages in the community, bringing about a general overall improvement in their health status.





Health promotion for and by children has the greatest potential for bringing about positive and perceptible changes in their health knowledge, attitudes above all, practices and behaviour. The major emphasis is placed on the child-to-child approach.

The concept of child-to-child approach evolved from the recognition of the role that older children can play in caring for their younger siblings. In rural area older children are often required to feed, bathe, dress and play with younger brothers and sisters and to protect them from sustaining injury.

The child-to-child approach helps children to learn about health in active and meaningful ways. It helps them to find out information and to take action for the better health of themselves.

In 1978, David Morley from the Institute of Child Health, and Hugh Hawes from the Institute of Education, at the University of London, conceptually integrated health and education concerns in what has become known as the Child-to-child approach to health education. Child - to - child aims to equip children with the knowledge and skills required to promote curative and preventive health messages. Children learn the messages through games, stories, songs, dramas, puppets, folk dances; and role plays which elicit and sustain children's interest. It is expected that school age children (6-14 years) can pass on these messages to other siblings, parents and neighbours thereby effectively improving the health status of the Community.

The principal object in the child-to-child approach is to develop in children the knowledge and to change their attitudes and behaviour necessary to manage their own health and the skills to help other others to do the same. The approach identifies many ways in which the children can help themselves, help each other, help younger children. They can also help families and communities through individual and joint action.

The objectives of child-to-child programme can be listed as follows:

- To improve the levels of health, nutrition and development of children through child-to-child activities.
- To make learning a relevant, meaningful and enjoyable experience for children.
- To enable children to make qualitative improvements in life of their younger sisters and brothers, their parents and their neighbours, thus applying facts learnt in school to daily life.
- To improve the school and neighbourhood environment through organised activities.
- To help children feel a sense of being in control of their lives.

A list of situations and what children can do is given below. The list can be expanded based on local needs and priorities.

	The Message/Situation:	What Children Can Do
1.	**Personal and Community Hygiene and Safety**	
1.1	Prevention of Accidents	Identify accident hazards and eliminate them. Watch and protect younger children (especially from home accidents eg: burns).
1.2	Care of Teeth Protect teeth by good eating and tooth care habits.	Pass on good habits to younger children.
1.3	Neighbourhood Hygiene	Be aware of unhealthy surroundings. Individually and together seek to improve them and teach other children to do so.
2.	**Prevention and Control of Disease**	
2.1	Oral rehydration saves lives of children with diarrhoea.	Recognise signs of dehydration. Mix a pinch of salt, a scoop of sugar in a glass of water and use it.
2.2	Learn to recognise danger signs of illness.	Recognise danger signs, particularly of respiratory infection and high fever in babies. Seek help immediately.
2.3	Care of sick children.	Give fluids and feed a sick child. Keep fever down. (Much conventional treatment denies sick child food and wraps children with high fever.)
3.	**Child Stimulation and Development**	
3.1	Play and mental stimulation help children develop.	Recognise stages in the development in babies and young children. Learn to play creatively with them.
3.2	Toys and games can be made which aid growth and development	Make toys for babies and younger children, appropriate to their age. Help them to play with these.
4.	**Recognising and Helping the Handicapped.**	
4.1	Children with mobility, sight hearing problems need to be identified and their understood.	Recognise children with these problems. Learn simple tests for sight and hearing. Learn to help integrate children with these disabilities.
5.	**Better Nutrition**	
5.1	Signs of malnutrition can recognised and its causes understood.	Recognise signs of malnutrition in young children.
5.2	Better feeding is usually possible even though more money may not be available.	Spread messages about better feeding practices. Help apply them to younger children.

These messages or situations are not so simple as they seem, for in a number of cases there are other beliefs which need to be examined and discussed.

Three main criteria may help in selecting situations:

1. Do the activities address important health priorities, central to the concept of "primary health care "and were the health messages contained in these priorities clearly, correctly and unambiguously stated ?

Elements of Primary Health Care	
1. Nutrition	5. Health Education
2. Mother & Child Care	6. Safe Water & Environmental Sanitation
3. Family Planing	7. Control of Communicable diseases
4. Immunization	8. Supply of Essential Drugs

2. Are the priorities selected those in which the power of children could be effectively used ? Is there any danger of misuse by children ?

3. Are the activities such as would engage the interest of children. Were they fun to do ?

Child-to-child - The concept widens

As messages spread it is evident that though the original concept and rationale for Child-to-child remained as strong as ever, there were many ways in which it was being enlarged and developed by those who were using and adapting it.

1. From sibling care to child power:

In the first place it is apparent that in place of the narrower concept of an older child helping a younger one, the power of children to spread health ideas and practices can be used in four ways.

- Through the care they provide for younger brothers and sisters and other young children in the community ***(Child-to-Child)***.
- Through their influence upon other children in their age-group, especially those with less opportunities and education than they have had ***(Children-to-Children).***
- Through the individual influence of children upon their families ***(Child-to-Family).***
- Through the influence of children as a group upon their own communities ***(Children-to-Community).***

2. ***From health messages to ways of learning and teaching health:***

Equally it has become apparent that Child-to-child is not merely a series of messages. It is an educational approach which embodies a certain methodology especially when it is introduced into the formal classroom situation moreover such methodology is very different from that conventionally used in health and hygiene lessons.

The step approach :

In almost every case Child-to-child embodies the following steps for the learner.

Example: A case of diarrhoea.

1. Develop real understanding of the health concepts and health problems being addressed.

Main causes of diarrhoea and dehydration.

Why dehydration kills - how to recognise it.

2. Find out more about the problem

How many cases of diarrhoea?

How do people conventionally treat it?

3. **Talk over solutions**

   What can "I" do - to prevent diarrhoea, to combat dehydration? What can "we" do - if another child is affected?

4. **Apply solutions**

   (Starting with learning the necessary skills). Learn to make and mix the special drink. Learn to give it to others. Learn arguments to persuade others to accept the rehydration message. Be prepared to take action and help if necessary.

5. **Seek to evaluate the effect of the message**

   How many of "us" can make the special drink? How many have passed on the ideas to others in our family and community? How many of us have applied rehydration to children with diarrhoea?

Such a methodology poses a great challenge to the teacher and to the school. In the first place, it is based on co-operation rather than competition. Secondly, it takes learning out of the classroom and into the real life of the child. It invites schools to consider health not merely as a classroom subject but as an area of experience which can be related to teaching and learning in many subjects, to the life and organisation of the school and to activities generated by the school which take place in the community.

The Role of the Health Personnel Teachers and others in Child -to-Child Programme:

Child-to-child activities can be led by health personnel, school teachers, parents or anyone who like working with children. But health personnel can play an especially important role in promoting and developing these activities with children.

Involving the non-school children:

Some children often miss school because they are needed at home to care for younger brothers and sisters. Other children have to work to help their families earn a living. Health workers also need to look for ways to reach these children who do not attend school. After all, they are the children who can benefit most from Child-to-child.

Encourage these children to come to the sub-centre / health centre with their younger brothers and sisters, especially on days of baby weighing, "under-fives" clinic or child nutrition programmes. Try to organise special meetings to involve them in Child-to-child activities. Invite parents and school children to help.

Sometimes, school children themselves can become the "teachers" of those who do not attend school. If a health worker can help this to happen, he will not only be acting to solve immediate health problems but also be preparing children to help build a healthier community as they grow up.

Avoiding parent-child conflict over new ideas:

People, including parents, often have very fixed ideas about managing common illnesses.Is it fair to ask children to take home new ideas that may conflict with the beliefs and customs of their parents? Could this weaken children's respect for their parents or for local traditions? Or will it make parents angry with the children and perhaps, with the school ?

These are valid questions. In many areas, for example, parents believe it harmful to give a child with diarrhoea anything to eat or drink. They argue from experience that giving food or drink to the child may make him have another watery stool more quickly. How, then, can a boy or girl convince parents that, even though the sick child continues to have diarrhoea or to vomit, it is very important to give lot of liquid and also food?

There are no easy answers to these questions, but one thing is clear. It is not enough to work only with the children in these activities. Health workers and teachers need to work with the parents and the community as well. There are ways they can help families become more receptive to the new ideas children bring home from school. These include discussion groups, and evenings of entertainment with role plays and skits.

It is better when both children and adults take part. A good way to win community acceptance is to involve parents and opinion leaders from the first.

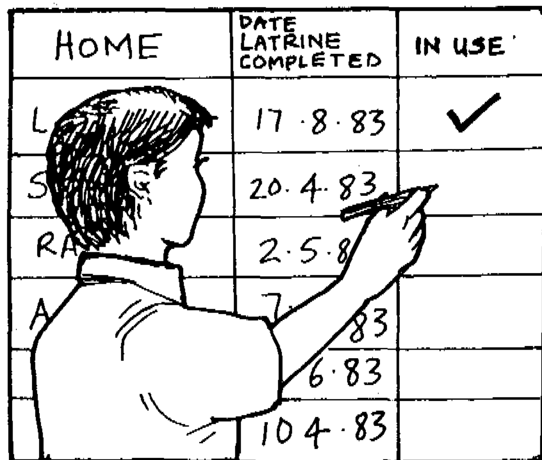
It is important that teachers and health workers show respect for the ideas and traditions of the child's parents. At the same time, try to prepare the children for some of the difficulties that may arise when they introduce their ideas at home.

Child-to-Child - An activity based approach.

1. Activities must be seen to be useful.

   They must touch real needs of communities and must be recognised as such by children.

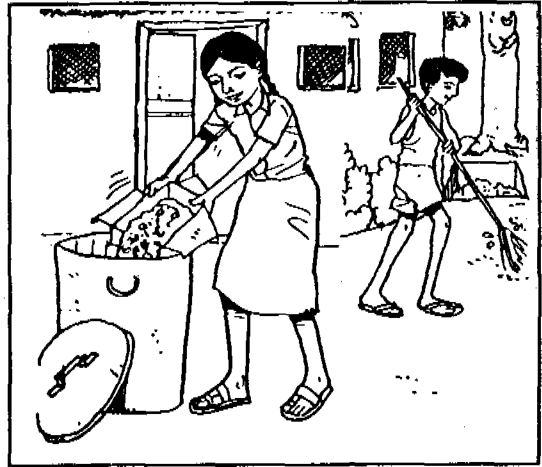
   It is no use proceeding with activity unless all the children working on the material can tell you what it is important to them and their families.



2. Activities must be easily done by children and they must not demand of children knowledge and skills or time they do not have.

3. Activities must be fun.

   Think about your own children or the children of friends or relatives and ask "Would they enjoy it"?



The activities should-

- be demonstrative, participatory and problem solving
- be child centered
- integrate health, nutrition sanitation and child development
- use varied materials and teaching aids
- apply knowledge (learning by doing) through direct care of younger siblings or other children.

Social and educational principles behind child to child approach

1. Children
    - First priority
    - Enormous resource
    - With assistance children can do more to improve the well-being of their younger brothers and sisters.
    - At a far lower cost.
2. Active and practical learning leads children to better parents.
3. Introduces new learning processes into schools. Meet the needs of children, families and their communities. Develops children's communication abilities.
4. Makes children more aware of their own ability to change and improve their situation through sharing and helping each other.
5. Prepare them to analyse problems posed by the search for answers to these problems. Children must be able to take decisions and thus children will take responsibilities.
6. Children too can act as group leaders.
7. Flexibility is very much a part of the approach.

Types of benefits reported are:

1. Older children have increased knowledge of health, nutrition and education, improved health practices and beliefs and more nurturing attitudes towards younger children.
    - They act as `message carriers' to others in the community.
    - These activities promote self-esteem and confidence in children.

2. Families and communities improved knowledge which leads to changes in practices.
    - Children have conducted surveys and brought attention to health problems that require corrective action.
    - Communities have benefited from direct actions to improve the environment and community conditions.

3. Teachers and schools have enhanced the quality of primary school education by promoting creativity in children.
    - The school health education curriculum is strengthened and health conditions in the school are improved.

CHILD TO CHILD ACTIVITIES

Some of the topics that have already been developed and used in the Child-to-child programmes:

1. Diarrhoea management
2. Clean drinking water
3. Scabies
4. Worms
5. Personal hygiene
6. Environmental hygiene
7. Care of teeth
8. Care of eyes
9. Care of ears
10. Measles
11. Malnutrition - Growth monitoring
12. Vitamin `A'
13. Immunization
14. Accidents prevention
15. Anaemia
16. Disabled children
17. Community resources

TIPS FOR TRYING OUT CHILD-TO-CHILD ACTIVITIES:

- Choose a place that is not too noisy or distracting.
- Start small, if possible with no more than 20 childran.
- Allow enough time, so you do not have to rush.
- Have all materials ready a head of time. Try to have enough so that all children can take part activily, instead of just watching.
- Use words familiar to the children. Avoid big scientific terms.
- Do not try to do too much at once. One activity sheet may have enough ideas to help you plan several meeting with the children.
- Before doing activities in a school, speak with the head master or teachers. Try to get their interest, understanding, and cooperation.
- Also discuss the activities with parents, so they will be more accepting of the children's new ideas. Perhaps some parents will want to help.

Lessons for Implementors

Evaluations found that all of the projects achieved positive results in increasing health knowledge of both children and teachers. It is less certain, however, how much of this knowledge spread to parents and the community. The difficulty in measuring the "outreach" component of Child-to-child stems from the fact that people have many potential sources of information. Knowledge of how to mix oral rehydration solution, for example, could have come from a health worker, a neighbour, a television programme, and or a child participating in a Child-to-child project. The evaluations only measured the knowledge, not the source.

Nevertheless, a comparison of the evaluations reveal a number of practical lessons for those considering the Child-to-child approach. These are:

1. Consider using schools for Child-to-child projects. The formal school system provides access to large numbers of children - a captive audience. They also allow others "to come in," whether in the form of visiting health workers, or experimental programmes. Schools are highly valued and respected in the community. By comparison, outreach from health clinics to children can be costly, requiring an infrastructure that does not yet exist.

2. Make teacher training a priority. Often, too little attention and follow-up is provided with training. No matter how much teachers learn from a five-day training course, most will not be able to follow through on what they have learned unless they are provided with additional training sessions and \ or regular meetings with others. If possible, more than one teacher at a school should be trained in the approach so they can share experience. If the school has only one teacher (as is often the case in rural areas) then regular supervision and encouragement are required.

3. Provide administrative support. When the total organisation is behind the effort, Child-to-Child is more easily accepted. Rather than leaving teachers on their own, the support of heads of schools \ central administrators is a critical factor in getting programmes off the ground.

4. Make everyone feel involved. All staff should feel involved in the decision making process. Those who are affected by the project in any way, whether or not they are directly involved with children, should be able to provide input from the time the project is initially presented.

5. Don't underestimate the difficulty of changing teaching methods. Teaching styles are not likely to become more child-centered simply because of the introduction of Child-to-Child. Teachers tend to teach in the way that they ;have been taught. If teachers have been expected to copy notes from the black-board and memorize information that is not linked with their own reality and experiences, then they are likely to try to pass on knowledge in the same way. To introduce the Child-to-Child approach most effectively, great emphasis must be placed on the development of appropriate pre-and in-service training for teachers.

6. Use locally-made teaching materials. While mass-produced Child-to-Child activity sheets are useful as models, it is more effective to have teachers create new activity sheets in training workshops. This is one of the best ways to teach teachers the purpose and their role in Child-to-child, and to obtain their commitment to the approach.

7. Integrate Child-to-child into the school curriculum. Teachers need to be convinced that Child-to-child can help them to do their job better and more easily. Using an active learning approach can take more time, and many teachers are under pressure to "complete the syllabus" no matter what the level of comprehension. Therefore, it is important to ensure that the Child-to-child approach is fully and realistically incorporated into existing programmes.

8. Make topics relevant. The more familiar children are with a disease, the more likely they are to learn and to practice better prevention and treatment. Discussions of the necessity of boiling water are likely to fall on deaf ears if there is little fuel, for example.

9. Use a recognised authority to back up the information that children are sharing. Adults may be skeptical if children's messages are not reinforced from time to time by a respected "expert". In the Malvani project, in Bombay, the children initially became discouraged when no one would listen to them. But after a health professional visited the community to confirm what the children were saying the parents began believing the children. The "authority figure" can vary. Educational television programmes play a similar role in reinforcing health messages spread by children.

10. Use incentives. Introducing Child-to-child techniques requires commitment from the teachers and workers. Often simple recognition is enough. Other effective incentives include free health checkups, training certificates, prizes and honoraria for participation in training courses.

Possibilities for Following Up Child-to-child Activities:

- Older school children can lead activities with younger grades.
- School children can lead activities with pre-school and non school children.
- Children can report back to the group about ways they have used their new knowledge at home with younger children.
- Children's surveys can be repeated to check for improvements.
- Children can put on public skits, puppet shows, or demonstrations.
- Children from one school or village can introduce Child-to-child to children in another nearby shool or village.
- Teacher can discuss how they might apply Child-to-child principles to the rest of their teaching, to make schooling relate more to children's lives.

Since 1979, Child-to-child is being formally practiced in over 80 countries and the numbers are growing. The approach is being used for projects from community health education to early child education and development. The minds and energies of the children can be used to mobilize communities, and spread important information.

Child-to-child - Impact

The information available from various child-to-child programmes is fascinating. The range of applications of these ideas is enormous. They range from direct use of the material in school, to non-formal programmes such as scouts, to use in creches, health centres, and in the community. On the whole, however, initiatives seemed to be on the small side, sustained by the interests of small groups and individuals rather than by government bureaucracies.

Several findings were particularly interesting and a few important ones are mentioned below:

The first, is the passive resistance of official school programmes to many aspects of this innovation, despite the support of many professional leaders to the concept. There are many predictable reasons for this - the rigidity of school curricula and examination structures being foremost among them.

The second is the essential need for cooperation between Education and Health personnel to achieve real take up and success - the difficulty of achieving it particularly at higher levels. However, the results are very encouraging, and we have numerous examples of how co-operation particularly at more local levels leads not only to better health education but to a more interesting and exciting deal for the teachers and learners.

