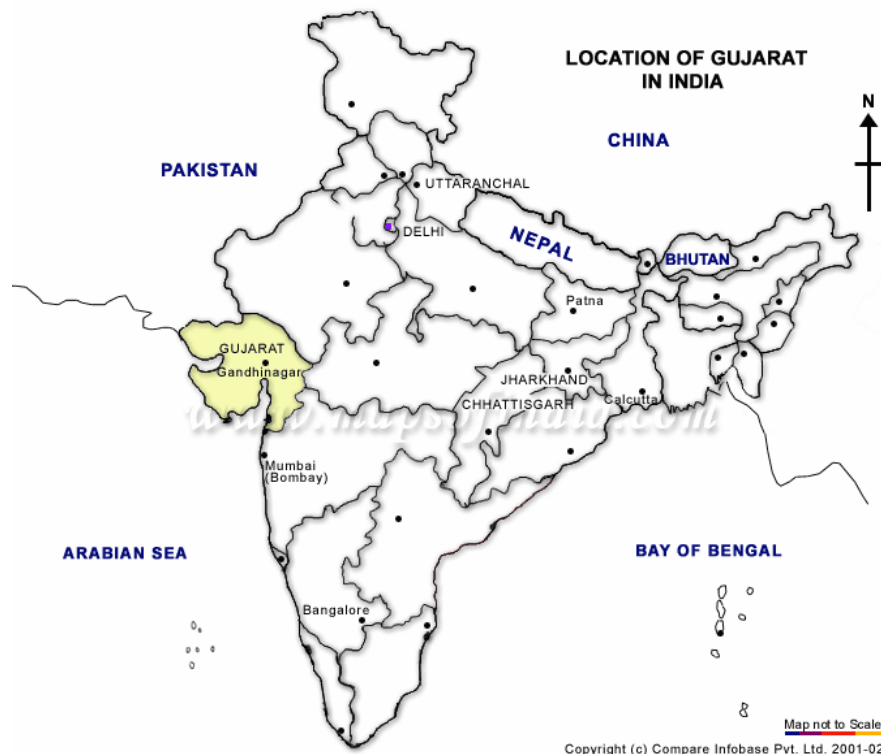


RAPID ASSESSMENT AND ACTION PLANNING PROCESS (RAAPP) IN GUJARAT, INDIA

September 2004-June 2005

*A Method and Tools to Enable Ministries of Education and Health to Assess
and Strengthen their Capacity to Promote Health through Schools*



August 2005

Department of Health and Family Welfare, Government of Gujarat
World Health Organization

(India Country Office, New Delhi, Regional Office and Head Quarters)

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Acknowledgements

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Section-1 A

Introduction to RAAPP

What is RAAPP?

RAAPP stands for the Rapid Assessment and Action Planning Process, a method and set of tools for national government officials to assess and strengthen their country's ability to promote health through schools.

What does RAAPP measure?

RAAPP measures the actual or realised capacity of a nation to promote health through schools as perceived by key players in the national system. Teams are formed to collect data by interviewing ministry staff about the elements of national capacity. These teams will also be responsible for analysing data, reporting findings, and making recommendations that will strengthen national capacity to improve school health programmes. Additionally, a small illustrative sample of persons outside of the national ministries—those affected by these programmes—will contribute their views on how to strengthen the nation's infrastructure.

The purpose of RAAPP is to assess and build national-level capacity to promote health through schools. By using the tools and methods described, a core team of education and health professionals from the central government can create an action plan to this end.

RAAPP is built on the two concepts put forth by the World Health Organization's Expert Committee on School Health Education and a joint agreement by international agencies. These are the concepts of fostering Health-Promoting Schools (HPS) and of Focusing Resources on Effective School Health (FRESH). Health is described as the physical, social, and emotional well being of students and teachers. An HPS strives to build health into all aspects of life at school and in the community, because health is essential for learning and development. FRESH is a commitment by international agencies (World Health Organization [WHO]; United Nations Educational, Scientific, and Cultural Organisation [UNESCO]; United Nations International Children's Fund [UNICEF]; and the World Bank) to work together to encourage schools worldwide to focus resources on four key interventions (UNESCO et al., 2000).

The agencies participating in FRESH emphasise the significant and immediate benefit to both health and education if all schools were to implement the following:

1. School health policies
2. A healthy school environment, with the provision of safe water and sanitation an essential first step
3. Skills-based health education
4. School-based health and nutrition services

UNESCO et al. (2000),

To support implementation of FRESH, Health and Human Development Programs—a division of Education Development Center (EDC), a non-profit research and development organisation based in Boston, U.S.A.—working with WHO Headquarters, regional, and country offices; Education International—a worldwide trade union organisation of education personnel based in Brussels, Belgium—and country partners, developed this current edition of RAAPP. Through RAAPP stakeholders assess national capacity, specifically as it relates to HPS and FRESH.

