KHEJRI SARVODAYA TRUST AND HEALTH CENTRE
Village Todiramzanipura, Jagatpura, Jaipur-302025, India

SCHOOL HEALTH AND HEALTH EDUCATION

August 1999 – December 2006

A Report

Introduction:

In 1995 on the request of the village people the two family Khejri Sarvodaya Trust started a charitable health centre in the rural area east-southeast of Jaipur to provide much needed basic medical care to the marginalized population of about 35 villages and hamlets in this arid, at that time desolate and impoverished area. To the north of the health centre there were several villages and many hamlets of low-income Muslims, to the east there was an entire belt of villages and hamlets of so-called lower cast people, to the south there was a mixed economically deprived population. No modern medical care facilities were available.
In 1999 the health centre, which had till then functioned in an annex to a garage, moved into its own spacious building, thanks to the munificence of many personal donors and organizations in India and abroad. The majority of the patients have always been women and children (more than 50%). The health centre's aim has been to provide quality medical care to the deprived sections and much attention has been paid to raising the awareness about health, sanitation, nutrition, immunization, etc. among our patients. From clinical experience we found that children were generally underweight and in great need of medical attention. To contribute to an improved health scenario we decided to develop a school medical check-up and treatment programme and subsequently a school health education programme. In July 1999 we conducted a survey in the area around the health centre in a 10km radius and 63 primary and upper primary schools – both government and private – were identified in 25 villages with a student population of 11980. Record cards were developed, which have been used all these years, and separate staff, equipment, a vehicle and funding were put into place. When we offered free medical examinations and follow-up treatment to the schools, several responded positively, but there was also an undercurrent of suspicion and disbelief as to why we were doing this.

Subsequently to the medical examinations, the need soon arose for creating greater *health awareness* amongst the children and their own roles in this both for their personal well being as well as for sharing this information with their families and neighbourhood. From this the *School Health Education Programme* was born. As most children were underweight we decided to run a supplementary *Nutrition programme* in these schools. The general condition of the schools, the buildings and environment, were in an extremely rudimentary state without space for the children to sit, no light, air, water and toilets. With the financial assistance of other charitable organizations we decided to help several schools with *infra-structural arrangements* and support to the very poor amongst the students. The teachers in these schools are mostly untrained and lack pedagogical skills. We organized from time to time *meetings and training programmes* for the

teachers. Also we used *street corner theatre performances* to raise the level of health awareness, both in the schools and in the community.

Implementation:

1) *School Health Programme:*

In August 1999 we started medical examinations in 5 schools with 517 children during 9 days; 5 doctors and supporting personnel were in attendance. Till the end of 1999 we had examined a total of 1765 children in 19 schools during 31 days.

Implementation of the programme from 1999–2006:

year	no. of Schools' visits	no of students' checkups	no. of referred cases
1999	19	1765	110
2000	25	2703	320
2001	18	1343	181
2002#	07	723	106
2003	16	1285	200
2004	16	1433	419
2005	26	2836	635
2006	21	2491	375
Total	148	14579*	2346**

doctor was not available during 4 months.

*Most children continue to be under weight for their age and height; the older they get the more is the gap with the required weight for their age. Height increases, but not the commensurate weight as the children grow. Another disturbing finding is the anemic condition of the children. Medicines have been given on the spot. Initially Vit.A has been given to all and de-worming tablets has been given to about 70% of the children.

** Out of the total number of referred cases between the ages of 4 – 15 years the largest number were dental cases, followed by skin, e.n.t., eyes, stomach ailments, upper respiratory infections and a surprising number with heart ailments. The Health Centre finances specialized treatment and investigations of children at other hospitals and clinics. This will remain an ongoing programme out of a special treatment fund we have.

Participation of the school administration, teachers and above all the parents became evident. Meetings were organized with these stakeholders to inform them about the importance of general health, how to administer medicines, and Khejri's desire to reach the individual child up to the home.

All schools were regularly provided with referral booklets; sick children could be – and will continue to be - sent by the school to the health centre at any time for free

treatment. The Digantar schools' health coordinator regularly brings the children for specific check-ups to the Health Centre.

The lady doctors made special efforts to discuss with the pre-adolescent and adolescent girls their specific growth phenomena. Our proposal to have special sex education sessions was discussed at great detail and letters in this regard were written to the schools with the request to get parents written approval to introduce sex education. While some schools approved, the majority did not and at one particular school there was strong resistance from the parents. After that doctors made a special attempt to explain the importance and methodology with the parents, also in view of HIV/Aids. Parents, however, expressed the opinion that such education was important, but the present schools' environment was not suitable for this kind of education.