The third lesson is the delivering of the same health messages at the same time to different members of the community; children, adults and youth. Very frequently we talk of formal and non-formal education as alternatives. In Health as in many other fields we need rather to think of them as complementary. If a child at school is asked to bring home a new health message to his parents he stands a mere chance of being rewarded. But if the messages from school, radio clinic, temple, church or mosque corroborate then the power of the child to demonstrate activity what people have absorbed passively is very great.

The final lesson is the great ability and willingness of people at local level to adopt and modify materials and to devise new innovative ones provided they are helped and encouraged to do so. Child-to Child materials have creativity and ingenuity which may serve as an example to others. (Such material are available at TALC - See appendix.)

Cooperation Between Education and Health:

Education of mothers is more important than even socio-economic factors in the chances of children surviving. So the work of the primary school teacher and the local health worker are already closely bound together. So many primary school teachers are frustrated as they accept young children for whom schooling will be a problem. Children who have survived episodes of malnutrition or perhaps worse, children who for long periods have been undernourished thus resulted in limiting their activity for learning.

The health worker is similarly limited and frustrated in communicating simple health messages to a community. She is seldom in touch with the school teachers who could communicate the messages to children in their most formative years.

Perhaps if we could sit down together we could achieve so much more, and how exciting it is when we do sit down together and find we have so much in common.

- Child-to-child is not a training for 'doctors', 'mini-doctors' or 'little doctors', it is health promotion programme.
- Child to Child programme is not selecting a few star pupils by teachers to oversee others in a rather bossy way. This is contrary to the approach where children help each other rather than telling them what to do.
- The point that is well worth making strongly is that the programme costs so little.

Richard Lansdown
Child to Child Trust, London.

CHAPTER : VI

TEACHERS INVOLVEMENT IN SCHOOL HEALTH PROGRAMME

This chapter looks at the role of the teacher and argues how the teacher is more suitable for the tasks relating to the school health programmes. It further examines the role of the teacher in each of the components of school health, especially in the area of health instruction. It also deals with the aspects of mental health and role of teacher in promoting mental health.

1. Teachers are where the schools are, and they are a rich local resource. They are available in large numbers, present even in remotest areas.

2. Teachers are best equipped to undertake the task of health education. Their educational background and skills befit them for this work.

3. Teachers have considerable acceptability personal as well as what they teach - with pupils and their parents and through them with the community. Most teachers are natives of the region and know the beliefs and customs. Convincing them to change those affecting health will be an example for the community.

4. Teachers have social status in the community and faith of the people.

5. Teachers also have good relations with voluntary agencies, government bodies and the local organisations.

6. The teachers are familiar with customary behaviour and therefore can pick any deviations. A good teacher understands the students physical, social and emotional needs better than outside health personnel.

Health education helps the teacher in developing and maintaining his or her own health. It can help objective consideration of existing prejudices and superstitions about health care. Preparation in health education helps the teacher to meet the expectation of society and he will be able to help to develop health habits attitudes and knowledge among the children. It also makes the teacher aware of his own health requirements and learns how to meet them. Action is more important than just theoretical knowledge. Hence a trained teacher's approach is "action oriented" rather than "knowledge oriented" No one is better equipped than a trained teacher who can observe and encourage good health behaviour.

The Teacher's Role:

One of the first things the teacher can do is to take care of his own health and practice desirable health habits both in school, and in private life in order to set an example to his students-both boys and girls.

Every teacher can determine, to some extent,, what health knowledge children already have. Some type of test can be given. Observations can be made to learn about some of the practices of children. Such a knowledge will help the teacher to plan in a more practical way. Finding out about the home and community conditions will be essential in making the teaching practical.

The teachers of special subjects such as languages, science, mathematics, social studies and the like, can fulfill their responsibility in distinct ways:

First, by helping the students to develop practices which will be conducive to learning.

Second, by including health topics in the particular subject being taught.

For example:

a. In language study, topics on health may well be assigned for essays, themes, stories, etc.

b. Social studies could contain much on health as a part of civic duty of individuals and governments.

c. Science is receiving a lot of emphasis at present. Learning to apply scientific knowledge to the lives of the people and especially for the promotion of health and prevention of disease may be an important part of science study.

d. It is possible to make mathematics relate to health concerns-like: health through ratios, health through percentages, child growth, heights, weights through measurements, population growth, births and deaths, proportions.

The teacher can use examples and problems related to health of the community to make the classroom mathematics more real, alive and easier to understand.

Role of Teachers in The School Health Programme:

This could be grouped in four areas:

1. Health education to school children.
2. Health care services
3. Maintenance of student health records
4. School environment

1. Health education to school children:

a. Observe the health practices of school children regarding personal hygiene, habits, and posture, and encourage them to develop good health practices.

b. Plan for health educational activities in the school based on specific health needs, interests and practices of the students.

c. Involve the students in organising health campaigns and health projects in the school and in the community.

d. Plan with parents to develop a common health practice code to be followed both at school and in the home.

e. Plan and integrate health teaching through special subjects, like languages, environmental sciences, mathematics etc., appropriate to his subject.

2. Health care services:

a. Observe students with a view to spot any deviations from normal health.

b. Observe students for signs and symptoms of communicable diseases.

c. Provide simple treatment for minor ailments

d. Provide first aid in case of accidents or emergencies

e. Educate parents regarding the importance of school health services

f. Take height, weight and chest measurements of students.

g. Coordinate with parents for referral and follow-up of cases in whom defects or deviations from health are detected.

h. Arrange parent teacher meetings at regular intervals to discuss educational and health problems of children and measures to be taken to solve these problems.

3. Maintenance of student health records:

a. Complete the relevant parts of the student health card

b. Make entries regarding treatment for minor ailments provided to them in the school

c. Whenever a child is referred to a medical institution (PHC or hospital), fill in the referral card which should be returned after the treatment

d. Maintenance of health cards of the children including family history.

4. School environment:

a. The teacher should assess the environmental situation in the school so as to plan and organise the basic requirements.

b. The teacher should make his observation known to proper authorities-those who can do some thing about it.

c. The teacher should be able to do what he can in order to makes improvements. eg:- adjust seating arrangements. make the classroom comfortable for study and more conducive to learning.

d. The teacher to take leadership to provide safe drinking water

e. The teacher should stress the proper use and cleanliness of latrines

f. The teacher should work for a healthful environment which is conducive for learning and promoting better health.

Teaching so that learning can take place

1. Teach and learn together with your school children.
2. Start with what the students already know.
3. Let students see and then do.
4. Let children help each other.
5. Teach about teeth and gums together with other subjects.
6. Be a good example.
7. Make the community part of your classroom.

Mental Health:

Mental health is an adjustment of psychosocial environment.

Mental health is an ideal to be pursued. We can give a direction to it.

Mental health is being comfortable in which ever situation you are in and you are able to make others comfortable in differet situations.

Real mental health is constant wish and striving in this direction.

TEACHER: An Agent of Mental Health Promotion *

Perhaps the best way to find out what personality traits a teacher should have is to turn to the children themselves. Some years ago Witty, collected 14,000 letters of school students on the subject, "The teacher who has helped me most." He then analysed the responses and listed the following traits in order of importance:

1. Cooperative, democratic attitude
2. Kindliness and consideration of the individual
3. Patience
4. Pleasing personal appearance and manner
5. Fairness and impartiality
6. Sense of humor
7. Good disposition and consistent behaviour

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* *Extract from Proceedings of the Workshop on Promotion of Mental Health with Community Participation.*

8. Interest in pupil's problems
9. Flexibility
10. Use of recognition and praise
11. Unusual proficiency in teaching a particular subject.

The following year, 33,000 more letters were collected. From these, Sample letters were drawn at random, and the nature and frequency of undesirable characteristics were ascertained. They were arranged in order of rank:

1. Bad tempered and intolerant
2. Unfair and inclined to have favourites
3. Disinclined to show interest in the pupil and to take time to help him
4. Unreasonable in demands
5. Tendency to be gloomy and unfriendly
6. Sarcastic and inclined to use redicule
7. Unattractive appearance
8. Impatient and inflexible
9. Tendency to talk excessively
10. Inclined to talk down to pupils
11. Overbearing and conceited
12. Lacking in sense of humour.

A comparison of the lists of positive and negative characteristics reveal clearly that the school child responds favourably to the teacher who practices the mental hygiene in the classroom. It is important that during the school years the children be under the guidance of well integrated intelligent individuals in order to strengthen their personalities.

Positive principles of Mental Health in the Personal Philosophy of Teachers:

According to Bernard (1970), by incorporating into the personal philosophy of the teachers, those values and action patterns which are conducive to good mental health, the humanistic approach could be ensured in classroom. The following are positive principles of mental hygiene, which are a means of exercising the various aspects of personality and of satisfying fundamental human needs.

1. The better one's physical health, the greater is the likelihood that he will have the initiative and energy to achieve mental health- 'A sound mind in a sound body'.
2. The better one understands the reasons for goals of his own conduct, the greater will be the control exercised over mental health processes and interactions.
3. One's mental health is enhanced by improvement of his relationship with others. Mental health consists, in large part, of human relationships.
4. Having a confidential relationship with another person-selected friend, therapist, counsellor - adds to the probability that one can establish and maintain the perspectives on his own problems that are essential to mental health.
5. The view one takes of problems, situations, and dilemmas is often as important as are the actual objective events.
6. Worry and anxiety may be reduced by careful assessment of current situation, by examination and possible revision of goals and by devising more appropriate plans.
7. Increasingly, as one approaches maturity, a genuine sense of security derives from developed skills which enables one to meet and solve problems.
8. A mentally healthy life will more readily be achieved when there is an appropriately balanced regime consisting of both work and play.
9. While planning for the future is a part of proactive man's opportunity, mental health is fortified by giving major attention to the present situation.
10. One tends to see what he looks for and the zest for living can be increased by one's tuning in to the humor which resides in daily situations.
11. One should instead of expecting perfection of himself, learn to be satisfied with doing the best he can at any given time..
12. One approach to human affiliation which is essential to mental health is to capitalize on the values and aspirations of a religion of love.
13. The person who is able to enjoy the ordinary occurrences of daily living tends to be substantially above average in mental health.

Tutoring Therapy Model: Building self esteem in children

Self esteem seems to be the foundation of self confidence. Keeping self esteem alive is necessary for each human as water for plants. Self esteem is the daily food of emotional health. Building self esteem is a process, usually a slow one. Berne and Savary (1990) named the procedure as Tutoring Therapy. Some of the suggestions which could be put into practice are given below:

1. Spend as much time as possible with the children. Give undivided full attention to them. Let them get the feeling that you care them enough.
2. Listen to their problems and difficulties and even the subtle messages. Listening heals broken self esteem.
3. Accept the children and their friends. Show interest in them.
4. Do not hesitate to share the `good ' and ` bad ' moments of your life with them.
5. Take the children to special places - picnics, temples, parks, and exhibitions, zoo, museum - expose them to new experience.
6. Avoid pretensions and be sincere in your reactions and relationships with the children.
7. Allow them to share with you their imagination or fantasies, do not challenge them.
8. Do not embarrass the children in any way.
9. Ask them questions that do not threaten.
10. When you ask a child to do things, choose tasks that the child can do successfully, success builds self esteem.
11. Acknowledge the positive qualities in a non evaluative way.
12. Have realistic expectations. Let them move at their own pace.
13. Avoid boredom as far as possible. Joy and fun are attractive to children.
14. Share some of your personal belongings with the children.
15. Allow the children to be of help to you.
16. Trust the children and be trustworthy yourself.

17. Help them release their tensions through physical exercises.
18. Tell them nice and interesting stories.
19. Use humour in building relationship with them.
20. Convey caring feelings through touch.

Elicitation Model - A Teacher's Recipe for Approaching Parents:

The goal of any parent - teacher contact is to promote a working alliance. One approach of this working alliance is the use of `elicitation model' proposed by Hetznecker at al (1978). The guidelines are given below:

1. Assume that the parent has as much good faith and good intention as you do.
2. Assume that parent acts with as much consistency in his role as you do in yours.
3. Adopt listening attitude rather than teaching, telling or advising.
4. Assume that there are many experiences of the truth. The experience and expression of that truth depend on the focus one chooses.
5. Elicit the parent's views, particularly their views of the child and their experience with the child.
6. Restrain the impulse to criticize the parental handling of the child at home. Also refrain from suggestions for home management unless requested.
7. After you listen to what the child does at home and what the parents want him \ her to do, show some positive thing the child does at school. Then show some other things he does and what you would like the child to be able to do.
8. Do not say what the child is. Describe what the child does or is unable to do.
9. Focus on developing a working alliance through which you and the parent can find ways to help the child to be more comfortable at school, like himself better, and feel capable.

10. Note things we expect the child to do. Elicit from the parent ideas of ways how this could be accomplished.

11. Say what you as a teacher will try to do at school to help the situation.

12. Tell the parent when you will report on how the plan has worked and ask the parent to share with you at that time how his efforts have worked.

13. If the parent asks for suggestions on how to help at home, be specific. Say what learning tasks to help with and how to go about it.

14. If a child is using school work to get attention at home, suggest that you or someone else help him with homework. Suggest that the parents save their time with the child for mutually enjoyable activities.

15. As things improve at school, let the parents know what a good job the child is doing. Congratulate them for the efforts they have put out, and their success in your joint venture. (Tell the child the same good news and label his success for him. It is helpful to point out to the child the specific ways in which he achieved improvement).

16. If things do not improve, do not complain. Arrange another conference. Better yet, at the end of each conference plan for the next one at some predictable time in the future. The object is to maintain the working alliance and to find new ways to help the child and to encourage him to help himself.

17. Try to find ways to help the parent feel comfortable, competent and helpful in the situation. If the parent feels better, so will the child. If the child feels better, so will the teacher.

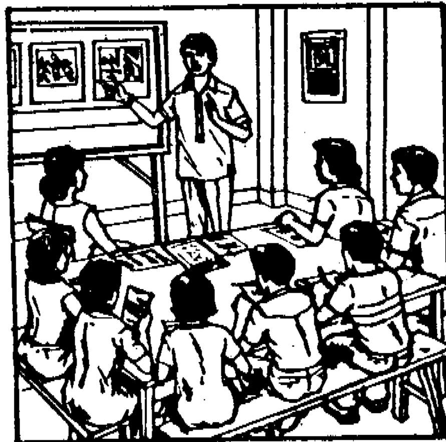
18. Be sure that the child has responsibility for himself and experiences the consequences of his behaviour. Prevent him from carrying last week's mistakes into this week. Depending on the child's age and readiness, it might be well to include the child in the Parent-Teacher conference at an appropriate time. Be sure that such an inclusion does not result in a barrage of criticism or blaming of the child by either parent or teacher.

19. Be comfortable with your own natural human need for positive feedback, whether from child, parent, other teachers, or principal. Remember that if parents fail to give this feedback, it does not mean that they are malicious or that you do not deserve it.

CHANGING ROLE OF TEACHERS

	Past Role	New Role
1.	Teaching facts and techniques	Preparing child's capacity to handle facts, to know where and how to find them and what to do with them.
2.	Preparing child to pass examination	Preparing the child for life long learning.
3.	Isolating child from environment	Stimulating the child to identify himself / herself with the environment and awakening in him/her a loving concern to take care of it.
4.	Teaching a curriculum irrelevant and divorced from life needs and aspirations of the community	Implementing a curriculum relevant and related to life, needs, aspirations of the community.
5.	Being indifferent to the place of school in the community.	Taking loving care to make the school an integral part of the community and a centre of love, learning, of beauty and harmony.

New Role

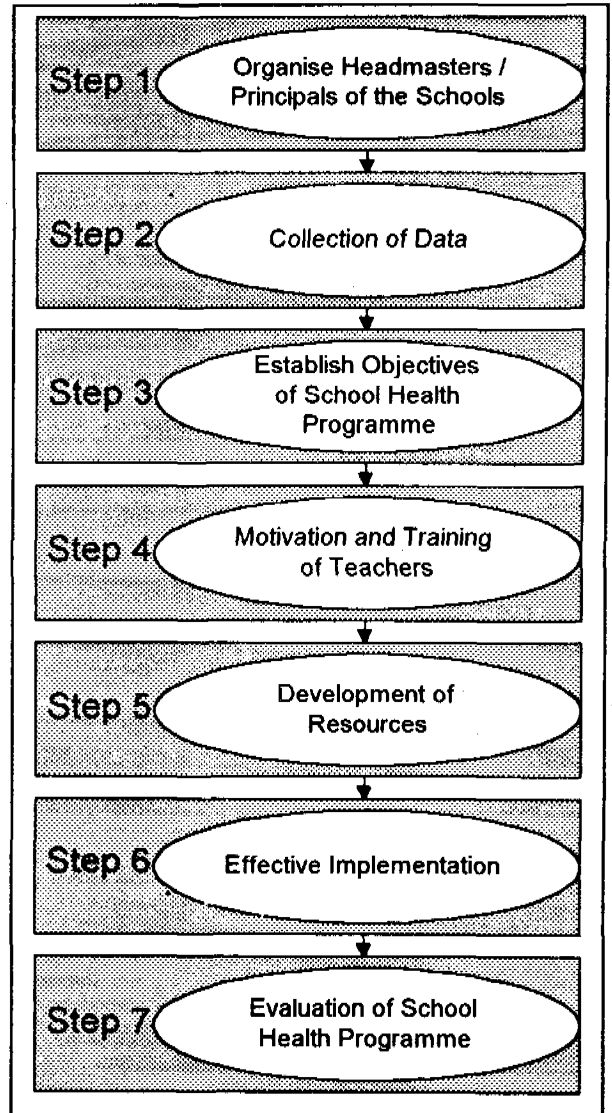


Past Role

CHAPTER VII

STEPS IN ORGANISING SCHOOL HEALTH PROGRAMME

The chapter describes different steps to be followed in organising school health programmes. It is essential to understand the steps, so that the programme can be organised in a systematic way. A note on sustainability is also examined in this chapter.



Any one can be instrumental in getting the School Health Programme started. In some places the Programme was started by school administrators in cooperation with voluntary organisations, in others, by teachers; yet in others by the government departments of education and health. Energetic and enthusiastic teachers are usually likely ones to implement and sustain school health programme.