The planning, data collection, data analysis, and action planning phases of RAAPP are organised around five national capacities, which any nation would need to effectively implement the concepts of HPS and FRESH. These are:

1. Information and knowledge
2. Policy
3. Leadership and management
4. Collaboration
5. Monitoring and evaluation

Through RAAPP, a core team of individuals from education, health, and other relevant ministries will collect information based on the concepts of HPS and FRESH. Individuals who create, develop, implement, or support policy for school health programmes will be asked to assess performance in each of the five capacities. Additionally, the core team will seek opinions from a small illustrative sample of persons outside of the government who are directly affected by education and health programmes (e.g., non-governmental organisations, parent-teacher associations, and community groups).

RAAPP is divided into three phases:

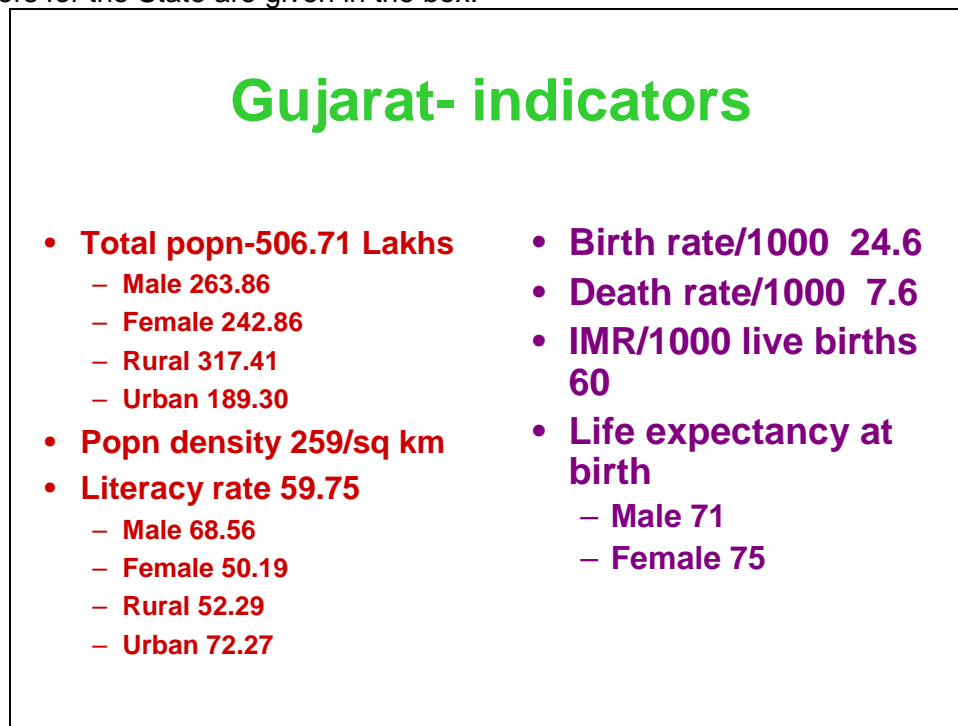
1. Planning
2. Training and data collection
3. Analysis and action planning

A core team—an inter-ministerial group responsible for conducting all phases of RAAPP—is required to coordinate the logistics, build support for the process, manage the data collection, and facilitate the completion of an action plan based on the findings. Every country may require a different amount of time to conduct RAAPP, depending on the mechanisms and networks already in place. Below we provide broad time estimates for each phase, which will vary depending on each country's particular conditions.

Section-1 B

School Health Activities in Gujarat

Gujarat is a State in the Western part of India and been a pioneer in school health since a long time. Selected indicators for the State are given in the box.



Gujarat has In 1909, Sir Sayajirao Gaikwad, King of Baroda, started School Health Programme in Baroda region. It was the first school health program in the Country. To ensure good health for our school children the state of Gujarat has launched a major School Health Programme. This is the single, largest, health programme operating in the state of Gujarat for the last 8 years.

The Government of India launched the 'Special School Health Check-up Programme' in the year 1996 in coordination of Department of Health & Family Welfare and Department of Education for school going children of Primary Schools with the following objectives;

- Detection of health related problems that are commonly occurring amongst primary school children
- Screening of children for appropriate referral,
- Building of health awareness in the community through primary school children and
- Follow-up arrangements for detailed check-up and treatment of referral cases at Government health facilities.

It was a programme throughout the country and the Multi-Purpose Health Workers undertook primary screening. Referral services were provided at the Primary Health Centres. The programme was however discontinued after sometime.

Government of Gujarat Initiatives

Government of Gujarat, Department of Health in collaboration with Education Department started an innovative School Health Programme in 1997, wherein medical officers of primary health care system did primary examination.