2) School Health Education Programme:

Prevention being better than cure, lot's of minor diseases and injuries from which children suffer, can be prevented with a basic knowledge of one's own body, health care, sanitation and nutrition. During the first 17 months of medical check-ups of 4468 students in 44 schools it became apparent that the medical investigations and where necessary treatment, had to be supplemented by health education. By November 2000, after discussions with the respective school headmasters, we formalized a timetable and started in various schools for the upper primary classes. Discussions were repeatedly held with the school headmasters, teachers and the community members to further strengthen this programme. The importance of such a programme required a separate health education coordinator and Shri Lohit Kumar Joshi was appointed for the implementation of this programme in February 2001. A continuous interaction and evaluation of the field work made us realize that the following were essential:

1) teacher training, as most of the staff of these small rural schools also lacked basic health awareness, pedagogical skills and the awareness of the importance of their roles in the development process;
2) supplementary nutrition, as most children were underweight;
3) regular revision followed by standardization and publication of the lesson material for students and teachers. On the basis of our experience in the field and with considerable input from our doctors, resource persons and coordinators we developed and published *a) a student's workbook in February 2004; b) a student's textbook in September 2004 and c) a teacher's manual in 2005*. The workbooks and textbooks have subsequently gone into second editions.

School Health Education Programme

year	No.of schools'visits	no. of students	no. of lessons	no. of days
2000	5	100	15	19
2001	17	450	34	59
2002	11	178	54	54
2003	10	189	66	66
2004	17	229	93	81
2005	13	266	132	87
2006	13	339	165	94
Total :	86	1751	559	460

We learned that most students come to school after having a cup of tea only and with no breakfast. Clothes were dirty, neither bathing nor brushing teeth, hands were not washed before eating or after toilet. This was the situation, also with the parents, in at least 80% of the households. The schools did not want to emphasize issues of personal hygiene, because they were afraid that if they did, the children would be withdrawn from the school. On the other hand, corporal punishment to enforce 'learning' by the teachers was never feared to be an issue of withdrawal of the child. It was actually encouraged by the parents. The horrific saying we came across in this area, given by the parents to the teachers was: 'khaal aapki – haddi hamari' (you take care (of the child) -only the bones are ours). No wonder we received at the health centre children with torn ears, eyes into which fingers had been poked and hair that had been pulled out! Subsequently, we went to the schools and emphasized the extreme negative impact of *corporal punishment* on the physical, mental and psychological growth of the child, besides there is a law against it in India!

The *street theater* artists of Goonj Sansthan prepared a detailed script about various aspects of health, including corporal punishment and have been giving special performances in the schools. These nukar nathaks (street performances) proved to be a most effective method to convey the important health lessons taught to the children and we have since then till the end of 2006 used this medium most effectively. Performances at these nukar nathaks given in the local dialect, village attire, familiar tunes with health messages by young boys and girls were greatly appreciated by all the children of the school and the assembled village folk. This was an excellent way to create awareness about health in general and the health centre's services in particular.

Especially the children in the government's upper primary schools, who come from the most deprived backgrounds, had greater difficulty to grasp the material and lessons had to be regularly repeated. All parameters of health and sanitation in their living quarters are absent. Dirty non-ventilated homes and filthy lanes, no water connections, absolutely deprived surroundings, both parents leaving early to find daily labour, which they get on an average 10 days per month, and the children are left to themselves. This shocking situation, worse than in urban slums, met our health educator during his personal visits. But while these homes were empty of the most basic things, everywhere there were at

least 4-6 children per household. The girl-children add to the family income by gathering firewood and waste material and look after younger siblings and other people's goats.

After a year or two it was a pleasure to see that the general appearance of the children had improved: clothes were clean, nails were cut, hairs were combed and 75% of the children, who had had the check-ups and the health education lessons, came to school after eating some breakfast and taking bath. They also remembered a lot of the previous lessons and had talked about health related issues at home.

By February 2004 the health education workbook was ready and put to use in the schools. After the initial surprise of the students to receive such an attractive book, there was also a certain amount of trepidation that the health educator would take back the book and assess their performance. However, the workbook strengthened their learning of the material to a great extent. After the course was over, at the time of the prize distribution, the workbook was given to the children to be kept by them. In September the health education textbook was published and from then onwards the children used to receive both the textbook and the workbook. They were happy that they could take these books home and show it to their parents and siblings.

In July 2005 the Teacher Manual in Health Education was ready. This manual follows closely the student's textbook, but in a much more elaborate way, so that the teacher will be able to give suitable replies to out-of-textbook questions by the students. A continuous process of evaluation and adaptation of both the School Health and the School Health Education took place during the years under review, so that the service delivery improved.