Step One: *Organise headmasters / principals of the schools.*

Organise and orient headmasters / principals of the schools about the importance of school health programmes. They are the key to the programme success and it is around them the teachers revolve. If he acts as an animator or a coordinator, the SHP can be effectively planned, implemented and sustained. Thus the school, through the children, teachers and parents can be channel of change in health status of the community.

Role of headmasters / principals:

1. Coordinate between the school, the home, and the individuals and agencies in the community that can contribute to the health of the child.
2. Provide supervision and guidance to the school health programme.
3. Create healthy school environment for interpersonal relationships with other principals and school staff.
4. Discuss and plan with staff the health education principles of learning.
5. Encourage health experimentation by students and appreciate achievements.
6. Supervise campaigns through students to educate the community about common and immediate health problems.
7. Encourage them to take remedial and preventive measures.
8. Coordinate with local education health personnel for their support in the programmes.
9. Provide for on-going evaluation and improvement of the School Health Programme.
10. Ensure adequate physical facilities in schools for satisfying the health needs of school children viz. safe water for drinking, sewage disposal facility, waste disposal arrangement, adequate toilet facilities, classroom lighting and ventilation.
11. Ensure safety in the school and supervise a programme of safety promotion.
12. Provide means for building up a better relationship among students and teachers and other school personnel.
13. Assume responsibility for a healthy and educational school programme.
14. Obtain instructional material for health education.
15. Arrange necessary in-service training on health education for the teaching staff.

Step Two: *Collection of Data*

To plan the school health programme, the headmaster / principal needs reliable data. The data required and from where and how it can be obtained is indicated below:

Morbidity data of students	:	Simple surveys and discussions with teachers and health personnel.
Absenteeism and scholastic backwardness	:	Discussion with teachers and parents.
Local community health problems	:	Simple surveys and discussions with health personnel, teachers and community leaders.
Economic background social status of parents	:	Survey and review
Health beliefs,knowledge,attitudes and behaviour of students	:	Observation of students
Parents	:	Observation and discussions with health personnel and parents.
Sanitary facility in the school	:	Observation of school environment and sanitary facilities.

Data such as these will enable the headmaster / principal to make an assessment of the present health situation of the children and school environmental condition. Accordingly they will be able to identify and prioritise areas needing improvement.

Step Three: *Establish objectives of school health programme*

Educational objectives should specify what actions (including attitude and behaviour modifications) are expected of students, teachers and community as a result of action. This in turn will help to solve the health problems and make improvements in school environment.

1. To provide healthful school environment.
2. To provide children with protection against communicable and other preventable diseases.

3. To detect defects and abnormalities in the children at the earliest and refer for correction to health care institutions.
4. To develop the knowledge and attitudes which will enable the individual to make intelligent health decisions.
5. To encourage and develop desirable health habits.
6. To develop school, home and community cooperation in health promotion.
7. To develop in children a scientific approach to problems solving.
8. To develop children's abilities to apply knowledge to actions.

Step Four: *Motivation and Training of Teachers*

The achievement of the objectives of the School Health Programme will depend upon developing the capacities of teachers. This will be done by in service training and continuing education.

The School Health Programme requires energetic and enthusiastic teachers. One way of motivating these teachers is to take them to visit a good SHP. If not, then select at least two teachers initially and the headmaster/principal from the school and a local health functionary for the training. Experience has established the fact that with out training, the headmaster/principal does not develop the understanding and commitment to provide team backup support. Therefore the headmaster/principal must get good orientation by separate orientation sessions along with School administrators or managers. Another way is the headmaster / principal to join the team for training course. During training, he is a part of the learning groups composed of teachers and other health personnel and a cohesiveness develops. Team members learn together and work together. The headmaster/ principal will make effort to provide necessary resources, facilities for effective implementation.

Training of Teachers:

Health education helps the teacher in developing his own health; objective consideration of existing prejudices and superstitions about health are made. i.e. Positive behavioural change.

The principle objectives in teacher preparation for health education according to the WHO / UNESCO Expert Committee are to develop:

a. A standard of personal health practices which will help maintain the health of the individual and serve as an example to the pupils

b. Understanding and developing skills in maintaining an optional emotional environment through desirable interpersonal relations

c. An appreciation of the value, importance and place of education in health, as a part of the total education programme

d. A willingness to play an appropriate part in the promotion of health in school and in the community

e. An adequate background of professional knowledge about child growth, development, personal and community health, and programmes and procedure in school health

f. Understanding and appreciation of a healthy physical environment and how it is maintained

g. Skill promoting health education and in working cooperatively with others in this sphere

h. A knowledge of community health and social agencies and the ways in which the teacher may work effectively with them and with the home. Preparation in health education enables the teachers to meet the expectations of society. They will help to develop attitudes, habits and knowledge in the field of health which are needed by the young children.

Training also makes the teacher aware of her/his own health requirements and she/he learns how to meet them.

a. It helps the teacher understand the child psychologically

b. It helps the teacher work more effectively with the other members of the school staff and contribute more to the community

c. The teacher understands the health problems of children and can collaborate with the home more effectively

d. It helps the teacher to realise that knowledge of fundamental health facts are essential for any positive changes in health behaviour.

Action is more important than just theoretical knowledge. Hence a trained teacher's approach is "action oriented" rather than "knowledge oriented". No one is better equipped than a trained teacher who can observe and encourage good health behaviour. The training could be more meaningful and effective if local health problems are studied.

Step Five : *Development of Resources*

To a large extent, the effectiveness of the programme will depend upon the resources-teachers, students, parents and health personnel, materials include books, films, slides, and other audio-visual; and costs generally involve fees for trainers, and the trainee expenses.

Schools must raise their costs through matching money or full support. They can approach the communities, voluntary organisations, government departments or private sector corporations for assistance. Each school must establish a School Health Fund.

Most of the education materials should be prepared in the schools with the help of teachers and children. Some of the useful relevant materials may be available free of cost from Health Department and local UNICEF Office.

Step Six : *Effective Implementation*

The effective implementation of the School health programme can be possible only if the children's potential is utilised. Learning is possible through activities and as such children should be involved in health activities. In this way they act as change agents in the family and the community.

Close coordination and regular field visits to schools is necessary to facilitate programme functioning. This includes maintenance of records, regular supplies, keeping in touch with resource persons and materials to fulfill local needs.

Step Seven: *Evaluation of School Health Programame*

From the programme point of view, accountability and evaluation have been considered as important. Two aspects of the SHP should be evaluated:

a. Effectiveness of the programme activities

b. Performance of those activities

Evaluation of Effectiveness provides answers to the question:

Did we achieve the objectives of the programme activity?

Evaluation of effectiveness should be:

- Carried out both by persons who did not perform activities as well as by persons performing activities
- Carried out periodically
- Indicative of the degree of success in reaching the objective
- Expressed in numbers so that comparison can be made (descriptive / narrative qualitative data including observations should be included).

Evaluation of performance answers such questions as:

Are we carrying out the activities as we should?

- The purpose is to find facts improve performance
- To evaluate performance, evaluations may be made by those who carried out activities, incharge of the programme etc.
- Decide when to evaluate performance
- Collect information about the quantity of activities performed and quality of activities performed
- Plan to use this evaluation of findings to improve future programme activities.

A word about sustainability:

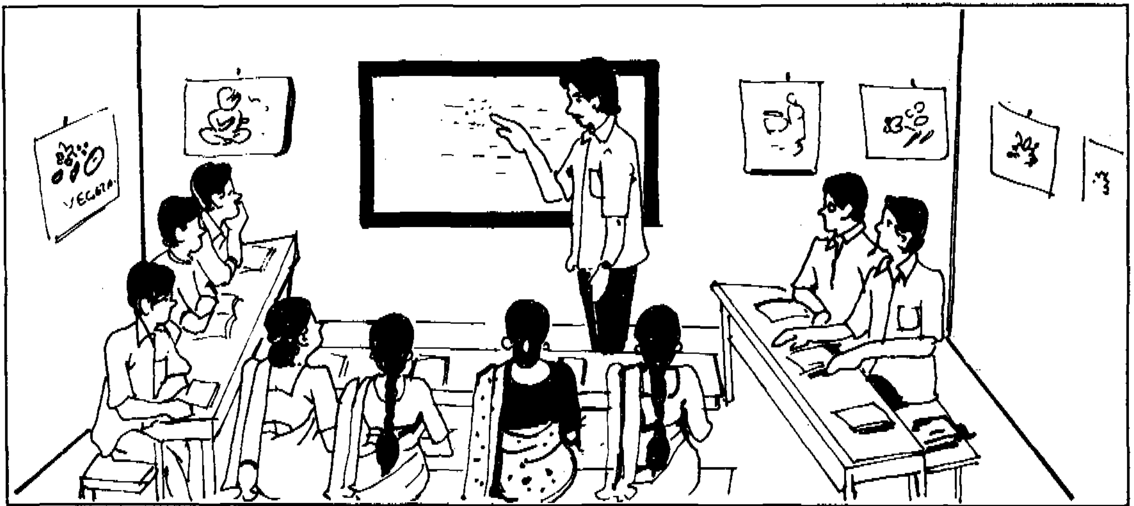
For the School Health Programme to function successfully, essential teaching-learning resources must be ready and available. Minimally, this requires supportive headmasters, trained teachers and health personnel, informed parents and community groups and the audio-visual materials required for the classroom. From the beginning parents must be invited to participate in the school health activities and discussing the information their children bring home. Voluntary organisations such as state T.B Association, Dental Association, Cancer Society, St.John's Ambulance Association etc. are excellent resources for speakers and provide classroom materials. Through the programme, they can present their messages about disease prevention to the future adults of the community. Other health specialists are excellent resource people for the programme. Through these health professionals who take time to visit the children in their classrooms, and to answer their questions, the children learn and they see that some one cares about them and about what happens to them.

The teacher, the headmaster / principal, managers, parents, the health personnel, the community - all are brought into the SHP because that is the way of life and health happen - in the context of others.

CHAPTER VIII

TRAINING OF TEACHERS AND HEALTH PERSONNEL

In this chapter, we discussed the improvement of training and motivation of teachers in school health programme. The objectives and the processes involved in training of teachers is also considered. Training of trainers and various constraints that may crop up, are also addressed in this chapter.



The proper training and motivation of teachers to involve the pupils in learning about health is perhaps the most important component of this programme. Without the willingness motivation and efforts of the teachers, all inputs may be wasted and the entire impact of the programme lost. In fact, all education and health personnel who are expected to be connected with the implementation and functioning of the school health programme will need to receive some instruction and training related to health education and services components The content, nature and duration of this training will depend on their professional background and on the nature and extent of their involvement.

The training may be effected through in service courses for current teachers, workshops and seminar for headmasters, supervisors, administrators, etc. Provision should be made for refresher courses for teachers and health personnel at fairly short intervals, especially during the first few years of implementation.

Inter-disciplinary workshops and seminars, e.g. involving health \ education and mass media personnel can make a significant contribution to mutual understanding and cooperation.

All programmes designed to prepare individuals for participation in school health activities of any kind should emphasize motivation as well as content.

Developing programmes: Some general objectives that may apply to all types of training are:

i) to create awareness and understanding of the role of health education in the field of general education;

ii) to develop an interest in, and a favourable attitude towards health teaching;

iii) to develop the ability to recognize opportunities to incorporate effective health teaching into everyday work;

iv) to increase the ability of teachers and pupils to communicate with individuals, families and community groups to enlist their participation in the school health programme, and to identify health development roles for pupils and teachers in support of community health programmes;

v) to promote team work for health education, as found appropriate;

vi) to encourage recognition of the role of specialists in related fields and of the advantage of drawing on their resources as and when necessary.

Among many learning experiences, provision should be made for practice in teaching health. It is commonly stated that improvements in educational methods are slow because "teachers teach as they were taught and not as they were taught to teach". Student teachers should be involved fully, and should participate in the health services and education programme of the school.

The success of school health activities depend on the quality and motivation of teachers. It is unrealistic to expect teachers to give training in habits to which they themselves are not accustomed. Priority attention must be given to training in health education during the basic preparation and in-service training of teachers for the successful implementation of health teaching programmes.

Teachers enter the training programme with different levels of understanding and feelings about the school health. Some feel their knowledge is insufficient, some have misconceptions. Some are secondary grade teachers and higher grade teachers, some are generalists and some others are specialists (Science or physical education teachers). Some tend toward more traditional or rigid teaching methods. Some are reluctant to prepare and try new materials and methods.

The purpose of the training programme is to resolve these insecurities and problems and to give the teacher a solid foundation in understanding and skills to organise health activities in the school.

The process involves:

1. information development
2. attitude formation
3. learning and teaching techniques
4. interpersonal relationships.

Information Development

During training, the teachers review their own school surroundings, common health problems and how to prioritise them and plan health activities for the children by the children and with the children.

Attitude Formation

As the teachers become excited about the programme, the enthusiasm is renewed about the merits of teaching health. Through the activity based approach, teachers develop confidence in themselves and the abilities of the children.

Learning and teaching techniques

There is every possibility in learning and improving the teaching techniques during training. The trainers may use appropriate techniques for different sessions and this might give inspiration to the trainees.

Interpersonal Relationships

During training all the participants are considered as equals (teachers, administrators, headmasters, health personnel etc.). They have many occasions to meet, share their experiences of the training and plans for the implementation of the programme.

Identifying Training Needs :

Training needs should be identified in consultation with the school children, teachers and with community.

Assessment of training needs :

- Training must seriously and systematically undertaken to fulfill it's role.
- Therefore, every effort must be made to develop training activities which are relevant and appropriate to he needs of the community, organisation and the individual.
- To accomplish all this, the training activity must be preceded by an assessment (or analysis) of training needs.

What is a 'Training Need'?

- a gap in skills or competency
- that thing which a person / group needs to learn in order to meet some *specific* requirements; it is *not* an 'interest'
- can be *remedial*, which most immediate present training needs are.
- can be *potential;* i.e., a projected future training need, anticipated as a result of growth and development of the project and / or the individual.
- the foundation of any effective training programme

Important considerations:

1. ***Expected role of Teachers and Health personnel:***

   The functions of school teachers embrace all aspects of school health programme: healthy school environment, school health services, health teaching and education and school, home and community relationships.

2. ***Local health situation:***

   If Malaria is common health problem in a particular area, more emphasis will be required to the subject so as to have effective preventive and curative methods. If anaemia is a major cause among children, this should be given special attention.

3. ***Accessibility of health services:***

   If health services are not within easy reach, the teachers will be required to handle some emergencies. (eg: cuts , wounds, stomach ache, fevers etc.)

4. ***Educational background and experience:***

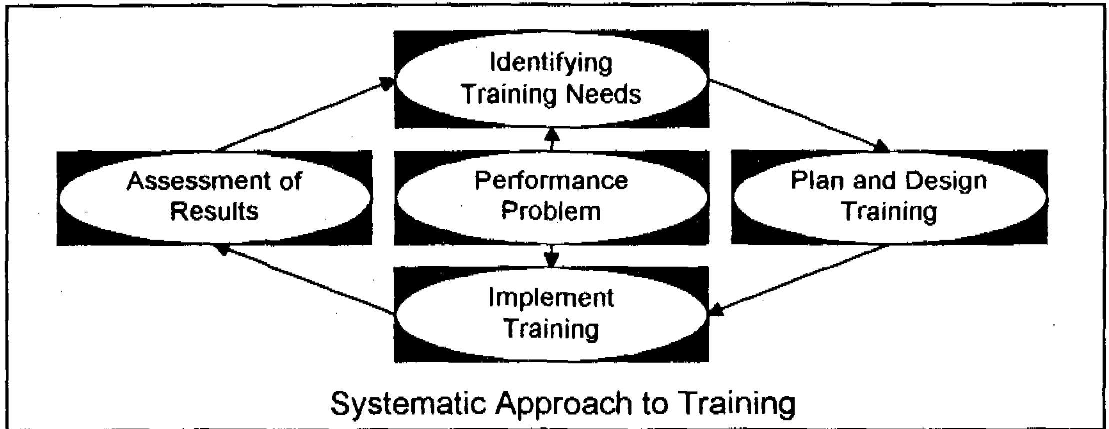
   The educational background and years of experience will determine the training requirements. The use of interesting training methods and allowing the teachers to relate their own experiences are also important for effective training.

5. ***Knowledge and Skills required:***

   During training, periodic needs identification will help determine what the teachers already know, what they need to unlearn and gaps that should be addressed. Another consideration in the process of knowledge and skills assessment is the pattern of utilisation in practice.

Systematic Approach to Training:

In organising training prgrammes we have to develop a systematic approach to training. The steps involved in systematic approach to training are : identifying the training needs, planing and designing training, implementing training and assessment of results. These steps must be closely associated with real performance problems. The following figure illustrates the overall approach to systematic training and the relationship between performance problems and other aspects.



Systematic Approach to Training

Training of Trainers :

In the training of the Trainers of teachers and health personnel, the following must be considered:

- Provide briefing on overall objectives and plans regarding training
- Adapt and translate training materials
- Emphasise the importance of trainer-teachers relationships
- Discuss the venue of the training
- Demonstrate the teaching methods and provide "hands-on" practice to the trainers
- Orient the trainers regarding the principles of teaching of adult learners
- Demonstrate the teaching methods to be used by the trainers
- Identify and provide the support material which the trainers would require during training.

The trainers must clearly understand the objectives of training the teachers and health personnel. They should be informed about plans regarding training. The trainers should be given considerable flexibility in adapting to the local needs. The trainers must also be encouraged to select the training methods with which they feel most confident, selected teaching methods have to be demonstrated, after which the trainers should practice them so as to ensure that these will be used with confidence independently.

Practical sessions for the trainers are important:

- Observation of children for signs of health and ill health
- Practicing how to take weight and height of children
- Learning to make entries in the school health card accurately.

Without supportive materials, the trainers receive poor training and they are likely to ignore the subsequent use of support materials in their work because they either do not know how to use them or have not understood their importance.

Video films, slides, transparencies for over head projection and illustrations can be useful training support materials.