Steering committee for school health:

A State level steering committee, under the chairmanship of Health Minister was formed for planning School Health Program. Chief Secretary, Additional Chief Secretary (health), Additional Chief Secretary (finance), Additional Chief Secretary (education), Health commissioner and Members of legislative Assembly are other members of the steering committee. Before launching the programme, meetings of CDHOs, CDMOs, RDDs and programme officers are called and detailed discussions are held for effective implementation of the School Health Programme.

Planning process:

Individual Medical Officers prepare Micro plans at the PHC level which include date, time and place of examination, number of schools and number of school children to be examined. District health authorities collect and compile micro plans and send the same to the state authorities for compilation and analysis.

At the state level Health Education Bureau compiles and analyses all Information and prepares a state level master plan, which includes inter alia the requirement of; Manpower, Drugs, IEC Materials, Stationary and Contingencies. Medical officers with their teams examine all school going children and ICDS beneficiaries in the primary schools and Anganwadies (centres for children below the age of 6 years). Children with minor ailments are treated on the spot in the school. Children requiring examination by specialists are sent to the related referral centres where different medical experts like ophthalmic surgeon, physician, pediatrician, dentist, skin specialist and ENT surgeons examine and treat them. Those children who require spectacles are provided the same free of cost.

Performance 2003 – 04:

Villages / Wards covered	18878
Total No. Of Anganwadi's	35656
Non School going children	1.07 mn
Total Children Registered	10.8 mn
Spot treatment	1.34 mn
Referral service provided	0.05 mn
No. of schools covered	36704
School going children	8.2 mn
Total No. of Children (A.W.)	1.7 mn
Total Children Examined	9.9 mn
Total Children Referred	0.05 mn

School Health as a part of Primary Health Care:

From health side-a health functionary visits the school once in 2 to 3 months, to ensure hygiene. The Male multipurpose worker of the Primary health centre chlorinates the school water supply.

Teaching health in schools:

Educational syllabus already has health topics (nutrition, sexual health, hygiene etc). These topics are a part of the subject called "Environment" in the 1-2 classes. From 3rd class onwards these topics are a part of the science curriculum. There is a special subject "Health Education" with a special textbook in the 5-7th class. The science teacher teaches health in school.

Mid Day Meal Programme:

Gujarat State MDM programme covers all the primary schools run by the state / local bodies / District Panchayat. In addition to the cooked food, Government of Gujarat also provides from their budgetary sources, a package of micro-nutrient therapeutic medicines like Vitamin-A for improvement of eye sight and removal of night blindness, tablet Albendazole for deworming, and tablet Ferrous sulphate as iron buster to all the primary school children to sustain the health standard alongwith the nutritional standard. An expenditure of Rs. 4.0 core (approximately) is incurred on the account every year. This scheme is in force since 1993.

There are more that 26,000 MDM centers in 18569 villages that cater to the feeding of school children. Generally, each primary school has a MDM center. But, it is not the case with the large sized villages, towns and cities where there are more that one primary school in close vicinity. In such places, the MDMs center caters to more that one school. A semicentralized system has been evolved in 6 Municipal Corporations where all the schools do not have kitchen or dining place facilities. Therefore, the food is cooked at a centralised place and then cooked food is transported to the various schools of the area. This is very convenient and economical which reduces the infrastructural costs and provides speedier mode of reaching entire municipal schools.

Integrated Child Development Scheme:

The Integrated Child Development Services (ICDS) Scheme was conceived in 1975 with an integrated delivery package of early childhood services so that their synergistic effect can be taken full advantage of. The Scheme aims to improve the nutritional and health status of vulnerable groups including pre-school children, pregnant women and nursing mothers through providing a package of services including supplementary nutrition, pre-school education, immunization, health check-up, referral services and nutrition & health education. In addition, the Scheme envisages effective convergence of inter-sectoral services in the anganwadi centres.

The Scheme targets the most vulnerable groups of population including children upto 6 years of age, pregnant women and nursing mothers belonging to poorest of the poor families and living in disadvantaged areas including backward rural areas, tribal areas and urban slums. The identification of beneficiaries is done through surveying the community and identifying the families living below the poverty line.

Section-2

RAAPP in Gujarat

Background

In a meeting held in the Regional Office of South East Asia, WHO, on 24th October 2003, which was attended by professionals from WHO HQ, Geneva, SEARO and India, Education Development Centre, Bangkok, Secretary Health, Govt of Gujarat, Team from Central Health Education Bureau, representatives from National Institute of Communicable Diseases (NICD) Delhi, Central Board for Secondary Education (CBSE) and National Council for Education Research and Training (NCERT) it was decided to conduct RAAPP in one of the States of the Indian union. Gujarat expressed interest therefore it was agreed to do RAAPP in Gujarat.