3)Nutrition

In order to counteract the malnutrition we came across amongst the school children during our medical check-ups and those coming to the Health Centre we started a supplementary nutrition programme in May 2000. During the period July 2000 – December 2002 we distributed 7420.55 kg of high protein, specially prepared biscuits and laddoos (prepared by disabled children of Disha) and commercially prepared protein snack food to the children in 18 schools in our area, as well as to malnourished children at the Health Centre. We kept a close watch over de distribution within the schools, so that wastage would be kept to a minimum and the children would actually receive the food. We tried to evaluate the effect of this supplementary food on height-weight of the school children over a longer period, but this was difficult to assess and we found that:

-the amount of food per child per day was too limited;

-children were often not given lunch at home, because "they received food in school" (!)

Two MSc. Food and Nutrition students conducted surveys in this area and they too came to the conclusion that either we arrange for a full-fledged mid day meal system or we teach nutrition standards to the women in the villages or we concentrate on providing infant feeding for the babies coming to the Health Centre. Looking at our resources of (wo)manpower and funds we decided for the latter. From July 2003 to March 2004 we distributed a total of 500 kg high protein infant food, specially prepared at the health centre according to a recipe of the Department of Food and Nutrition, University of

Rajasthan to 746 infants by a separate health and nutrition assistant, who also taught the mothers the importance of breastfeeding and supplementary food. However, also here we found that the impact on the infants' health was not sufficient, mainly due to the irregular attendance by the mothers. The children of those few mothers who did feed their babies regularly the supplementary food, had certainly improved.
We are happy to report that since 2006, with the help of a major Jaipur NGO, children in some government schools in this area receive a substantial mid day meal and appear better fed.

4) Special Meetings and Training:

Besides the regular interactions with the schools we also organized special meetings and training programmes.
Initially we convened special meetings at the Health Centre to explain to the teachers the objectives of our school medical examinations and the need to involve the teachers and senior students to propagate the message of health in the rural area.
In March 2000 a very well attended eight days' first aid and health education training course for the teachers was held. Teachers from 22 schools gave full attendance. Topics covered were physiology, childhood diseases and their prevention, nutrition and normal growth, common injuries, accidents and practical first aid classes. In September 2000 there was a follow-up meeting especially for first aid and to review the use of the first aid boxes handed out to the schools and periodic refilling of exhausted contents.
In March 2001 a meeting was held with the teachers to evaluate the medical examinations, the health education lessons, distribution of supplementary food, and the programmes' follow-up, as well as to strengthen the schools' greater involvement. In July we went to the various schools for interactions with the teachers regarding the relationship of teaching methodology, mental and physical well being of the children.
In September 2002 we had a meeting with the teachers and parents of two schools in Kundanpura village and discussed with them the results of a detailed study of the height-weight-age related factors leading to poor growth of the children and the need for proper nutrition. Information regarding proper diet with local resources was also given.
In April 2003**,** also as a consequence of the surveys conducted in our area (see above under Nutrition), we organized an intensive workshop on nutrition in which teachers of 11 schools participated.. During June and July, at the beginning of the new session, we visited various schools to emphasise the need for alround development of the children and the importance of the teacher-child-parent relationship.
In February 2004 special sessions were held with the adolescent girls in some of the schools.In the same month a major two day teacher training workshop was organized at the Health Centre to share with them knowledge about the social responsibilities of teachers and to enhance their pedagogical skills.
In March 2005 15 teachers from 8 schools participated in a discussion for the preparation of the Teacher's Manual with editor Shri Rajaram Bhadu.
In July 2005 a two days workshop on the Teacher's Manual was conducted at Digantar Campus. The objective was to make the teachers understand the importance of health care and to implement this in their daily school activities for the wellbeing of the children. 52 teachers from 15 schools participated. There were lively interactions with the teachers, who gave valuable suggestions for the follow-up workshop in October. After this the manual was distributed. For the workshop in October teachers were asked to list

the health related programmes/issues they had introduced in their schools after the July workshop for children and parents. Fifty teachers, parents and some children also participated in the October workshop. All schools presented their reports .On the recommendation of the teachers the subjects “first aid” and “sex education” were covered in the follow-up Workshop.
In November we visited 13 schools to meet teachers and the parents, again to reinforce the importance of health and to strengthen the relationship with the Health Centre.
In February 2006 we conducted a meeting with 44 parents in one school in Khatipura, where we had made an in depth study of the growth pattern of the children, which was worrying. We stressed the need for proper nutrition and health care.
In March we had a similar meeting with 55 parents in a school in Dantli, where too the growth pattern was worrying. In this meeting we also discussed the problems of single mothers and widows with the collaboration of Ekal Nari Shakti Sangathan.
Just before the demolition of the health centre’s building the teachers of 16 schools met at the health centre on 12th December to evaluate the entire programme prior to its closure and to express its displeasure with the government action. There was general appreciation of the programme and its impact on the students’ well being**.** *Assurance was given that children will receive free treatment at the scaled-down health centre, for which referral slips will be given to each and every school.*