WHEN THEY ARE USEFUL

Methods	**Knowledge**	**Attitudes**	**Decision skills**	**Manual skills**	**Communication skills**
Chalk board	●				
OHP transparencies	●				
Slides	●	●			
Films	●			●	●
Handouts	●		●	●	
Demonstrations	●			●	
Manuals	●				
Discussion		●	●		●
Brain storming			●		●
Snowballing		●	●		
Games	●	●	●		
Case Studies		●	●		
Flow charts	●			●	
Role play		●	●		●
Written exercises	●		●		
Field visit		●	●	●	●
Simulation		●	●	●	
Paired practice	●			●	
Check lists				●	●

There may be some common constraints of the trainers while training teachers and health assistants.

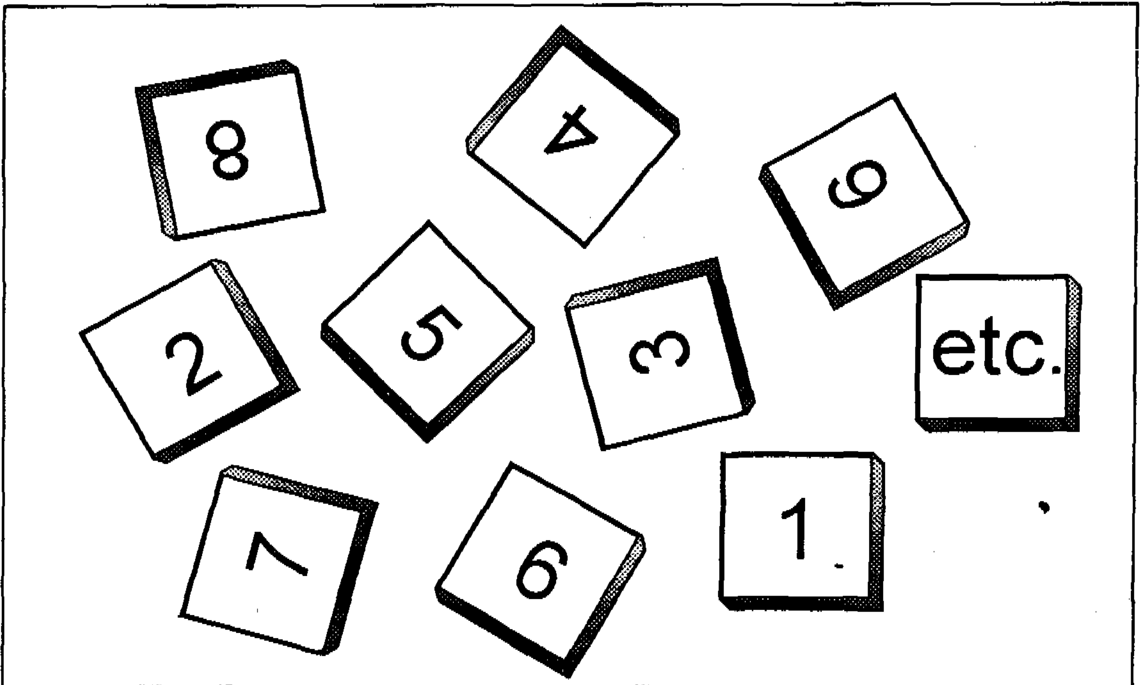
- The trainer is not properly trained to undertake the expected task of training. Consequently the quality of training suffers.
- Facilities for training are not adequate
- Sometimes the trainer may be too busy and so he delegates the training to some one else who is not trained or not motivated.
- The trainer does not understand the job or does not want to assume the responsibility.
- Other reasons, such as, poor health, personal problems, delegation of responsibility without authority may result in poor training.

The above mentioned problems need to be addressed if quality of the training of teachers is to be improved. This could be done by supervisory visits by the trainers periodically.

CHAPTER - IX

STRATEGIES FOR HEALTH PROMOTION

Various strategies for health promotion among the school age children are discussed in this chapter.



One of the important roles of school health programme in achieving health of the children is promotion of health habits and practices among them. This could be achieved by understanding the present level of awareness and practices relating to health, thus working out mechanisms to promote health awareness. The concern of the teachers should be to develop health attitudes and behaviour rather than merely imparting health knowledge. Children enjoy learning through activities and fun. They will be only too glad to involve in any of the health activities. The teacher should take the initiative in creating learning environment for children.

There are several ways of promoting health awareness, health attitudes and behaviour among school children. Some of them have been described below :

1. *Parent Teacher Association (PTA) :*

Parent Teacher Association, if already formed as a part of school's activity, could be made use of to promote health awareness among the parents, children and the community at large. If such an Association does not exist, the school authorities and teachers should take effort to form parent-teacher-association in every school. This would pave the way for a two-way communication. Parents will know what has been taught in schools thus enriching their knowledge. Such associations could jointly plan school health improvement projects and mobilise resources from the community.

2. *Health Club:*

Similar to other clubs in the school (literary clubs, science club, and the like) teachers can assist in organising school health club. The main purpose of the club can be to discuss various health problems in the school and plan to solve these problems with the help of the students, teachers, parents, health personnel and community members. The club can also organise health surveys, take up projects like development of school vegetable garden, safety and cleanliness of the school compound and other campaigns.

3. *Health diaries:*

Each child can write about all the health activities which he \ she carried out on the previous day.

Another way is to give each child a Health Habit booklet containing 10 to 12 health practices which he \ she should carry out every day.

eg: 'I got up 6 clock in the morning'
'I cleaned my teeth'

Each child can tick mark those activities which were carried out and mark a cross against those not carried out.

Weekly or fortnightly discussions could be organised in the class based on their health activities.

4. *Health Action Campaigns:*

Any activity related to health undertaken by a group of students for promoting health awareness in the school, home or community and which in turn will lead to health action - action to improve health of the students, or families or community at large. Health action campaigns can be : planting trees, cleaning the campus or neighbourhood, teaching children in the village or slums, anti smoking, rally on sanitation promotion, know your medicine, safety at school, home and neighbourhood.

Example of a campaign:

A campaign on safety first can be organised, based on the local need - eg: to reduce injuries and prevent deaths. Most of these accidents happen in the following four places at school, in the home, in the neighbourhood and on the road.

Accidents may occur in the classroom or in the play ground. Children's behaviour sometimes causes accidents.

These accidents can be prevented by repairing of broken or unsafe furniture or equipment and keeping the ground clean, free from thorns or broken pieces of glass. Help children to understand unhealthy behaviour and unsafe play and prevent accidents.

There are many common accidents at home, like burns from cooking pots, fires, boiling water or oil. They damage the skin. Cuts from sharp knives and broken glass can be deep and infect the wound. Children may drink harmful substances like kerosene or spirit, swallow tablets. Other accidents related to electrical appliances, like faulty plug or wires, iron box are also fatal.

Accidents at home can be prevented by keeping harmful things like spirits, tablets etc away from children. Keep the floor clean and remove any pieces of glass or sharp instruments. Teach children how to handle and when not to handle electrical appliances.

There are many dangers in the neighbourhood and on the road. Dog bite and bite of poisonous snakes are dangers and fatal. Drowning is also common in open wells, tanks, lakes and rivers. Many deaths and serious accidents occur on the road. Awareness of the neighbourhood, caution care are important in avoiding dangers and preventing some of the accidents. Help children understand road safety rules.

5. School children as Health Scouts \ Health Guides:

Another way of promoting health awareness is by selecting students from middle and high schools and training them as Health Scouts or Health Guides. From each class (VI to X), the teachers can identify about 6-10 students who are active and interested in health. These students can be trained in health and health related subjects, one hour every week. Gradually they will be able to assist the teachers in the effective implementation of the school health programme. They wiii help in organising health exhibition celebrating health week, preparing survey of the neighbourhood and planning and organising health campaigns. They can present health messages in the form of skits and plays during school assembly once a week. They can be useful health guides in promoting health awareness among the children in the school.

6. Organising health activities:

The teachers can prepare and get the students enact short plays and social dramas on health themes. They are used to explore people's attitudes,feelings and behaviour. Their main purpose is to increase people's awareness and to explore possibilities for action and change. A play could be on "who is great" in which different parts of the body and systems claim as the most superior over others.

Similarly, some themes can be enacted through puppets. Puppet shows are a form of play acting using puppets or sometimes masks or giant heads to act out stories or messages. Puppets are especially fun for children. Children can make their own puppets to look like people or animals. Using puppets, it is often easier to say things that people themselves cannot. For example they can talk openly about the bad food sold outside the school campus.

Role playing is often used as a learning game in class. Several students or a group, can act out a problem or situation. Each student pretends, or `plays the role' of a particular person - for example a sick child, older sister, child's mother or health worker. For role playing, no written script is needed. There is no memorization of parts. Each student tries to act and speak the way that person would.

7. *Health Education or Instruction:*

Health education in the class room should be behaviour centred. It is developed through direct instruction based on the child's changing needs and interests. It should be appropriate and problem solving approach. This programme of factual instruction should be presented to the student by the end of his schooling. This should help the child to develop positive attitude towards health and as a means of enriching life. They should include:

- Structure, function and control of human body and reference to the basic life processes of digestion, respiration, circulation, excretion, nutrition metabolism, organs and nervous system and the process of reproduction.
- The biological need for air, water, food, activity rest and sleep.
- Mental and social health.
- The dangers to health from organic and communicable diseases, accidents, poisons, alcohol, drugs, smoking and stress.
- Personal responsibility for health care.
- Factors involved in the establishment of the family and maintenance of its health and well being.
- Protection of health through community health services and consumer education.
- Local national programmes eg: T.B., Leprosy, AIDS Control Programmes, Malaria eradication programme, etc.
- Pertinent occupational safety aspects.
- Environmental protection.

The following principles are important while teaching health education / health instrumentation :

1. Carry out health education to the needs and interests of various grades.
2. Develop and use a variety of learning experiences adopted to the development level of pupils.
3. Select and use a variety of teaching materials, and prepare simple ones locally.
4. Evaluate health education in terms of knowledge, attitude and behaviour.
5. Develop suitable motivation for healthful living.
6. Keep abreast of new developments in health teaching.
7. Furnish an example of healthy living for pupils to imitate.
8. Interpret school health education to families and communities.

Methods of teaching health education:

- participatory teaching and learning
- use of models
- effective use of audio-visual aids
- activity oriented learning
- demonstration

Corelation with other subjects:

Biology	:	Study of insects as carriers of disease harmful micro organisms immunity disinfection sanitation
Physics	:	Ventilation heating temperature
Chemistry	:	Use of drugs Analysis of sugar, proteins
Social Science	:	Child care Mental health, Social health
Language	:	Health plays Stories, Novels, Essays Speak, Listen, Write, Read
History	:	Discovery of microscope, vaccines, vitamins
Maths	:	Health budget Disease incidence Growth curves Population Morbidity, mortality rates Proportions, ratios
Home Economics	:	Food preservation buying of food, clothing
Physical education	:	Importance of exercise Learning motor skills Fairness in sport and competition (keeping rules) First aid

8. Learning Resource Centres Approach:

Learning Resource Centres or multiple teaching centres is an educational method used for health teaching. It creates a centre of exploration out of the typical school situation of a classroom, a teacher, and boys and girls, by replicating the basic patterns of interaction in life. This method brings various elements of real life into the classroom, into a rich, carefully structured environment in which children can explore them, understand them, and use them.

The learning centres are physical areas in the classroom may be tables, a small circle of desks, a counter, or a section of the floor. Teaching centres may also be set up in a spare room, the auditorium, or outdoors. There are usually five or six simultaneous learning centres.

The resource materials are different types:

audio-visual materials - slides, movies, tape recorders;

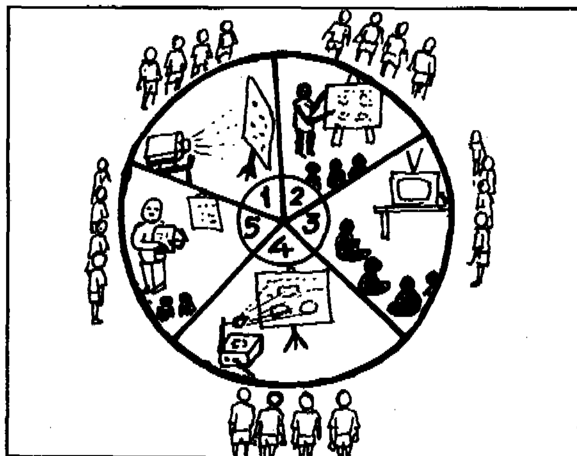
tools - scissors, microscope,

props - a miniature skeleton, water, balloons, heat, seeds, animal heart, lungs;

reading materials - newspaper articles, pamphlets, posters, games;

resource people - nurse, doctor, parents, teachers, people from voluntary health organisations.

Learning centres are a highly organised system. The resource materials (mentioned above) are integrated with the appropriate concepts and these are organised to develop the unit's content. Although five learning centres may be in use simultaneously and all five would probably be about the same basic subject, no two would be alike. The concept in each would vary slightly, and different resources would be used.



The children work in groups and rotate through all the learning centres. A rotation may occur after 20-30 minutes or next day, depending on the complexity of the centre activities. Occasionally, the learning centre involves the entire class, as when one group presents a skit or the class play a game a group has designed.

When the groups arrive at a learning centre, the materials and instructions, prepared in advance by the teacher, are waiting for them. A child who has been selected group leader reads and explains instructions to other children, distributes materials, and sees that all activities at the centre are covered.

Learning centres are Happenings:

a. Events happen - The children become fascinated by scientific experiments and they take home ideas and involve their parents in helping them set up experiments.

b. Mysteries unfold - As a result of their experiences, the children become very curious about the minute details of their daily environments and learn how to look more closely, more carefully, at everything around them.

c. Learning happens - They learn to think critically and evaluate information. They learn to discriminate between the useless and valuable, the trivial and important, the impersonal and personal, dislikes and preferences, feeling bad and feeling good. Learning and relearning occurs because messages are incorporated into games or group work, it is fun.

d. Creation happens - Children are given opportunities to express the experiences they have been using. They use art, music, writing, drama and other skills. They create mobiles, posters, cell models, lyrics, stories, plays, games and simple machines. Sometimes they work creatively by themselves, sometimes with others. Always, their creations are shared with others.

e. Interaction with peers happen - In learning centres, each child is an individual working simultaneously as an individual and as member of a group. The children work as team, cooperate with one another, help others and learn from others. In this process the boys and girls become more open with one another. Even discipline problems tend to disappear because children who previously were bored become interested children who previously were problems are now solving problems.

f. Decisions happen - Through the learning centres the children develop right attitudes toward their health. The children are provided with opportunities to find out what happens to the body if cigarette smoke enters it, if alcohol enters it, if proteins are lacking, and so on. They gradually develop capacities to make decisions that would keep their bodies in sound health and good feeling associated with good health

9. Competitions:

Competitions of different types both intra school and inter school can be organised. Students can take part in debates, symposia, panel discussions or group discussions related to health. Drawing, painting and poster making competitions and others like writing essays, stories, songs and rhymes can be conducted for the school children and prizes distributed. Such material prepared by students will be of great value for bringing health awareness among school age children. Selected ones can be produced in large scale for distribution in schools.

10. Health Education Calender:

Health education calender can give the teachers and health personnel an outline that they can follow for health awareness in schools. This can be made more appropriate and suited to the local problems and priorities. A brief and simple explanation can be added beneath the drawing or selected pictures or slogans. Make sure the calender is perfectly comprehensible to those for whom it is intended. Remember that the involvement of students in drawing it up will help in transmitting the messages effectively. Messages can be of health, nutrition, water, sanitation, environment, preventive measures, education about specific diseases and health habits and healthy life styles.

CHAPTER - X

SCHOOL HEALTH RECORDS AND REPORTS

This chapter examines different ways in which school health records can be developed, maintained and used for the purpose of promoting health and well being of school children. It also describes advantages of school health records.

A cumulative health record is meant to be a personal dossier of the child, giving particulars of:

1. Growth and the development during the school
2. The immunization record
3. Record of occurance of significant communicable diseases like TB, Leprosy etc.
4. Results of medical examination done routinely during school years
5. Medical history and treatment during the course of school years
6. Record follow up of the illnesses which require and of referrals to any doctor or hospital.
7. Record follow up of the illnesses by the parents and teachers

Advantages:

1. Sick and weak children not growing up physically and mentally along normal patterns can be picked up.
2. A careful recording of observations about the student can help in the early detection of defects and illness so that the child can be referred in good time for investigations and treatment.
3. Information about the various ailments occuring among the students can serve as an index of the state of health of children as well as of the community in general. It can help to take effective measures both in the school and in the community.

4. Priorities can be set intelligently.
5. Changes in overall health status of school children appreciated.
6. Those with communicable diseases like TB, leprosy can be given a good follow up treatment.
7. Record of health right through the school days is available to the child for later life.
8. Helpful for the doctors and hospital where school children referred in case of major illness.
9. Records are also helpful in planning for health education programmes and for selection of health topics according to the prevailing health problems. After studying the health record formats being used in several places the following details are mentions.

It is essential that some one be given the responsibility of maintaining health records which should be periodically supervised, and intelligent use of them made. Credit in some way may have to be given to the person incharge for this additional work load if it becomes very heavy. It can be a teacher or even the headmaster.

Important:

1. Keep records simple and up to date.
2. See that entries are made accurately.
3. Keep the records confidential and keep them in a safe place.