The project was initiated in Gujarat in September 2004. There were three phases to the project:

Phase I (21-22 September 04)	Planning
Phase II (February-March 05)	Training and Data Collection
Phase III (5-7 May, 05)	Analysis and Action Planning

Activities Phase-1:

Background materials were made available and focal points in Health and Education Ministry were identified. Dr. Dhananjay Bhatt, the Additional Director Family Welfare, Government of Gujarat is the nodal person for RAAPP. The focal person in education is Ms. Meena Bhatt the project director of District Primary Education Project (DPEP), Government of Gujarat.

An interdepartmental core team was selected with representatives of the department of health and department of education. Two field teams for data collection were identified from both the departments. An orientation meeting was held in Gandhinagar from 21-23rd September 2004 with an objective of orienting the teams about RAAPP and planning for the phase-2. This meeting was attended by representatives from WHO Geneva, EDC USA, WHO India, WHO SEARO, WHO Local unit in Gandhinagar, Focal points of health and education, Lecturers from the Gujarat Council of Education Research and Training, Block Resource Coordinators, Principals of schools and teachers.

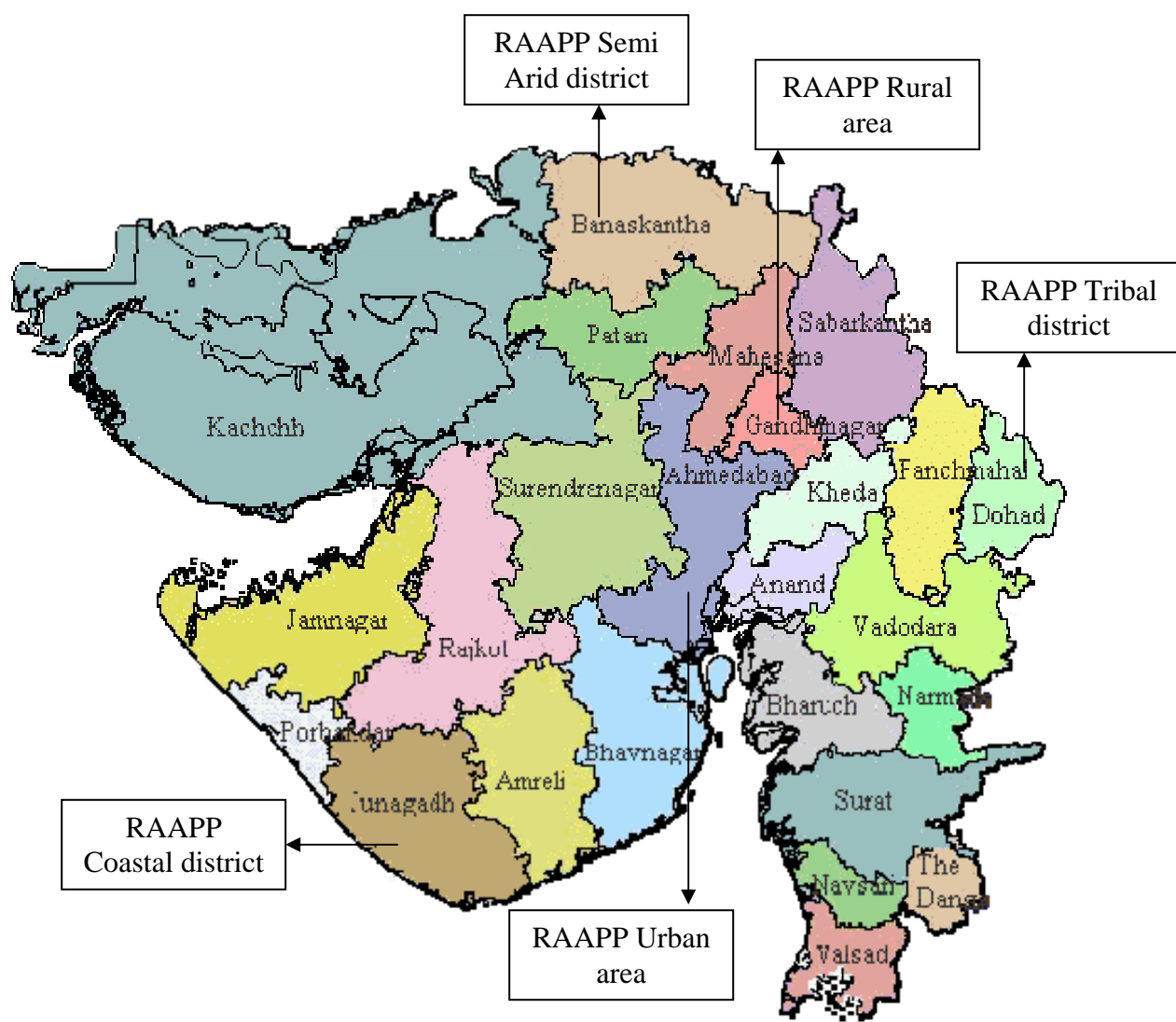
The WHO team with the focal persons met the Minister of Health and Minister of Education and briefed them about the project. Both the ministers were keen to implement the project in Gujarat. The team also visited a rural school to understand the field situation.