5) School Assistance Programme

To a limited extent the Khejri Sarvodaya Health Centre out of donations directly received, and on our recommendation certain charitable foundations have provided considerable funds to several schools for infra-structural developments (buildings, toilets, water pumps and connections, electricity connections, furniture, durries, playground equipment, toys, etc.) as well as help to individual poor and often orphaned students (fees, books, stationary, school uniforms and warm sweaters, midday meals, etc.).

Discontinuance of the programmes:

The land on which the Health Centre was built, was acquired by the Rajasthan Housing Board for the construction of a high way. In spite of all our and the villagers efforts to prevent this, the Housing Board destroyed the entrance gate to the Health Centre on 3rd December 2006; two days later the house of the caretaker and our registration assistant as well as part of the boundary walls were bull-dozered. On 6th December the Health Centre was to be destroyed, but with great difficulty we could convince the authorities to give us a one- month grace period. On 17th December the demolition of the major part of the building started and was completed on 4th January 2007. Patients are temporarily attended in a shed and in the mobile clinic. The minor part of the building, which was not destroyed, is being reconstructed for a small health centre and will be ready for occupancy in April 2007. Due to lack of space and other constraints our school health and health education programmes have regretfully to be discontinued, although children will continue to receive free treatment at the centre itself on referral by the schools.

Conclusion:

"Health of school students does not depend only on periodical medical examinations by the doctors ending with a note of diseases detected and intimated to the concerned authorities for further action. Doctors of the Khejri Sarvodaya Health Centre carefully examine the students and the disease/disability is recorded, if any. Remedial measures, considering the etiology, are taken up and followed up till the treatment is complete, with no financial burden to the school or parents. The difficulties experienced are, that teachers generally do not get the time and conveyance to attend the Health Centre with the students listed for attention at the Health Centre. Our vehicle is then sent.
Follow up of these cases are regularly made. Frequent interaction with teachers have been arranged, to make them conscious of their responsibility towards the health of the children, but also for the long term benefit of the school.
Hence, it can be mentioned with confidence that the medical examinations of the school students were completed by the doctors and para-medicals covering all parameters of preventive, promotive and curative health. Its discontinuance will greatly affect the students subsequently" – *Dr. A.K. Banerjee*.

"The purpose of this report is not just to document our work in the area of school health over a period of 7 ½ years, but also to share our experiences with other people and organizations engaged in this very important field. Public health at the macro level and the child's health at the micro level are foremost indicators of the country's wellbeing and development. In a very small way Khejri Sarvodaya Health Centre has tried to contribute to these parameters in the hope that the responsibility for health must ultimately rest with the government, the schools and the people.

The impact of this effort is difficult to measure and would call for a large-scale study. Working so closely with the programme, one's expectations will be greater than the achievements one attains. There have been many unforeseen bottlenecks and the hope, that the village people and the schools would 'own' the projects has certainly not materialized. We do, however, believe that over a longer spell of time the effects of regular medical examinations and where necessary, treatments, as well as the detailed health lessons must increase the quality of the lives of the children we have touched.

General positive results observed in the schools: several severely ill children, particularly with heart diseases, were provided extensive treatment; greater health awareness, positive effect of the use of the first aid boxes in case of accidents; quicker seeking of medical treatment; less school children are underweight than 7 years ago; better personal hygiene, cleanliness and mental alertness; better understanding of the relationship between health and education; improved relationship between teachers-children and parents; improved immunization awareness; improved general nutrition awareness; improved position of the schools in their community due to better infra-structure and educational standards; some more teachers show a greater social commitment.

Problems encountered working with the schools: the importance of health and immediate attention was not always realised by the schools as we would have liked. Often the schools put the responsibility on the parents, although at the same time they would blame

the parents for their ignorance and illiteracy; especially girl children, to whom we were ready to give extensive financial support for specialized treatment, were not taken to the hospitals by the parents; cooperation on the spot to our medical team was often absent, in spite of our previously made arrangements. There was a lack of courtesy to our doctors and medical teams; the onus of delivering these services was entirely left to the health centre's staff; too many declared and undeclared holidays and examination days in the schools.

Finally, we sincerely hope that in future school health and health education will be given due importance by the government agencies and the NGO's working in this area, as these provide major development strategies to meet the people's needs."

.- *Lohit Kumar Joshi and Gerda J. Unnithan*

March 2007