List all records required for effective implementation of school health programme:

1. School level
2. District level Number of schools managed by
3. State level particular organiation.

Information Required from every School Health Unit:

Name of School, address and date of establishment	:	
Name of Principal	:	
Management	:	Private
		Local Body (Panchayat / Municipality)
		Government (State / Central)
School Strength	:	Boys: / Girls:
Number of Classes	:	No. of Class Rooms:
Total Number of Sections	:	
Strength in each class or section	:	Boys: / Girls:
Number of absentees per day	:	
Absenteeism due to illness (average percentage total absenteeism)	:	
Tuition fees per month	:	

Data to be collected by class teachers:

Location of School	:	
Area and size of class rooms	:	Area wise if possible or merely adequate / inadequate
No. of windows, ventilators and doors in each class	:	Number Size Cross Ventilation
Seating arrangement	:	
Lighting	:	electricity or any other

Floor	:	mud / concrete
Walls	:	mud, brick, plaster
Roof	:	asbestos, tin, tiles, concrete
Play ground	:	
Verandah	:	
Toilets	:	Urinals and latrines for boys and girls with septic tank with running water / with water avail- able in toilet or water obtained in a tin or pot from well, pump etc.
Clean water supply (Well, Tap, Hand pump)	:	for drinking
		chlorinated how often?
		cleaning done by whom ?
		does it dry up in summer?
		water pumped out
		pulled out in bucket
		storage of water in pots / steel drums
Delivery of health care Who provides	:	PHC / Private practitioner/ Mission Hospital
How often	:	Biannual / annual / once in 2 years
Constituents of health services	:	Yes / No
		immunization
		medical check up
		referrals
		follow up
Health Education given to students	:	as part of curriculum

Stage	Date	Where referred -Dispensary -PHC -Hospital	Reason for referal	Outcome
Primary School				
Middle School				
High School				

Daily Records of children coming for treatment of simple ailments can be kept in a register. All the above records can be kept in a Register with 2-3 pages denoted for each child, if separate health cards are not easy to get them.

Cumulative School Health Records

Name ______________________________ Age ____________ Sex ______

Date of Birth___________ Class ______ School ___________________________

Town or Village _________________________ District ____________________

1. Family History - Number of family members

	Education	Occupation	Income	Health status
Father				
Mother				
siblings				

2. Home Conditions:	Type of dwelling - pucca \ kaccha	
	No. of rooms	
	No. of occupants	
	Drinking water facilities	
	Latrine facilities.	

3. Immunization Record :		If so when
	BCG	
	Diphtheria	
	Pertussis	
	Tetanus	
	Polio	
	Measles	
	Others	
4. History of Past health condition:		If so, frequency of episodes and date of last occurance
	fits	
	discharging ears	
	rupture	
	asthma	
	a chronic cough	
	any other	
5. Personal details following communicable diseases :		Year of infliction
	Measles	
	whooping cough	
	diphtheria	
	chicken pox	

(Note: The above data are collected at the time of joining school only i.e. only once)

General Condition - Teacher's Observation

Height		
Weight		
Chest (if easily possible)		
Personal hygiene:		
Regularity of attendance	Good \ Average \ Poor	
Educational attainments	Good \ Average \ Poor	
Food habits	Good \ Average \ Poor	
Posture	Good \ Average \ Poor	
Gait	Normal \ abnormal	
Speech	Stammering Nasal	
Behaviour	marked aggressiveness shy with little group participation nail biting under restlessness and anxiety looks sad and withdrawn excessive use of toilets	
Skin*	Sores and ulcers Scabies Skin eruption Hansen's patches Ring worm Dry rough skin Excessive itching	
Nutrition	Good \ Fair \ Poor tires easily, frequent headaches, under-weight, very thin.	
Protein Calorie Deficiency	Under weight, tires easily	

Vit. A. deficiency	Xerophthalmia Bitot's spots Keratomalacia Night Blindness	
Vit. B. deficiency	Sore red tongue Angular stomatitis (cracks at the angle of the mouth) Cheilosis (fissured lips) Beri Beri	
Vit.C deficiency	Bleeding gums	
Vit.D. deficiency	Rickets	
Iron deficiency	Anemia Paller, tires easily	
Iodine deficiency	Goitre	
Lymph nodes	Cervical submandibular Axillary Urinogenital	
Scalp and Hair	Pediculosis (lice) Alopocia (bald spots) Hypopigmental	
Ear	Wax Discharge (Rt. \ Lt.) Frequent earache Failure to hear (turning head to hear) Inattention	
Eyes	Trachoma Conjunctivitis (Sore eyes) Styes Blephoritis Squint Corneal opacity Vision Right \ Left	
Nose	Chronic nasal discharge Nasal septal defect	

Teeth and Gums	Caries decayed tooth Pyorhoea red bleeding gums Irregular teeth	
Mouth	Mouth breathing Bad odour Red sore tongue Ulcers	
Throat	Frequent sore throat Enlarged tonsils Enlarged adenoids	
Neck	Thyroid swelling	
Thorax	Bony cage abnormality (Pigeon chest, flattening, rickety)	
Respiratory System*	Tuberculosis Asthma Bronchitis	
Lung findings* Lt. \ Rt.	Pleurisy Pneumonia	
Heart Murmurs*	Functional \ Organic	
Bones and Joints	Orthopedic defects	
Spine Deformity	Scoliosis kyphosis etc.	
Bony joint	Knock knees, bow-legs, flat feet	
Acquired defects	due to fracture dislocations following accidents	
Abdomen*	Spleen enlargement Liver enlargement Any other masses	
Nervous System*	Paralysis Epilepsy	
Any other		

* To be seen by the doctor though during medical check ups other things are not to be neglected.

- The above record can be filled by a trained teacher, with the doctor filling in what the former is unable to fill.
- Keeping both their findings together systemwise has two advantages:

1. Teachers findings can be confirmed, and given due importance instead of the doctor or nurse, merely doing his \ her examination independently, completely ignoring teachers findings.
2. It is comprehensive as it deals with all the health aspects of a child and not half of what the teacher sees it.

The above format gives exactly what teacher, nurse, or doctor should look for, and there would be less chances of omission.

Ticking the result Yes \ No makes it easier to record, and interpret and collect statistical data if needed.

Medical Officers Comments on

1. Health Problems in the family
2. Previous health problems of the child
3. Mental status and scholastic performance of the child
4. Immunization status
5. Congenital anomalies and curative methods possible

Health appraisal by Doctor \ Health Personnel

CODE:		
	S	Satisfactory
	X	Needs observation
	XX	Needs immediate attention
	C	Correction of defects
	PD	Permanent defect, correction not possible.

(See Appendix for a simplified Student Health Card.).

CHAPTER - XI

COMMUNITY PARTICIPATION

This chapter deals with community participation in school programmes, particularly in School Health. It is to give teachers an insight into various aspects of community participation and also enhance their ability to enlist community support.

The community means a group of people who have common interests, needs and problems, living in inter dependency within a particular area - village or locality.

Generally it has been observed that the programmes introduced by the governmental agencies often do not achieve their goals to the desired extent, without sufficient community support. Active participation and involvement of the community is needed to meet the specific educational and health needs of the community and the qualitative changes required in the present context.

Generally, we tend to believe that help rendered by the community is community participation. But it is not always true. Participation has a wider connotation. Participation may also be of different types from the view point of willingness and desire of the community to participate in a programme.

The school is an integral part of the society and therefore it has to have the community support and participation.

There are areas where community's support through participation is needed and there are areas where school can play a positive role in enlisting community participation by bringing itself nearer to the community.

Thus the School and the community should work as co-partners which means, the community should be involved in the affairs of the school. A sense of belongingness and sharing is to be created among the community members for more concern and better participation.

There should be an organisation through which the community can participate. It can be called a committee or parent teacher association. What ever may be the set up, it has to be operationalised and activated; wherever a voluntary organisation exists, they should be approached for help.

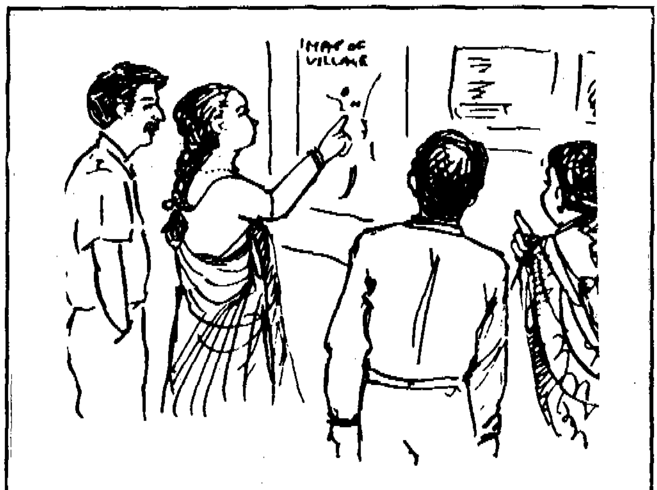
Involvement of the Community:

The emphasis on environment and work experience and also on the development of desirable personality traits and values, requires more urgently than ever before, the involvement of the community in supporting the school's activities. As the community comes to accept the school as its own and realises the value of education, many problems now being faced will be solved.

The community may be involved in three major ways:

a) as parents:

- attend parent teacher meetings and seek to understand the school's programme
- ensure attendance
- provide opportunity and assistance for doing homework.



b) as citizens: (and therefore owners and indirect managers of the schoo

- provide financial and other support for extending facilities as indivi
- help with organising special functions, games, art, music activities, and operation of midday meal scheme.
- giving education a high priority in the development programmes of the panchayat, mandal praja parishad, zilla praja parishad, municipality and municipal corporation in towns and cities.

c) as agencies providing facilities for work experience:

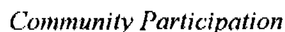
- the relevant members of the community and panchayat should assist the teacher as and when necessary in organsing practical work related to:
- agriculture and animal husbandry.
- public health and cleanliness
- road building
- local artisans skills (blacksmith, carpenter, tailor etc.,)
- local industries

Organising School Health Committee:

Through cooperative action we can achieve more than through individual action. It is in this context, we should think of organising a School Health Committee.

An effective school health committee might consist of about ten members with the following persons:

1. Headmaster \ Principal \ Manager
2. Teachers (especially interested in the programme)
3. Representatives from parents
4. One health person (Nurse or community health worker)
5. One student representative



The main aim would be to promote the health of the community especially the health of the children. It would also identify and solve school health problems. Finally it would also share the responsibilities and decentralise decision making.

If a school management committee already exists, perhaps special meetings could be organised in order to discuss and plan for the health and well being of the children.

The committee will meet every month and the main function would be to plan, guide supervise and evaluate the school health programme. The members will share the responsibilities and monitor activities regularly in order to achieve the objectives set for the school health programme. The committee will also be responsible for mobilising resources required for the school health programme. The committee must ensure active involvement and participation of the community.

Other local organisations existing in the community (Mahila Mandali,youth club, village development committee in rural areas and neighbourhood committee in urban areas) should be fully taped or best utilised in promoting health of the community and school age group children.

Functions and composition of the committee would depend upon local interest and needs. The following are some useful guidelines in this direction.

1. The purpose, objectives and policies of the committee should be stated clearly and reviewed periodically.
2. The committee should include representation from parents, teachers and health department.
3. Each member agency should be given an opportunity to select its own representative who may be selected for specified period of time.
4. The committee should meet at regular intervals with prepared agenda.
5. Particular attention should be given to the problems that require joint action by the community, school and professional group.
6. Although long term projects are necessary and appropriate projects which have a good chance of success in a short period of time should begin first.
7. Emphasis should be placed on solving pertinent problems rather than organisation or routine procedures.

Some of the functions of the School Health Committee are:

1. Survey of the entire school health programme for strengths and weaknesses.
2. Collect detailed data on the morbidity pattern, absenteeism due to illness etc.
3. Analyse school and community resources for meeting certain health problems.
4. Recommend to School Administration a course of action for meeting each problem.
5. Evaluate the influence of recommended improvements that are put into operation.
6. Develop long range plans for coordination of the school and community health programme.

Bring the school and Community closer:

As a trained teacher in school health, she can bring the school and community closer. It is possible with her skills and experience to contribute to a healthier community. Many a time, the school is seen as a place for children and teachers. It is important to involve parents in the life of the school. What the children learn in the school should be supported by the parents and the community. The school and the children should learn to respect the traditions and the culture of their communities. There are different ways of bringing the school and the community closer. Here are some ideas, you can think of more.

Health Worker:

Local Health Worker can be invited to the school. She can explain her job to the children, and tell them about the diseases, how she treats them. She can explain when the children can visit her centre and for what type of health problems. Of course the children can make a visit to the local dispensary or health centre.

A doctor at a local hospital:

If doctor is available in the village or town, he \ she can be requested to make a visit to the school. He can talk about the hospital, services rendered from that institution. Children can also make a visit to the hospital to see for themselves how the sick people suffer and what kind of steps would have prevented illness.

The village leader / panchayat president or any local leader:

A local leader will be very helpful whenever a community programme on health is organised. They can encourage children and teachers in their efforts. They can also understand the problems of the school, teachers and children and bring in more of community's participation wherever necessary.

Other experts from the community:

There may be some experts in the community -an engineer, community development officer, special education teacher. They may have skills and resources which can be made use of in the school health programme. They can be invited to the school.

Children's visit to homes:

Children's visit to the community, by visiting homes of other children can create a better relationship with the school. This will help the children to observe various health habits. This would be a further learning process in developing health habits among the children. This will also facilitate a link between school going children and non school going children. This will also help in promoting child to child programme through which basic health messages could be passed on to non-school going children of the same community.

Health map of the community:

Children could make a map of the community indicating health hazards. They could discuss about their observations and plan what action the community can take, what action school children can take in making the community a healthy place. Children can demonstrate different strategies through role-play or drama. Children could make another map indicating health services or resources available in the community. This would be a good education process for the children.

Children are important members of the community, and there are many things they can do to make their neighbourhood a healthier and safer place. They can

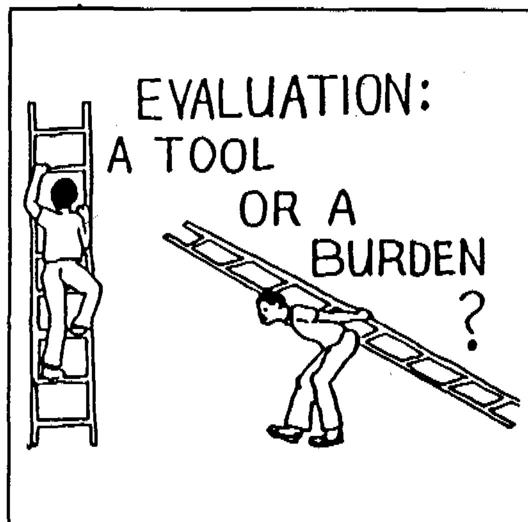
- find out what helps or prevents children from growing up safe and healthy
- find out about health care resources and services in the community
- think of ways of helping families in the community to improve the health and safety of their children
- take direct action to improve community health and safety
- pass on ideas about good health and safety to their own families, and to younger children.

Chldren can join together in groups such as 'Health Scouts' to make the community healthier.

CHAPTER - XII

MONITORING AND EVALUATION

Beginning with a discussion of the terms, viz., monitoring and evaluation the concluding chapter accounts for their significance in the school health programmes. It further examines the need for effective ways of planning for evaluation. It also explains how one should choose appropriate evaluation methods needed and how the existing records and written materials are to be used for the purpose. Some simple guidelines are also include at the end of the chapter to help the teachers in preparing the formats for evaluation.



Monitoring:

Project monitoring is an essential tool for proper management of a project. A constant and close supervision of all activities helps detect snags well in time for remedial action. It also helps to understand the reasons for varied degree of performance and levels of achievement of the objectives.

Monitoring is the continuous or periodic review and surveillance (over seeing) by management at every level of hierarchy of the implementation of an activity. It is to ensure that input deliveries, work schedules, targeted outputs and other required actions are proceeding according to action plan.

The purpose of monitoring is to achieve efficient and effective project performance by providing feedback to project management at all levels. This enables management to improve operational plans and to take timely correction in case of short fall and constraints. Monitoring is thus a part of the management information system and is an internal activity. Monitoring needs to be conducted by those responsible for project / programme implementation at every level of management hierarchy.

Precise and regular monitoring is very important to ensure that planned activities proceed at the desired pace. Monitoring would be carried out at various levels.

a. State	e. Teachers
b. District	f. Students
c. PHC	g. Parents
d. School	h. Community

The focal point for implementation of the project will be the school. Hence, it is necessary that regular reporting system be generated from the schools. The frequency of such reports could be quarterly. The reporting need to be kept to a bare minimum.

The monitoring schedule would cover all major project activities.

Evaluation:

Every programme needs to be evaluated in order to judge the impact. Continuous evaluation helps us not only to determine its impact but also to make any midcourse corrections if required. The evaluation of any programme is based on its objects.

Certain effects of the Project are obvious because they are readily observable in the classrooms. The motivation and enthusiasm of the students, the commitment of the teachers, the involvement of the parents and community.

Other hoped-for effects are more subtle to discern because they happen primarily with the mind and feeling of the children and are more long-term in their expression. Are children, for example, actually developing good health habits that will become part of their life styles as adolescents and adults? What are their attitudes towards themselves, one another, and their health? Has the Project provided the kinds of experiences that help children develop strong self-concepts and decision-making abilities?

Suppose the objectives of the school health programme are develop in children an awareness of their health and nutrition needs and to bring about a change in their day-to-day life style. Evaluation of the programme therefore includes collecting evidence of learning attained by school children, the behavioural changes observed in them, the changes in the classroom / school climate and the interaction pattern with their younger brothers and sisters and parents.

Evaluation is the process of finding out how well things are being done. It tries to answer the questions:

- How much are we accomplishing in terms of what we hoped for and planned?
- Where have we done well?
- Where do we need improvement?

The main purpose of evaluation is to see to what extent the specified objectives have been achieved.

Evaluation in the context of school health is concerned with the assessment of effects - benefits (intermediate objectives) impact (long term objectives) on the beneficiaries, who are preferably classified into students, parents and teachers. Its concerns are: who or which group has benefited (or has been adversely affected), by how much (compared to the situation before the activity), in what manner (directly or indirectly), and why (establishing casual relationships between activities and results to the extent possible).

The various elements that we think of under the School Health Programme are:

(a) Students own health awareness and behavioural changes
  knowledge
  understanding
  attitude
  practice

(b) The curriculum
  the content
  teaching / learning methods

(c) Training courses
  orientation training
  refresher training
  advanced training

(d) The Administrative logistics
  administrative procedures
  commitment

(e) The impact
  the final evaluation

STEPS IN EVALUATION:

Step 1 Determine what is to be evaluated

Step 2 Select suitable tools for measurement

Step 3 Measure the outcome

Step 4 Compare results

Step 5 Arrive at conclusions

Evaluation has certain well defined steps.

The first step of evaluation is to determine and clarify what is to be evaluated.

The second step is to select the suitable tools for measurement.