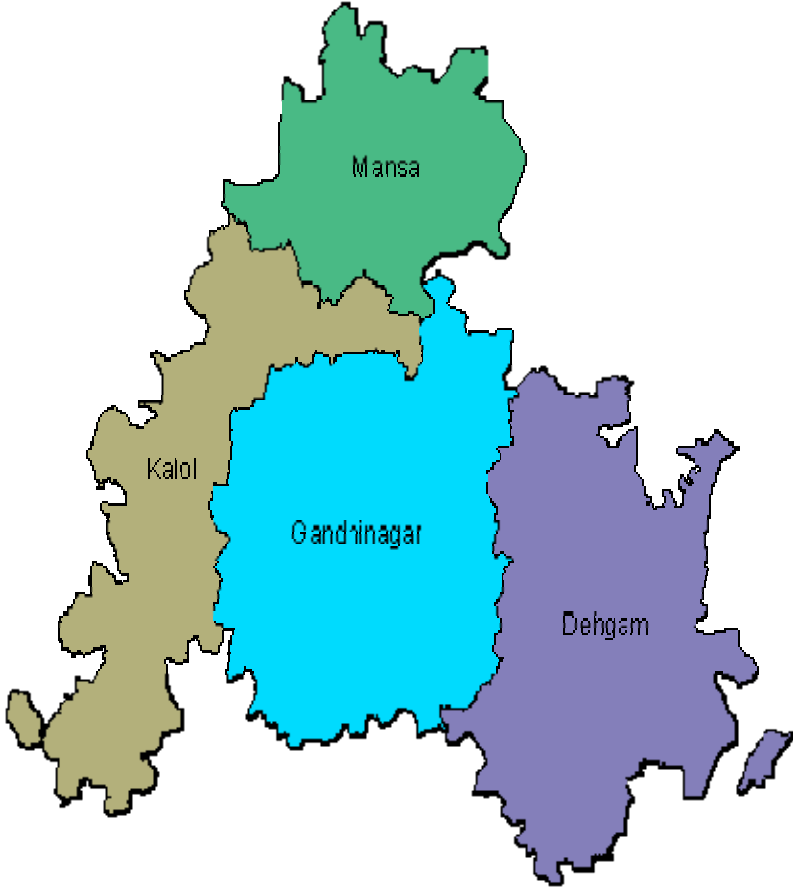
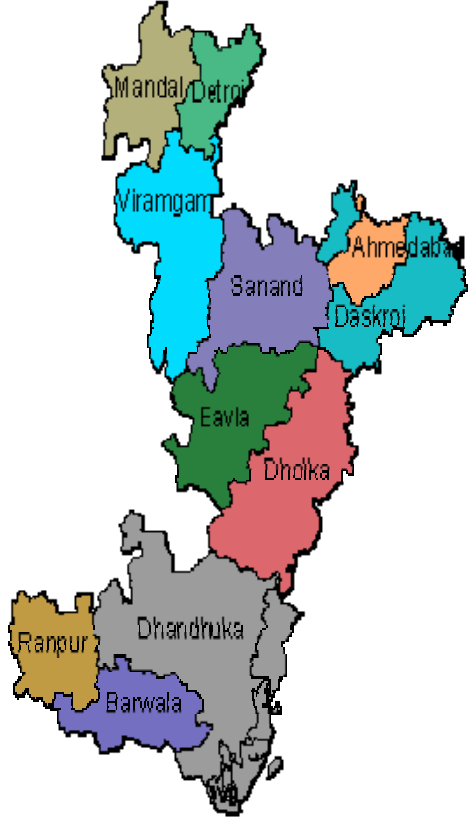
Gujarat has 35 Districts, 4 distinctive geographical regions and a sizeable population in tribal and costal regions. Areas were selected keeping in mind these variations and to ensure that all population groups and geographic areas were represented (Table 1).

Table-1. Areas selected for RAAPP

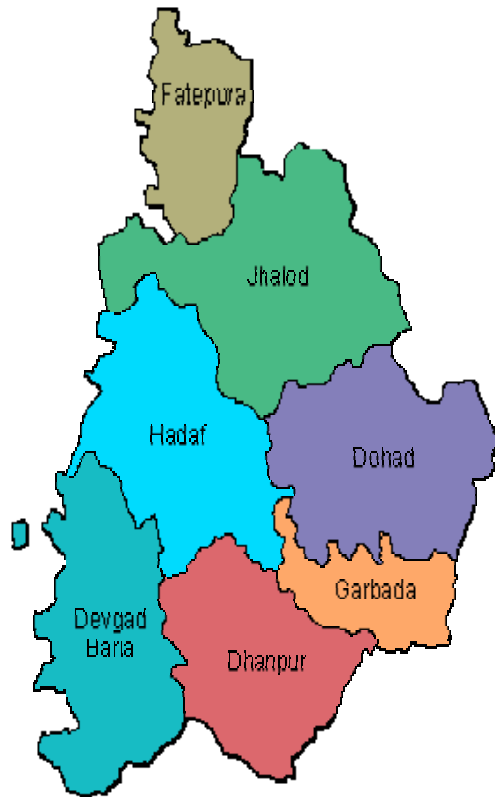
Area type	District	Taluka
Coastal	Junagadh	Veraval
Semi arid	Banaskantha	Deesa
Tribal	Dahod	Devgadh Baria
Other rural	Gandhinagar	Dehgam
Urban	Ahmedabad	Zone-3

RAAPP Districts

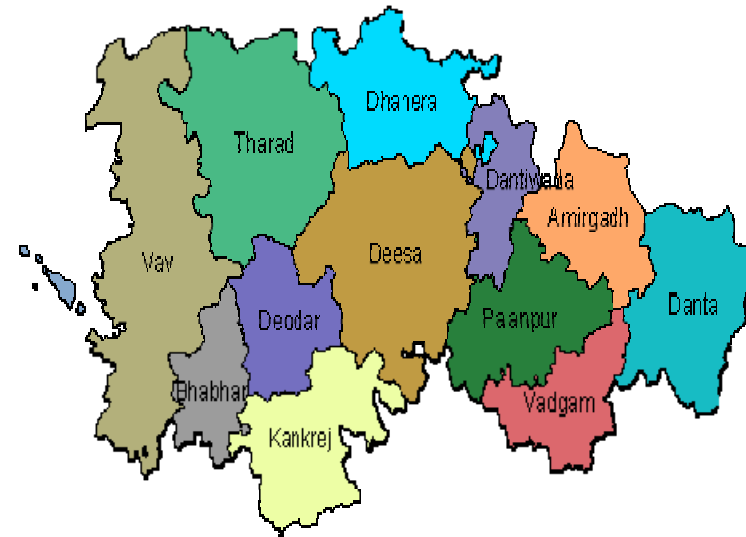


District Gandhinagar: Rural area Block selected for RAAPP: Dehgam	District Ahmedabad: Urban area Ahmedabad city selected for RAAPP
 <p>A map of the rural area of District Gandhinagar. The central block is highlighted in cyan and labeled 'Gandhinagar'. Other blocks shown include Mansa (green) to the north, Kalol (tan) to the west, and Dehgam (purple) to the east.</p>	 <p>A map of the urban area of District Ahmedabad. The city of Ahmedabad is highlighted in orange. Other blocks shown include Mandal (tan) and Detroi (green) to the north, Viramgam (cyan) to the west, Sanand (purple) to the west, Daskroi (teal) to the east, Eavla (dark green) to the south, Dholka (red) to the east, Ranpur (tan) to the southwest, Dhandhuka (grey) to the south, and Barwala (purple) to the southwest.</p>

District Dahod: Tribal area
Block selected for RAAPP: Devgad Baria



District Banaskantha: Semi arid region
Block selected for RAAPP: Deesa



District Junagadh: Coastal area
Block selected for RAAPP: Veraval



Activities Phase-2:

Training for data collection:

The two field teams were trained in RAAPP methodology from 21-25th February 2005. The teams practiced the data collection instruments in the classroom as well as in the field. Four research associates were recruited, with a background in social work and education who were a part of the field teams.

Objectives:

The objective the training programme was to facilitate field teams' understanding of the core concepts of the process, the elements of capacity and learn and practice the survey methods used in RAAPP- key informant interviews and focus group discussions, recording data, and analysis.

Training Methodology:

A participatory approach was followed where the participants learnt by practice in the class and in the field. There were group discussions to understand issues and categorize and look at them in the perspective of components of health promoting schools and the elements of state capacity.

Resource persons:

The resource persons for the training programme were Mr. Jack Jones Theodore who is the focal person for School health in WHO Geneva, Mr. Scott Pullizi who is a consultant from Education Development Centre, which is a WHO collaborating centre for school health in USA, and Dr. Cherian Varghese who is the focal person for health promotion in the country office of WHO, India.