The third step is to measure the learning outcome by using the already selected tool i.e., the evaluator has to administer the test. After administering, he has to score and find out how much each student has learned.

The fourth step is to compare the result of measurement with what is to be expected. It is possible that one may find that 90 per cent of students know and practice what was expected.

The last step is to compare the results or actual outcome with the expected outcome and arrive at some conclusions.

The objectives of the evaluation must reflect the main objectives of the School Health Programme:

a. Improved awareness and knowledge of health, nutrition and hygiene and environmental sanitation in the target groups-children, teachers and parents;

b. The application of knowledge as revealed by

   i) knowledge of nutrition revealed by changes in food habits (teachers, parents pupils)

   ii) improvement of nutritional and health status (pupils)

Principles of Evaluation:

1. It should embrace all important functions of S.H.P including instruction and activities.

2. It should be concerned both with the end products and the means to reach these ends.

3. It should touch upon all health aspects of school including.
    - curriculum
    - administration - finances
    - community relations

4. Evaluation should be with full cooperation from all those involved in S.H.P., administration , teachers, parents, health personnel.

5. Evaluation should be focussed upon the important values which underlie the health programme of the school and the success and failure of the programme should be assessed in terms of meeting these values held.

6. Long range evaluation should be planned and carried out.

7. Collection of data and maintenance of records are valuable as they help in identifying the weaknesses and priorities for action .

Who evaluates ?

Evaluation of students i.e. knowledge attitudes about health habits (measurement of health status) can be done by the teacher concerned.

Evaluation of the programme itself of improvements in school, home and community have to be done by school health council / or committee and some concerned members from health or education field.

Here are some simple ways to find knowledge and behaviour changes among children.

Using Simple Questions for children:

I. Fill in the Blanks

II. Completing the sentences

III. Match the Following

IV. True or False

V. Tick the correct Answer

VI. Multiple choice Items

Using Drawings

Using Dramatics (Role playing)

Through Visitors Observation

Evaluation should not only measure whether we have achieved our goals. It should help us judge whether our goals were appropriate in the first place.

I. Fill in the blanks:

1. Drinking dirty water causes ______________________
   (Cough / T.B / Diarrhoea)

2. Papaya, Carrot and Mango are good for ______________
   (Eye / Teeth / Ears)

3. Anaemia is caused due to lack of ______________________
   (Calcium / Iron / Vitamin 'A')

II. Complete the following sentences with suitable words.

1. We need free __________ free from dust to breath.

2. Fruits and vegetable must be ____________ properly, before use.

3. Germinated grains like ________ and ________ in the raw form are good for health.

III. Match the following:

1.	Eating food with dirty nails and hands	(a)	Mosquitoes breed
2.	In stagnant water ditches	(b)	are good for the eyes
3.	Carrot, milk, Papaya, Mango	(c)	symptoms of skin diseases
4.	Itching, boils and rash	(d)	increases iron content in the blood
5.	Eating sprouted pulses	(e)	leads to worms in the jaggery stomach

Deficiency Diseases

a.	Cereals	i) weakness
b.	green leafy vegetable	ii) defect in eye sight
c.	fleshy foods	iii) stunted growth

IV. True or False:

1.	You should face the source of light while reading	True-False
2.	People having fever should not be given anything to eat	True-False
3.	Vegetables should be washed before cutting	True-False
4.	While eating we should keep on drinking water in between	True-False
5.	Sweet and sticky foods are good for teeth	True-False

V. Tick the correct answer:

1. To keep ourselves clean we should
   - a. bathe some times
   - b. not cut long nails
   - c. wear clean clothes
   - d. comb our hair some times

2. To keep our school premises clean we should
   - a. write on the walls and windows of our class
   - b. throw papers all over the ground
   - c. clean the class everyday and make use of dustbin
   - d. keep toilets dirty

VI. Multiple choice items:

1. Where the digested food is absorbed by the blood stream? (large intestine, mouth, stomach, small intestine)
2. Carbohydrate is present in (green leafy vegetables, potato, eggs, fat, amla)
3. Select the protective foods from the following : wheat, rice, water, sugar, milk, fat, fruits, egg, meat, fish, vegetable.

VII. Other questions:

1.	Does your child wash hands	Yes / No
	before eating	Yes / No
	after toilet	Yes / No
2.	Does your child clean toilet	Yes / No
3.	Is your child happy at meal times	Yes / No
4.	Does your child go to bed in time	Yes / No

Other ideas for evaluation:

1. Observation of the pupils by the teachers: (can be scored)

Checklist by teacher: Always-usually-seldom- never

- Hands, face, neck, ears clean
- Finger nails clean and cut
- Clothes neat and clean
- Hair washed and combed
- Hands washed before meals
- Good sitting, standing posture

2. Interviews with students, with parents of students with poor health habits.

3. Diaries and other autobiographical records maintained by students.

4. Health and growth records.

   Average nutritional status of children, percentage of malnourished children, degree of malnutrition can be found.

5. Using drawings:

   Child can draw what would be the health environment. In terms of content, the drawing can convey a lot more than a written answer or a simple report.

6. Using Dramatics (Role Playing):

   Children can depict different situations how health hazards can be overcome at home, at school and among children themselves. They can make their potential to change their situation.

7. Visitors:

   The teachers or project managers can ask all visitors to write down their observations and opinions of the programme. The school health team can use these outside view points to help evaluate and improve their programme.

As part of School Health Programme Evaluation, the following must be taken into account.

1. Improved community health status.
2. Improved Environmental profile.
3. Improved awareness on health issues.
4. Improved behaviour.
5. Increased community participation (PTA) and cooperation.
6. Increased use of sanitary facilities like latrine etc.
7. Attitude changes among children and the community.

Impact Evaluation:

Impact evaluation or final evaluation would necessitate collection of base line data on various parameters, as well as repeating the same at the end of the Project to assess the changes, if any. It assumes that base line data must be accurate. Thus an effective final evaluation could be made after a period of three or five years.

Different aspects that need to be included in the evaluation are:

a. Knowledge, Attitude and Practice of teachers, students children and community.
b. Pre and Post-evaluation of training of teachers
c. Morbidity survey of children
d. Nutritional survey of children
e. Environmental conditions in the school

Subjects for research or short studies:

1. Effect of health education on health knowledge, attitude, behaviour and health status.
2. Educational strategies that are most effective in eliciting and sustaining attitude change to bring desired behaviour change.
3. Health improvement and school performance (attendance, interest, intelligence, understanding, practices etc.).
4. Situation Analysis of school environment.
5. Attitudes of teachers in school health programme.
6. Impact of school health programme at school, family and community.
7. Effects of good sanitation on health status of school children.
8. Attitudes of Administration (Health and Education) Departments concerned in School Health Programme.
9. Knowledge, attitudes and practices (KAP) of students, families and teachers before and after the school health progamme.
10. Ways of motivating teachers towards involvement in health teaching.
11. Process in child to child programme.
12. Case studies.

APPENDIX - 1

SCHOOL HEALTH SERVICES IN ANDHRA PRADESH

School Health Services in Andhra Pradesh:

In Andhra Pradesh School Medical Inspection was introduced in 1935 during Nizam's regime. The State could take credit for having initiated the school health services programme early during the decade 1960-70, but its development was imperfect and sporadic. At the district level, " District school health teams" were established but they were abolished due to financial constraints. The primary health centres are carrying out the services but not in a planned and systematic way. It can be said that the programme is on the rails but it requires lot of support.

In 1973, Central Referral School Health clinics were introduced in the urban areas of Hyderabad, Tirupati and Visakhapatnam which were attached to Paediatric Teaching Hospitals. The purpose of these clinics was to provide health check-up for the school children and provide health education to the students and teachers during their visits to school.

Similar, to many other programmes, the Government of India have been also extending support to school health programme. As a result, an intensive pilot project was launched during 1982, in a primary health centre (Donubai PHC) Srikakulam district, but it did not survive for long. Further, during 1984-85, Government of India proposed the extension of this scheme to five more PHC's but it could not operate due to financial constraints.

The school health service programme was introduced from 2nd October, 1985 under the Title "Telugu chiranjeevula sukheebhavam".

Salient Features of School Health Services Programme:

With a view to improving the health standards of the primary school children in the state, the government decided to strengthen the existing school health services programme. The activities proposed under the programme are in conformity with the

recommendations of different committees. The programme features differ significantly from the previous programme.

The highlights were as follows:

1. Opening of school health records for individual students, studying from 1-5 standards and who were in the age-group of 6-11 years.
2. Extension of the scheme to all the 41,291 schools covering a student population of about 60 lakhs in the age group of 6-11 years constituting 10% of the population of the state.
3. Examination of each student twice a year by the medical officers of the PHC.
4. Maintaining the school health card for a period of five years from 1-5 standards till the student leaves the school.
5. To examine all the teachers working in the primary schools numbering about 81,722 (60,335 male and 21,387 female teachers), providing a three day training for each teacher and headmaster concerned at PHC or block headquarters or any other suitable place. The curriculum for the inservice training programme of the teachers was developed and pretested.

The UNICEF and the Andhra Pradesh Voluntary Health Association, Hyderabad were also very actively involved (1985-86) in designing of training curriculum and providing initial training for teacher as part of demonstration training.

The student health card has been modified from the previous health cards keeping in view the present day requirements.

Inservice Training:

In the school health services programme, due recognition has been given for the inservice training of all the members of the school health team namely, the medical officers, health personnel and the teachers. Though the Government of India have suggested seven days training programme for teachers, the state government reduced it to three days, without sacrificing the quality greatly. The author was associated from the very beginning with designing the programme, preparation of training curricula.

The whole spectrum of training started with appreciation seminars for the senior administrators of the education department at the state, region, district and block levels. The medical officers and health staff served as trainers for teacher-training. The State Health Education Bureau and the Regional Health and Family Welfare training centres (RHFWTCs) and the Mandal PHCs were also associated with the organisation of training programme of teachers.

Course contents for Inservice Training:

The course contents for inservice training for the medical officers, health personnel and teachers are based on the students requirements. Care has been taken to work out the objective and course contents in a very scientific and systematic way.

Pilot Study:

Government decided to take up a pilot study both in urban and rural areas to work out the feasibility of implementing the comprehensive school health services programme throughout the state. For this purpose, the Panchayat Samithi, Hayatnagar with the PHC and the school health clinics of Hyderabad were chosen and the results were found to be encouraging. These studies were conducted in June, 1985 and after careful analysis of the results, the Government approved the state-wide scheme involving an expenditure about Rs. 3.08 crores - perhaps the first of its kind in the entire country in terms of allotment and coverage.

Health Education Equipment:

For health education, each of the 41,291 schools were sanctioned an amount of Rs.200/- for production / procurement of health education materials.

Team approach to School Health Services:

In view of the high priority accorded by the government to school health programme, a team of doctors belonging to specialties like dental health, pediatrics and Social and Preventive Medicine (SPM) visited the school as a team and examined the children. The common ailments found among the children were primarily anaemia, respiratory infections, water borne diseases, skin infections, dental diseases etc., (30 per cent). About 2.25 per cent required referral services to specialists for which provision was made. Immunization was given priority for the school children.

Computerisation of Data:

An extremely significant innovative feature of the school health programme in Andhra Pradesh was the computerisation of data collected in the school health cards. The information obtained from computer analyses was utilised for intervention measures, planning of better health services not only for school children but also for the general population of the state.

ANDHRA PRADESH SCHOOL HEALTH PROJECT (APSHP):

The Government of Andhra Pradesh requested the Overseas Development Administration (ODA) Govt. of U.K. in December, 1987 for financial support for the development of their existing school health programme. They also requested the health programme to run in parallel with phase II of the Andhra Pradesh Primary Educaion Project (APPEP). The U.K. consultants and planning teams visited the place, had extensive discussions and organised planning workshops in 1989. Finally the ODA approved in Jan. 1991 its financial assistance to the School Health Project of Andhra Pradesh for an initial period of five years, and assurance for support for another three years.

The aim of the Project is to improve the health of primary school children throughout Andhra Pradesh. This will be achieved by reorganising and strengthening the existing school health services. In close association with the Andhra Pradesh Primary Education Project (APPEP) phase II, the project will train teachers to provide health education, screen school children for targeted diseases and carry out simple first-aid, train health personnel to screen, treat and refer school children and provide health education to the community; improve management structures and practices and increase research activities. The project also proposed to strengthen three urban school Health clinics at Visakhapatnam, Hyderabad and Tirupathi.

To achieve the objectives and to carry out the functions the project is equipped with three cells viz., Health Promotion, Training and research, Monitoring and Evaluation each headed by a Deputy Director with overall supervision of Project Director.

At district level a post of District School Health Implementation Manager (D.S.H.I.M) is created in the office District Medical and Health Officer to carry out the project functions effectively under the supervision of D.M. & H.O.

The project is being implemented in phases covering the districts as follows:

Districts in the Year 1:	1. Visakhapatnam	2. Krishna	3. Nellore
	4. Chittor	5.Cuddapah	6. Mahabubnagar
	7. Nalgonda	8. Rangareddy	9. Kurnool
Districts in the Year 2:	1. Srikakulam	2. East Godavari	3. Prakasam
	4. Anantapur	5. Medak	6. Adilabad
	7. Karimnagar.		
Districts in the Year 3:	1. Vijayanagaram	2. West Godavari	3. Guntur
	4. Nizamabad	5. Warangal	6 Khammam
	7. Hyderabad		

In each district all the mandals will be covered over a period of five years at the rate of 20% each year.

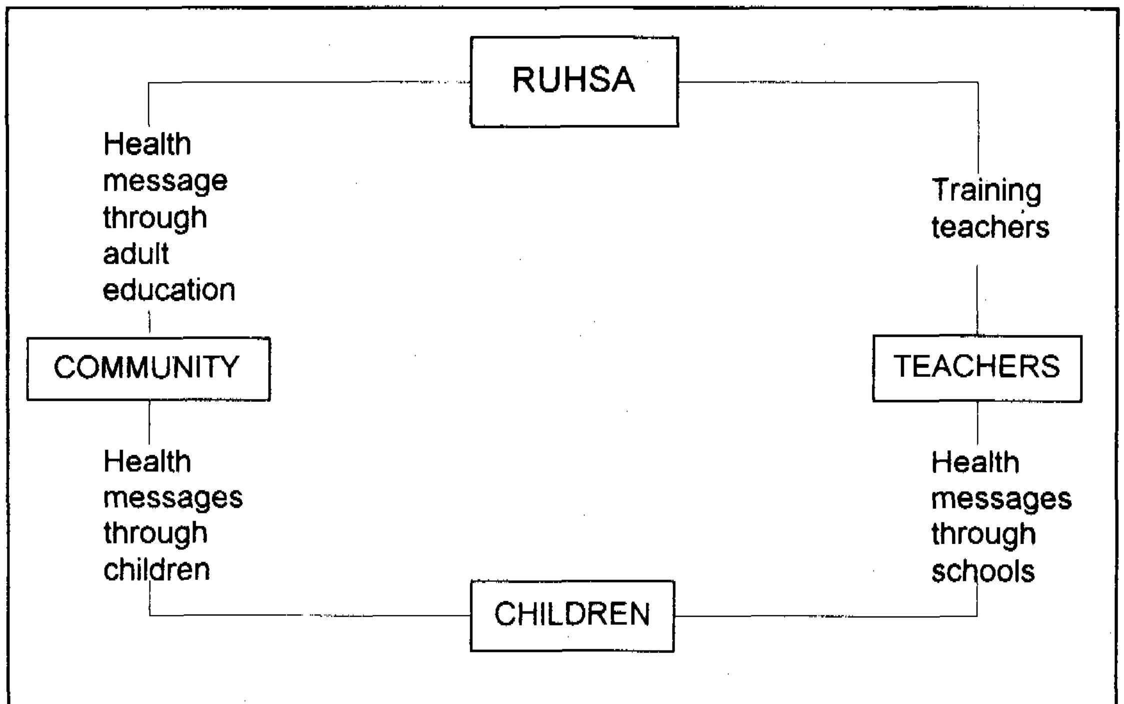
APPENDIX - 2

TEACHING HEALTH TO SCHOOL CHILDREN

-AN EXPERIMENT

This experiment is the achievement of *RUHSA's effort to institutionalise health education at school level in the K.V.Kuppam block of North Arcot District, Tamil Nadu.

The main objective of the programme was to develop health consciousness in the school going children of K.V.Kuppam block and through them to disseminate health messages to the community. It was done through teaching health as a regular subject in the schools and training teachers for the same.



* RUHSA - Rural Unit for Health and Social Affairs is a Department of the Christian Medical College and Hospital, Vellore, North Arcot district, Tamil Nadu

RUHSA initiated this programme as a pilot project in 1979. With the experience gained from the pilot project, instructional materials such as core syllabus, guide books for teachers and audio-visual aids in health care were developed for VI, VII and VIII grades of upper primary education. Necessary cooperation was sought from the government departments to implement the programme in a few selected schools of the block on an experimental basis during moral instruction periods. An orientation course was organised for the teachers in 1980-81 in order to equip the teachers with knowledge and skills needed for implementation of the programme.

The programme has been implemented in eleven selected schools of the block from the academic year 1982-83. Thus they trained 120 teachers and thus exposed nearly 10,000 pupils to concepts and practices in health. RUHSA also carried out the following activities in collaboration with them to sustain the programme.

1. Helped teachers to organise health councils / committee in the schools.
2. Organised refresher courses for teachers.
3. A newsletter was initiated to share experiences of the efforts that were taken in health promotion through children.
4. Regular visits were made to the schools to know the progress and difficulties in implementation and to take necessary steps to overcome the problems.

At the end of three years, the programme effectiveness was assessed and the following were some of the high lights:

1. created basic understanding about health and its related practices among school children.
2. inculcated health habits among children particularly in hygiene and oral health practices.
3. developed positive attitudes, interest and readiness to receive further health information even in higher classes.
4. reactions of teachers have been favourable.
5. health information disseminated from children to their parents and siblings.
6. parents expressed that they observed some behavioural changes among the children related to personal hygiene and environmental sanitation.

APPENDIX - 3

SCHOOL HEALTH PROGRAMME IN ORISSA

United Artists' Association (UAA) Ganjam dt. of Orissa, started a pilot project on school health programme in 1985 with 12 schools. Initially a team from the Association had a meeting with the heads of the schools and brief orientation on school health was given. This was followed by a ten-day training for teachers. Later with support and guidance from Voluntary Health Association of India, New Delhi, the programme expanded to 50 more schools through trained teachers.

As a second stage, teachers decided to form 7 zones, comprising of 8 to 10 schools in each zone. The main idea was that one of the teachers in each zone will be able to guide other teachers in effective implementation of school health programme. Thus a central committee was formed with the teacher representatives from each zone, one representative each from health and education departments and two from UAA. As a result of discussions at this meeting, school health committee comprising of student - representative, teacher - representative, one representative from the parents and local health functionaries was formed. The head of the institution became the chairperson of the school health committee in each school.

The organisation (UAA) conducted regular training for teachers and supplied educational materials and relevant information from time to time. They visited schools regularly for better follow-up. New idea generated. Certain number of students with interest from each school were trained as student health guides. They were very enthusiastic and took up activities like survey of target children for immunization, identification of physically handicapped children for financial assistance from government, organising exhibitions, staging drama, puppet shows etc.

The school health committee raised funds in addition to some small grant provided by the organisation(UAA) for the purpose of providing sanitary facilities i.e. latrine and urinals in the school campus. Two schools constructed open wells. The teacher and students organised lottery, staged short dramas on health education to raise funds for the purpose. All most all the schools created ' School Health Fund ' to meet emergency needs.

The students also contributed regularly to this fund. Every school owned a First Aid Box and some schools obtained low cost water filters by utilising the health funds.

The organisation (UAA) extended the programme to another 100 more schools in 1987-88 making a total of 162 schools in the project. At this phase a training programme on child-to-child was organised initially for 17 teachers and 25 students in about 30 schools. The school planned to involve the students to promote health messages to other children and the community.

APPENDIX - 4

SCHOOL HEALTH PROGRAMME AT KANGAZA, KERALA

TEACHER - PUPIL INTENSIVE STRATEGY

Background:

The programme area is rural, situated in the hilly belt in kotayam district of central Kerala. 30 schools with a total student population of 30,000 were selected for implementation. In this area almost every child attends school and the drop-out rate at primary level is extremely low. The adult literacy rate is nearly 95 per cent.

The beginnings:

The programme was started in 1975. The idea of training of teachers and health workers was discussed with school administrators. Although initially skeptical about the success, the schools decided to cooperate in this initiative. The health problems analysed in a few selected schools became a basis for training the teachers.

A three-tier approach was adopted. The First tier comprises of a trained teacher with a school unit at the peripheral. The school units were later linked to primary health centres or visiting health team where the teacher could refer problem cases as the second tier. The base hospital was responsible for referral services and training of teachers and this health care institution was used as the third tier.

The programme in progress:

The programme had aimed to make teachers and students aware of primary health care, what it stands for and what role they have to play in it. In addition to providing simple and practical solutions to health related problems at school level, the programme attempted to carry to the community the message of primary health care in such areas as nutrition, parasitic and communicable diseases, sanitation and safe water.

Phase I - Teachers as Health Workers (1975-76):

The programme started off with the training of 30 teachers from 10 selected schools. The training was task-oriented. The initial training was for four days. After the training the trainees organised a health unit in each school by acquiring the simple items of drugs and equipment. The drugs used initially by the teacher included specific remedies against scabies, skin sepsis, red eye and the vitamins and drugs for simple ailments. The programme was well received by the school community and the teachers enjoyed their new role.

Phase II Students as participants and Beneficiaries (1976-77):

A new idea emerged during this period that students are not merely beneficiaries but active participants. Seventy-five students were trained at the base hospital for the participatory role. Thus the students acquired skills to assist the teacher in record maintenance, daily appraisal of pupils, assist teachers in screening procedures and to create health awareness among pupils.

The review of the work at the end of the year showed that improvement of attendance in school, utilisation of simple curative facilities at school health unit, significant reduction of common health problems among children and better understanding and health awareness among the pupils. The teachers were given initial training and refresher training in different batches. Along with this, selected students from each school were also trained.

Phase III Teachers and students play a role in the Village Health Programme (1977-78):

During this period, a comprehensive village health and development scheme was initiated in the areas around the schools. The teachers and students were actively involved in this programme. The school health network was strengthened by incorporating more schools. A seven point programme for student was formulated with the following targets:

1. get ten under - fives immunized.
2. vitamin 'A' for ten under-fives
3. organise compost and soakage pits for five houses
4. chlorinate five wells
5. give simple nutrition messages to ten families
6 organise kitchen garden for five houses
7. give a simple lesson in dental hygiene to ten families.

The scheme was organised in the form of competitions. Participation by the students in the above programme sensitised to the needs of their younger brothers and sisters. Thus the child-to-child programme was nurtured and extended to the family and to the community.

Phase IV Towards more self-help (1979-80):

The programme was reviewed at intervals. Some issues came for discussion: Whether to extend the programme to a large scale and whether to simply training and tasks. A team of teachers were identified to take up the study. This exercise revealed the need for a curriculum design and a manual for teachers.

Phase V Teachers and Students in Integrated Development:

The teacher and the students who were initially the agents of change in health have gradually were involved in other developmental activities. This strengthened the community participation and provided ground for the students to take up community development activities.

Highlights of the Programme:

1. The programme had flexible and open-ended objectives.
2. The intensive and resourceful participation of teachers and students was the essence of the programme. The community participation was achieved by close relationship and mutual trust.
3. The training of teachers included scientific approaches to problem- solving. The teachers were encouraged for creativity and initiation. They trained teachers in other schools aimed at self - propagative of the programme.
4. The resources were largely from the community. The cost of the programme was kept as low as possible.
5. The programme was open to growth and improvement. Teachers were encouraged to try out alternative strategies.
6. A school-based health programme with the participation of teacher and student can be the second front in health development of a community.

APPENDIX - 5

GOOD HEALTH CHARACTERISTICS OF SCHOOL CHILDREN

A healthy child can be recognised by his physical conditions, social and emotional behaviour and work habits as given below:

Physical	Social / Emotional	Work Habits
Alert, pleasant	Curious, interested in a variety of things, enters into activities	Persistent in work; works independently
Clear skin, clear bright eyes, clean, neat in appearance.	Confident, expects success appreciation and understanding from others, meets failure.	Responds quickly and cheerfully to directions
Completes a task without undue fatigue	Enthusiastic	Attentive
Enjoys vigorous play	Objective interests like friends, hobbies, games.	Carries a task through to completion.
Eats and sleeps well	Shares group responsibility, shows courrage in meeting difficulties. Adapts to new situations, exercises emotional control.	Cooperates with peers

Signs and Symptoms of ill health

Points of Observation	Signs and Symptoms
General appearence and behaviour	Fever, failure to gain weight, over weight,pallor, weary expression, poor posture, unusual gait or uncleanliness, lethargic, unresponsive, easily fatigued, shortness of breath on little exertion.
Hair and Scalp	Stingly lusterless hair, small bald spots causing crusting sores on scalp, nite/lice in hair.
Ears	Discharge from ears, ear aches, buzzing or ringing in ear, ears feel stuffy, fails to follow directions, persistently inattentive.
Eyes	Inflammed or watery eyes; red, encrusted, swollen lids, crossed eyes, senstivity to light, dry, scaly conjuctive, holds objects too close to or too far from eyes, night blindness, reads poorly.
Mouth and Teeth	Cavities in teeth, excessive stains, tarter; irregular teeth, bleeding or inflamed gums, swollon jaw; sores in mouth, cracking of lips at corner of mouth.
Nose and Throat	Frequent or long continued colds, cough, persistent nasal discharge, persistent mouth breathing, enlarged glands in neck, difficulty in swallowing.
Skin	Dry or coarse rashes, inflammed skin areas, scales and crusts, persistent coras, boils, bleeding spots.
Muscles and Skeleton	Flabby muscles, pigeon or funnel chest, bow legs, lateral curvature of spine, winged shoulder, clubbed fingers, painful or swollen joints, defective gait, odd gestures or movements, tremors, involuntary urination.
Mental Health	Over timidily, over aggressiveness, temper-tantrums, undue - restlessness, gradual deterioration or marked sudden drop in education achievement, stutering, lying, stealing, school phobia, difficulty in reading or reciting.

A careful observation on the part of the teacher can give the clue to the child's illness which can be acute like infectious diseases, allergy, and throat infection or chronic malnutrition, vitamin deficiencies, tuberculosis, heart disease etc.

APPENDIX - 6

HEIGHTS AND WEIGHTS FOR AGE CHART

Body-size:

Body size is dependent on many factors. Good food plays an important part in determining body size. When small children do not get enough amounts of food or if the food does not contain adequate protein, they fail to grow properly. This is very common in children 1-4 years old. Milk helps children grow best. Children much below average weight get tired more easily. Underweight children find it more difficult to cope with the school activities. Here is a height-weight-age table which can be a guide for finding out whether the heights and weights of children for their age are normal or not.

HEIGHTS AND WEIGHTS OF NORMAL INDIAN CHILDREN

	BOYS		GIRLS	
AGE (Years)	Height (Cms.)	Weight (Kgs.)	Height (Cms.)	Weight (Kgs.)
1+	77.5	8.8	76.3	8.8
2+	86.1	11.6	82.2	10.3
3+	92.5	12.7	91.3	12.4
4+	101.4	15.2	99.0	14.1
5+	108.9	17.0	106.6	16.1
6+	113.8	18.7	112.6	18.1
7+	119.7	21.0	116.3	19.7
8+	123.9	22.0	122.8	21.6
9+	128.4	24.7	127.1	23.6
10+	135.4	25.9	132.5	26.7
11+	139.6	31.0	140.6	31.0
12+	142.8	32.5	145.5	35.2
13+	152.9	39.9	149.0	39.3
14+	159.9	44.5	152.4	41.6
15+	162.0	45.7	153.1	43.4

(NIN - 1992)

APPENDIX - 7

SCHOOL HEALTH SERVICES - A KIT

Medicines, Health Education Materials and Equipment for schools:

Medicines (First Aid Kit)

Tablets:

1. Acetyl salicylic acid tablets.
2. Paracetamol tablets.
3. Iron and folic acid tablets.
4. Oral Rehydration salt packets.
5. Chloroquin tablets.
6. Piperezine tablets.

Local applications:

1. Antiseptic cream
2. Sulphacetamide eye and ear drops(10%)
3. Benzyl benzoate emulsion (20%)
4. Gention violet
5. Clove oil
6. Tincture iodine

Others:

Cotton

Gaze cloth for bandages

Health Education Materials and Equipment:

Equipment:

Height scale	-	For the purpose of measuring height
Stand-on weighing scale (Bathroom scale)	-	For the purpose of measuring weight
Measuring tape	-	For the purpose of chest measurement

Health Education Materials:

A chart indicating signs and symptoms of ill health.

Student Health Card

Referral Cards

A Handbook on School Health (For the purpose of reference)

Eye chart	-	For the purpose of preliminary screening of vision.
A thermometer	-	For the purpose of taking temperature

Teaching aids:

Charts or posters	-	For the purpose of explaining body systems. Some of these may be available in the market. Otherwise the teacher and the students could prepare them or collect them from newspapers, magazines or advertisements.

Large sheets of white paper

Pair of scissors

Needle and thread

Packet of colour pens (Sketch pens)

Health education materials may be available with the health department. Teachers can find different sources from where they can obtain useful health education materials. Health department is one such source.

The following may be available with the Health Department:

Pamphlets	*Video casettes*
Posters	*Slides*
16 mm films	*Technical assistance & guidance.*

APPENDIX - 8

ORIENTATION TRAINING PROGRAMME FOR SCHOOL TEACHERS AND HEALTH PERSONNEL IN SCHOOL HEALTH PROGRAMME

Introduction:

The Orientation Training in School Health Programme for Teachers from Primary Schools and Health Assistants from Mandal PHCs has been designed for a period of five days. This has been designed with a view to familiaring them with the aims and objectives of the School Health Programme, and assume reponsibilities to perform the necessary roles voluntarily and effectively for the promotion of the health of the student community studying in the primary schools .

General Objective:

After the completion of the training programme, the primary school teachers including the Head Masters and health assistants concerned shall be able to, actively associate themselves with the implementation of School Health Programme and assist the Medical Officers and staff of the health centrs and the other medical institutions rendering School Health Service.

Specific Objectives:

At the end of the five days training programme, the participants shalll be able to:

1. Recognise and appreciate the need for their voluntary involvement in the effective implementation of School Health Programme in their respective schools in the promotion of the health of the school children.
2. Identify his role as a member of the School Health Team.
3. Identify and list out the areas/sections in the School health record of each student to be filled in by him.

4. Observe the students to detect any deviations from normal health behaviour and refer to the Medical Officer.
5. Make necessary entries in the School Health Card after observing the students.
6. Measure the height, weight and chest and record the same in School Health Card.
7. Screen children for vision and hearing defects and detection of deformities.
8. Provide simple first aid to the pupils in case of need and render necessary followup.
9. Give necessary treatment/issue medicines, to the students as prescribed by the Medical Officer for the ailments daignosed at the time of health check up, including referrals and follow up.
10. Identify the students who are to be given immunizations and assist the health personnel in this task.
11. Help the medical officer and health staff at the time of health check up of the students.
12. Assist the management in the maintenance of healthful school environment.
13. Identify areas/activities for health education of the pupils to inculcate and encourage the students and their parents for health promotion and good health practices.
14. Assist the Head Master and the Health Team in the whole range of activities under School Health Programme including the maintenance of necessary records, registers, and equipment etc.

Venue for the Training Programme:

The venue of the training programme of the Teachers should be selected close to the place of their work. The location of the training place should be finalised in consultation with Mandal level PHC and School Health Committee well in advance. The venue may be the PHC or Sub Centre Head Quarters or any building suitable for training.

School Health Training Team:

The training team shall consist of the Medical Officer of the PHC/Medical Institution, Health Supervisor, Block Extension Educator and Health Visitor of the concerned areas of the primary health centre.

The other staff members multipurpse health workers , Female Health Assistant, Male Health Assistants will assist the School Health Training Team. Experienced trainers and other resource persons will also be part of the training team.

Training Batch:

Each training batch should have about thirty participants(teachers and health assistants) to facilitate effective and purposeful training.

Resource Utilisation:

All the resources available at the Primary Health Centre/Sub-Centre(PHC/SC) or other Medical Institutions and the local school can·be utilised in the conduct of the training programme (physical facilities, accommodation, use of educational aids etc.)

Skill Development among the Teachers:

During the 5 day training programame maximum opportunity should be provided to the Teachers in observing the students health condition, deviations etc., and filling the School Health Records. In conducting this training maximum provision should be made for practicals, discussions,demonstrations to make the situation learner oriented.

Selection of Teachers and Health Personnel and Calender for Training:

All the Head Masters and Teachers of the primary schools under the management of Government, Local bodies, Panchayat Samithies, Municipalities and Private aided institutions have to be trained for five days under the comprehensive School Health Programme in the first phase. The others who are working in other managements also have to be identified and trained.

The dates and timings suitable for the training have to be finalised by the medical officers concerned with the active involvement of the educational authorities and the managements of concerned schools well in advance.

The teachers identified for the training should be informed at least ten days in advance to facilitate their preparation and participation.

Maintenence of Attendance Register:

A separate Attendance Register is to be maintained by the medical officers concerned for each batch of teachers trained.

Background Material:

Each Teacher/Trainee shall be provided with necessary and appropriate background material at the time of Training to serve as reference material for use during the training course and at the time of rendering School Health Services.

Preparation of Trainers:

All the Trainers concerned with training the teachers should be more proficient and should have received special training in planning and organising training programmes for the Teachers.

Development of Training Plans :-

The trainers have to prepare a training plan well in advance.

1. Selection of the participants
2. Selection of the venue
3. Preparation of the budget
4. Selection of appropriate Training methods
5. Conduct training
6. Evaluate training

Each lesson plan should cover:

a. What will be taught(content)
b. How to teach the lesson(training methods)
c. How time will be scheduled
d. Use of equipment(slide projector, OHP, etc)
e. Teaching aids
f. Acceptable standards of performance

Award of Certificates:

After the successful completion of the five day orientation training course,each teacher/participant will be awarded a certificate of attendance.

Course Content(Curriculum):

A curriculum for the five day training course of the teachers is included in this mannual. The course content was tested and found suitable for adoption by the trainers. Subject to local needs the training programme may be suitably altered without deviating from the content and methodology suggested.

APPENDIX - 9

TRAINING MODULE FOR SCHOOL HEALTH
(FIVE DAYS)

FIRST DAY

Time	Topic	Contents	Objectives
8.30 am to 9.30 am	Registration of participants		
9.30 am to 10.30 am	Welcome and introduction 1 - Introduction of primary Health Care and School Health Services. - Objectives, scope and components for School Health Programme. - Formaion of groups.	- Definition of Health Primary Health Care and School Health Programme. - Objectives, scope and components of School Health Programme. Importance of conducting orientation training course toTeachers in School Health Programme.	At the end of the session the learner participant shall be able to (a) List out the objectives of the School Health Programme. (b) List out the components of School Health Programme.
10.45 am to 11.45 am	2 - The role of Teachers in School Health Programme.	- Why Teacher is more effective - Teachers key position and different roles in the school premises and in community - School Teacher as a member of the School Health team.	Shall be able to identify his role as a member of the School Health team and list out areas in which he can participate.
11.45 am to 01.00 pm	3 - Importance of School Health Survey in School Health Programme. (Assignment)	The survey Form (Questionnaire) contains various components of School Health Programme. The Teacher has to fill up the form relating to the situation of the School where he is working (This forms the basis for detailed discussions during the rest of the training period).	Shall be able to fill in the questionnaire so as to serve as the base for future discussions in the training programme.
2.00 pm to 5.00 pm	4 - Common Health Problems among Primary School Children.	- What are the common health problems and diseases. - Need for timely identification of problems - Need for timely intervention and application of remedial measures and followup.	Shall be able to identify and list out common health problems among students detect any deviation for timely intervention, remedial measures and followup

SECOND DAY

Time	Topic	Contents	Objectives
9.00am	Review	Review	
9.30 am to 11.00 am	5 - Basic human Anatomy and Physiology	- Structure of Human body (Male and Female) - Different systems in human body. - Function of different systems and important organs in the human body. Elementary aspects.	Shall be able to list out the systems of the human body (Male and Female) List out the functions of different systems and organs of human body. Observe and detect any deviations among the students normal health.
11.00 am to 01.00 pm	6 - Systematic approach to Health care	Signs and symptoms of Health and ill health - Head -Hair. - Eyes, Ears, Nose, throat - Mouth and teeth, (dental health) nails, skin - Care to be taken for health promotion and maintenance of students health.	Shall be able to screen children for vision and hearing defects and detection of deformities
02.00 pm to 04.00 pm	- do -	- Screening for defective vision - Screening of hearing defect - Screening for growth defects and nutritional deficiency. - Identification of dental caries bleeding of gums. - Detection of deformities (significance of observing posture and gait).	
04.00 pm to 05.00 pm	7 - Immunisation services	- What is immunization - Advantages of Immunisation given during infancy, preschool age groups. - Types of diseases that could be prevented by immunisation (T.A.,D.T.,T.T.)	Shall be able to identify the students who are to be given immunisation and assist the health personnel in conducting immunizations to the school children.