Description of the sessions:

Understanding concepts:

The first two days of the training were spent in understanding the four components of HPS:

1. Health Supportive School Environment
2. School Health policy
3. School based health and nutrition services
4. Skill based health education

And the five state capacities:

1. Leadership and management
2. Collaboration
3. Monitoring
4. Policy creation and implementation
5. Knowledge base

An exercise in groups was given to the participants before discussing these concepts so that the participants could understand these in the perspective of their own school health programmes and policies.

Group Exercise-1:

On Index cards write down your answer to the following question:

1. What are all the different activities your ministry is doing to promote school health?
2. What does your ministry need to do in order to improve these current school health programmes?
3. What new activities should your ministry do to promote health through schools?
4. What are the resources your ministry would need to carry out these new activities?
 - »Materials
 - »Personnel

Step-1:

The participants were divided into four groups. They discussed four questions in small groups. The discussion points were written, on index cards.

Step-2:

The four components and five elements of capacity were explained in detail with examples.

Step-3:

The participants were asked to categorize their responses to the four questions in the perspective of these 4 components and five capacities. This was done on the wall and each categorization was discussed by going around with the group. The responses of this exercise are summarized in the Table-1 given as annex-2.

Group exercise-2:

Through this exercise the groups were able to:

1. Realize that many things can be done without additional resources.
2. Realize how, many times small improvements at the grassroots level may require change in state level policies, programme strategies and managerial support from the state.
3. Understand more clearly the four components and five elements of state capacity and their relationship.



The participants were again divided into four groups for this exercise. Their responses are summarized in Table-2 of Annex-3.

Practicing instruments:

All the instruments were practiced thoroughly:

- Each instrument was first read and understood in a larger group.
- It was demonstrated through a role-play and discussed again.
- This was followed by practice sessions in the classroom in small groups.

Group exercise-2

Yesterday we discussed the four components of Health Promoting Schools (HPS):

1. Healthy school environment
2. School Health Policies
3. Skills-based education
4. School-based health and nutrition services

And we also discussed the five elements of State capacity:

1. Collaboration
2. Monitoring and evaluation
3. Leadership and management
4. Information (knowledge base)
5. Policy-making process

This morning's activity is:

Think about your discussion yesterday. You made an assessment of current programmes, and you decided on ways to improve them, and you thought of additional programmes.

In your groups, can you decide 2 or 3 actions the ministries of health and education can take to improve school health programs?

There are three conditions: For each suggestion,

- decide on one outcome, e.g., a component of HPS, and
- one or two elements of state capacity (process measures)
- And, finally your suggestion should not cost any money.

- Finally the participants practiced the instruments in the field.

The instruments were translated into vernacular and the groups checked the translation for easy understanding. For the field practice the participants went to two nearby villages Ognaj and Lapkaman where they interviewed the Medical Officer of the Primary health centre, conducted focus group discussion with the Village education committee and the Mother Teacher Association members. They also interviewed the ICDS worker, the multipurpose worker female and some schoolteachers. The school premises were observed.



Focus group with members of village education committee Ognaj.



Interview with the ICDS worker, Lapkaman.

Focus group with members of MTA.



Focus group discussion with MTA/PTA of Lapkaman

The groups were asked to summarize the data from the field in terms of: "Did they find anything new about school health which they were not aware of"?

Group-1

- School health check-up programme:
 - Should be more frequent – not just once a month.
 - The services of private doctors could be taken
 - Health needs should be assessed regularly
- Developing healthy habits:
 - Permanent exhibition of health in the schools.
- Mid Day Meals:
 - There should be a kitchen for preparing mid day meals.

Group-2

- Chewing Tobacco by children:
 - Tobacco packets are sold from a kiosk near the school. There are no mechanisms to implement policy. The parents are helpless although they have tried.
 - There should be a strong programme to counsel children against tobacco chewing.
- Mid Day Meal:
 - Quality of food grains is an issue. The village education committee refused to accept grains, which were spoilt.
 - The village should be given the management of mid day meals.
- First Aid:
 - There is a first aid box given to each school but since education department gives it the health worker does not take interest in replenishing it.
 - Teachers have not been trained in first aid.
- Health Check-up:
 - Should be more frequent
 - Backed by strong referral system. Referral is very weak right now.

Feedback on instruments:

The group found the instrument –1 needed more practice. A lot of time was spent in understanding the abstract concepts such as "Leadership and management", what can be called a "Policy", what really means by "Knowledge base", various components of monitoring and evaluation etc.

Preparation of a new instrument:

While practicing the instrument –2 meant for the CBOs, the group felt that there needs to be a special instrument for the groups such as the village education committee. A new instrument was prepared for such a group.

Analysis and interpretation:

Using the manual on RAAPP various methods of data analysis and presentation were discussed with the group.