THIRD DAY

Time	Topic	Contents	Objectives
9.00am	Review	Review	
09.00 am to 10.45 am	8 - Introduction to Student Health Record and its maintenance	Details of the contents included in different sections of the Student Health Record. - Guidelines to be followed in filling Student Health Records. - Identifying the Teachers role in maintaining the Health Record of the student.	Shall be able to (a) make necessary entries in the School Health Record after observing the students as indicated in the guidelines of the School Health Record.
10.45 am to 12.00 pm	9 - do -	- Demonstration of filling Student Health Record. - The observed data in Student Health Record. Methods of observation and Identification of defects. - Methods of recording.	(b) measure height, weight, chest measurements and enter the same in the relevant sections of the School Health Record.
12.00 pm to 01.00 pm	10 - Health check up of students by doctors.	Health check up and medical examination of students - Procedure for preparation of Health check up. - Role of Teachers - System of referrals and follow up by teacher. - Involvement of parents at the time of Health check up and for follow up action.	Shall be able to assist the medical officer and the staff at the time of Health check up of the students.
02.00 pm to 03.00 pm	11 - Personal Hygiene	Importance of personal hygiene - care of body. - Exercise and rest - Healthful instruction - Factors responsible for ill - health among children	Shall be able to identify areas / activities for health education / healthful instruction for health promotion for good health practices.
03.00 pm to 05.00 pm	12. - Environmental sanitation.	- What is environmental sanitation definition components - problems due to lack of sanitation - Types of diseases that occur due to bad sanitation at home and its environment, diarrhoeal diseases, worm infections. - Importance of and need for safe drinking water supply, safe disposal of human excreta. - Solid wastes, liquid wastes, food sanitation. - Method of improving and maintaining home and school sanitation. - Role of teachers. Discussion on Questionnaire (previously filled by participants)	Shall be able to assist the management in the maintenance of healthful school environment.

FOURTH DAY

Time	Topic	Contents	Objectives
9.00am	Review	Review	
09.30 am to 09.45 am	13 - Methods of identification of common communicable and non-communicable diseases among students.	Tuberculosis, Leprosy, Scabies, Malaria, Mumps, Measles, Diphtheria, Pertusis, Tetanus, Polimylitis, Typhoid, Filaria, Worminfections, Rheumatic fevers, Diarrhoeal diseases. - Role of Teachers.	Shall be able to give necessary treatment and issue medicines to the students as prescribed by the physician, for the ailments diagnosed at the time of medical check up, including referrals and follow up. -Provide first aid to the pupils in case of need and render necessary follow up.
10.45 am to 12.00 pm	14 - Treatment procedures (by teachers) treatment of minor ailments.	What are minor ailments. Treatment of minor ailments. Treatment procedures. - Use of equipment and drugs etc. supplies with school medical kit. - Temperature taking, use of eye drops and ointment, use of ear drops, use of measuring tapes etc. First aid, bandaging and dressing.	
12.00 pm to 01.00 pm	15 - Control of Diarrhoeal diseases among children.	- Signs and symptoms of Diarrhoeal diseases. - *Causes - treatment identification* of cases and control measures. - *Components of ORS and its' use* - Preparation of ORS fluids.	Shall be able to identify causes for diarrhoeal diseases shall be able to prepare ORS fluids.
02.00 pm to 03.00 pm	16 - Nutrition and deficiency diseases	- Nutrition & Deficiency of diseases. - Nutrition education & balanced diet. - Nutritional programmes for children - Protein - calories and - Vit. deficiency of diseases A.B.C.D. - Use of local food to improve nutritional status, - Screening for growth defects - Role of teachers.	Shall be able to observe the students to detect any deviations from normal and refer to the Medical officer.
03.00 pm to 04.00 pm	17 - Mental Health	Mental Health and behavioural problems among children of the primary school age group. - Remedial measures and correctional procedures.	Shall be able to observe the students to detect any deviations from normal health / behaviour and refer to the Physician / specialist.
04.00 pm to 05.00 pm	18 - Use of resources	Community Participation Formation of School Health Committee. Parent - Teacher Association Parent involvement at the time of Health check up. - Involvement of voluntary organisation. - Role of Teachers.	Organise / assist in forming School Health Committee and Parent - Teacher - Associations.

FIFTH DAY

Time	Topic	Contents	Objectives
9.00am	Review	Review	
09.30 am to 11.00 am	19 - Activity oriented Health education	Activity oriented Health education - Child-to-child programmes - Health games.	Shall be able to identify areas / activities -Child health activities- for Health education of the pupils to include and encourage the students and their parents for Health promotion and good Health practices.
11.00 am to 01.00	20 - Healthful Instruction by Teachers	Preparation of lessons for Teaching Healthful living through education preparation and use of simple visual aids for effective teaching with emphasis on personal hygiene and habits.	
02.00 am to 04.00 am	21 - Reporting kit and equipment management.	- Maintenance of student Health Records (submission of periodical reports by the school authorities). - Management of kit and equipment. - Role of Teacher and Headmasters. - Review of the content with special reference to teachers; role in the maintenance of student Health Records.	Shall be able to assist the Headmasters and health team in the whole range of activities under School Health Programme including the maintenance of necessary records, registers, equipment etc.
		- Role of Educational Authorities - Role of Teachers and parents - Role of Health Personnel	Recognise and appreciate the need for the voluntary involvement in the effective implementation of school Health programme in their respective Schools for the promotion of the Health of the school children.
04.00 pm to 05.30 pm	22 - Review of the 5 days training course. Closing Session.	- Review of the areas required for strengthening of knowledge and skills. - Review of teachers role in school Health Services programme. - Discussion on back home Project and presentation. - Feed back by the Teacher Trainees. - Award of certificates	

ANNEXURE - 10

SCHOOL HEALTH CARD

Name of Child: ______________________ School: ______________________

Date of Birth: ______________ Sex: ____________ Religion: ______________

Date of Admission: ______________ Admission No: ___________ Class: __________

Parent/Guardian: __________________________ Education: ______________

Address : _________________________________ Occupation: ______________

Home condition: Very Satisfactory ____________ Satisfactory ______________

Unsatisfactory: ______________

Socio-economic condition :Good _________ Fair ______ Poor _____ V.Poor ______

Health Status of Parents ____

Brothers: ______________________________ Health Status: ________________

Sisters: _______________________________ Health Status: ________________

Immunization	Date	Date	Date	Date
D.T.P				
Polio				
B.C.G.				
D.T.				
T.T.				
Typhoid				
Others (Specify)				

Past history of the Child:	If so, frequency of episodes, Date of last Occurance & treatment.
Fits	
Asthma or chronic	
Bed wetting	
Measles	
Chicken pox	
Whooping cough	
Typhoid	
Malaria	
Dysentry	

(at the time of joining School)

1.	Date										
2.	Grade										
3.	Age										
4.	Height										
5.	Weight										
6.	Chest										
7.	Personal hygiene										
8.	Regularity of attendence										
9.	Educational attainment										
10.	Posture										
11.	Gait										
12.	Food habits										
13.	Speech defects										
14.	Behavioural problems										
	Average										
	Poor										
16.	Nutritional deficiencies PCM										
	Vitamine - A										
	others										
17.	Iron deficiency										
18.	Iodine										
19.	Nose defects										
20.	Eye diseases										

21	Vision Rt...										
	Lt...										
22.	Ear diseases										
23.	Hearing Rt...										
	Lt...										
24.	Skin problems										
25.	Leprosy signs										
26.	Lymph nodes										
	Thyroid										
27.	Scalp & Hair										
28.	Teeth & Gums										
29.	Mouth										
30.	Throat										
31.	Chest Heart										
	Lung										
32.	Abdomen										
	Liver										
	Splean										
	Hernia										
33.	Genitalia										
34.	Orthopaedic										
	Spine										
	Bones										
	Joints										
35.	Nervous system										
36.	Other abnormalities										

This card is to be filled in every six months
1 - 15 to be filled by the Teacher
16 - 36 to be filled by the Medical Officer/Nurse
Mark ✓ if normal X if defect found.

Any remarks:

Record of Illness:

Date	Problem	Treatment	Signature

Record of Referrals:

Date	Referred for	Diagnosis	Treatment given & results

Record of Weight & Height:

Date	Age	Weight	Height

Hieght

Weight

Age

APPENDIX - 11

SCHOOL HEALTH SURVEY FORM - ASSIGNMENT

1. Venue of the Training Programme : ______________________________

2. Mandal : ______________________________

3. Location of the Primary Health Centre : ______________________________

I. Personal Hygiene of the Students:

1. Do you check the personal hygiene of the students as regarding the following (by observation):

(a) Hair	(Yes/No)	(d) Teeth	(Yes/No)
(b) Eyes	(Yes/No)	(e) Skin	(Yes/No)
(c) Nails	(Yes/No)	(f) Clothes dress	(Yes/No)

2. Are the children of your class generally neat and clean?
(Write briefly the situation in general not exceeding 5 - 6 lines).

II. Immunization:

How many of the students in your class have had the following imm exercise)

2.1 Before admission to school in 1st standard

1. B.C.G.
2. D.P.T.
3. Polio
4. Measles

2.2 After having entered in 1st standard

1. D.T.
2. T.T.
3. T.A.B

NOTE (If not known mention-not known both for 2.1 and 2.2).

III. Healthful School Environment:

1. Location of the School
   - Crowded Locality Away from the residential locality ( )

2. Play Ground
   - Does the School have a play ground? Yes / No
   - Is it safe for children to play? Yes / No

3. Classroom (where you teach)
   - Is the classroom neat and clean? Yes / No
   - Is the classroom well-lighted? Yes / No
   - Is the classroom well-ventilated? Yes / No

4. Seating arrangements :

   a. Where do the students sit?
      - On the floor :
      - On impervious flooring :
      - On wooden planks :
      - On classroom benches :
      - Any other (specify) :

   b. Are the seating arrangements conducive to the good posture of the students? Yes / No

nking Water

a. Mention the source of water supply to the School (check)

River	( )	Spring	( )
Tank	( )	Taps	( )
Canal	( )	Others	( )
Well	( )	Specify	( )

b. Is the water safe to drink without any treatment   Yes / No

c. How is the water stored in the School previses
(Mention the method of storage)

d. Is the water treated before use by students in the School?

Treated	Yes / No
Filtered	Yes / No
Boiled	Yes / No
Chlorinated	Yes / No

6. Sanitary Latrins (Toilets)

a. Are there latrines in the School premises?   Yes / No

b. If yes, how many :

For Students   No. of latrines/urinals
Boys
Girls

For Teachers   No. of latrines
Gents
Ladies

c. Type of Latrines Dry earth type:

Water seal closet

Borehole latrine

d. If no, what other arrangements are available in the School premises(mention)

For students

For teachers

7. Medical Care / Heatlh Checkup:

a. Do the students have a School Health checkup? Yes / No

b. If yes, at what frequency?

Healf yearly

Yearly

Other(specify)

c. Who conducts the Health check up?

(mention the personnel who does the health check up)

d. Are the sick children given necessary treatment in the School? Yes / No

e. Where are the students referred to for special care?(mention the details)

8. Training in First-Aid:

a. Did you receive any training in First-aid? Yes / No

b. If yes, where and when were you trained?(mention)

c. Indicate the conditions which you can handle (specify the areas in first aid)

1.
2.
3.
4.
5.

9. Provision of First - Aid Medical Kit :

a. Does your school have a first aid kit? Yes / No

A medical kit for treatment of minor ailments? Yes / No

b. If yes, what does the medical kit contain? (mention the contents)

10. Health Education (Health Ful Instuctions)

A. Parent-Teacher-Association(P.T.A)

1. Is there a Parent-Teacher-Association? Yes / No

   Is there a School Health Committee? Yes / No

2. Is the association (P.T.A) or Committee active? Yes / No

3. What are the activities usually organised in your school by the Parent - Teacher - Association or by the School Health Committee?

Sl.No. Nature of activities

1.
2.
3.
4.
5.

B. Healthful Instruction:

1. Has the School made any attempt to undertake health education activities for the students? Yes / No

2. If Yes,

(a) Topics covered:

1.
2.
3.
4.
5.

(b) Methods used:

1.
2.
3.
4.
5.

(c) Audio-visual aids used:

1.
2.
3.
4.
5.

Name of the Teacher: ______________________

Name and address of School: ______________________

____

____

____

Name of the Management: ______________________

Date: ______________

Place: ______________

APPENDIX - 12

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APPENDIX - 13

RESOURCE CENTRES
(HEALTH TEACHING AND LEARNING MATERIALS)

1. Child-to-Child Programme Primary & Elementary Education Unit, NCERT
   Aurobindo Marg
   New Delhi-110 016

2. School Health Programme Central Health Education Bureau
   Kotla Road, Temple Lane
   New Delhi-110 002.

3. Voluntary Health Association of India
   Tong Swasthya Bhavan
   40, Institutional Area South of IIT
   Near Qutub Hotel,
   New Delhi - 110 016.

4. UNICEF
   73, Lodhi Estate, New Delhi - 110 003.

5. School Health Education
   World Health Organisation
   Indra Prastha Estate
   New Delhi - 110 002.

6. Health and Education Unit
   Aga Khan Foundation, Sarojini House
   2nd Floor, 6 Bhagawan Das Road
   New Delhi - 110 001.

7. Health Accessories for all
   Catholic Health Association of India (CHAI)
   Gun Rock Enclave, Staff Road
   Post Box No.2126
   Secunderabad - 500 003.

8. Andhra Pradesh School Health Association (ASHA), Post Box No 2006
   Secunderabad-500003(A.P.)

9. CHETNA
   2nd Floor, Drive in Cinema Bldg., Thaltej Rd.
   Ahmedabad- 380 054

10. Audio Visual Department Chritian Medical College and Hospital
    Vellore- 632 002 Tamil Nadu.

11. Educational Multi Media Association
    12, Murrays Gate Road, Alwarpet
    Madras - 600 018.

12. Parent Teacher Association of India
    C-1/25-26 Malkaganj Delhi
    Delhi - 110 007.

13. Teaching Aids at Low Cost (TALC)
    P.O.Box No.49
    St.Albans. Herts AL1 4AX, U.K.

14. Child-to-Child Trust
    Institute of Education 20,Bedford Way
    London, WCIH OAL U.K.

15. Appropriate Health Resources & Technologies Action Group Limited (AHRTAG)
    1 London Bridge Street, London SE1 98G UK.

16. Institute of Child Health
    University of London, 30, Guilford Street
    London, WCIN 1EH U.K.

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If we have not included ideas you think are important, we would appreciate your suggestions.

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____

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____

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Why?____

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____

Why?____

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____

____

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____

____

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most are helpful?________________ many are not helpful?________________

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____

What changes in the book would you suggest?______________________________

____

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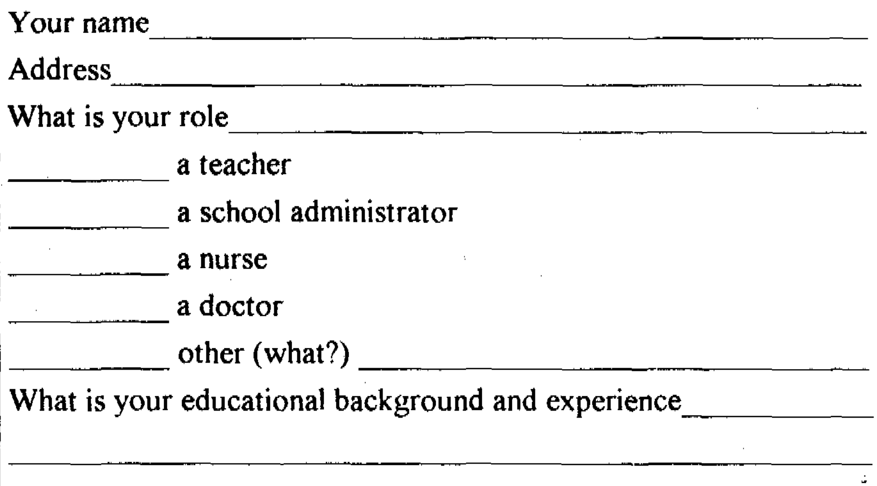

Your name ______________________________________

Address ____

What is your role ________________________________

__________ a teacher

__________ a school administrator

__________ a nurse

__________ a doctor

__________ other (what?) ____________________

What is your educational background and experience__________

____

Thanks for your help !

Please send to: **Dr. D.Rayanna,**
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Andhra Pradesh, INDIA.

EVERY CHILD HAS THE RIGHT

- to affection, love and understanding
- to adequate nutrition and medical care
- to free education
- to full opportunity for play and recreation
- to a name and nationality
- to special care, if handicapped
- to be among the first to receive relief in times of disaster
- to learn to be a useful member of society and to develop individual abilities
- to be brought up in a spirit of peace and universal brotherhood
- to enjoy these rights, regardless of race, colour, sex, religion, national, or social origin.