The data should be able to:

- Look for consensus on what are the strengths and weaknesses of state in relation to the 4 components of HPS and 5 elements of state capacity.
- Prioritize issues based on consensus
- List of suggestions of what could be done for improvement
- Some clarity of roles of the State

The group was given an idea about how this data will be used to prepare a plan.

Local Action:

Since there were a lot of questions on what can be done at the school level for health promotion, there was one session conducted on "Local Action". As conducting RAAPP, preparing a plan and building a consensus on the plan with both the ministries of health and education will be a long process the guidelines for local action can help schools assess their health related environment and implement interventions at the local level immediately.

Each of the participants were given a booklet for designing local action.

Data collection:

The data collection tools were adapted and translated into the local language. Four pre-designed tools were used for data collection.

Instrument –1 for in-depth interviews of the State/District/Block level officials

Instrument-2 for focus group discussions with the MTA/PTA

Instrument –3 for focus group discussions with Voluntary organizations

Instrument-4, which was specially, designed for focus group discussions with the Village Education committees.

Immediately after the training programme, data collection was started from the first week of March 2005. Fifty-eight in-depth interviews and 30 focus group discussions were conducted from the 5 districts selected (Table-2). Office bearers and elected representatives including the ministers, from both the health and education departments were interviewed from the State, district and block levels.

In-depth Interviews:

At state level 13 interviews were taken, which included the Minister of health and the Minister of education, Directors of health and education, programme officers, and heads of training institutes. Two Focus group discussions of international and local NGOs were conducted.

At the district level, interviews included bureaucrats in charge of all developmental work in the district, district heads of health and primary education, supervisors in-charge of school based health or nutrition services, school supervisors in charge of routine school inspections, officers of other related departments.

At the Block level, interviews included Medical Officers and health workers in charge of the School Check-up programme, the revenue head providing the Mid day meals in schools.

A team of one interviewer and one recorder took the interviews. The responses with all the incidents related by the respondents were noted down in detail. In each team a data manager was designated who ensured the completeness and quality of data.

Table-2: Details of in-depth interviews at district and block levels

	Health	Education	Others	Total
District and Block Levels				
Ahmedabad city	5	4	-	9
Banaskantha	4	5	2	11
Dahod	5	3	6	14
Junagadh	6	3	5	14
Gandhinagar	6	3	1	10
State level				
State level	5	8	-	13
Total	31	26	14	71

Focus Group Discussions:

Category	Number
MTA/PTA	15
Village Education Committee	15
Local NGO	1
International agencies in Gujarat	1
Total	32

Focus group discussions of village education committees and MTA/PTA were conducted in 3 villages in each of the districts. A total of 32 FGDs were conducted. Two focus group discussions were conducted with the local and international agencies each.

Activities Phase- 3:

In the phase 3 the data was merged and tabulated in the local language and also translated into English. Simple analysis was done of each of the instruments separately. The State and the district/block responses were also kept separate.

Instrument-1:

- ♦ The score sheet of ratings given to State capacities in each component of HPS were aggregated for each district and the state separately
- ♦ Strengths, weaknesses and suggestions in each of the 5 elements of capacity were merged and tabulated for districts and the state level respondents.
- ♦ The priority action points suggested by each respondent were also tabulated

The responses of the respondents from the education and health departments were analysed separately

Focus Group Discussions:

The responses to each of the questions were entered in a word file. The data was organized into themes and simple frequencies of similar responses were counted.

Planning Workshop 6-7 May 2005:

The expert group from WHO, EDC and the core group and field teams examined the data for drawing conclusions and finding a way to use the data for preparing an action plan. The core group and the field teams prepared a summary report in which the strengths in each of the area and recommendations based on the data were stated. Representatives of International and Local NGOs were also invited to give their suggestions of the key findings.

The preliminary recommendations were presented to the Secretary Education Mr. Paneervel and the Secretary family Welfare and commissioner health Dr. Amarjit Singh (Annex-7).



Group for preparing the action plan based on RAAPP results May 5-7 2005

Section-3

Recommendations and Action Plan

Preliminary Recommendations:

The recommendations are based on the consensus seen in the interviews of the state level and district/block level officials of the education and the health department. The SWOT based on the consensus seen in the responses to the questions in instrument –1 is given in Table-3. Only the responses with consensus more than 50% have been presented in Table-3.

The data revealed very diverse responses indicating that there is a need for a common understanding/a common vision on school health.

Broad recommendations:

1. Establish a common vision for a school health programme that recognizes the following components
 - School health Policy
 - Changes in the school environment
 - Skills based health education
 - Health and nutrition services
2. The health and education departments should jointly plan, implement and evaluate the school health programmes at State, District and Block levels.
3. Health check up and school health programme should focus on prevention and health promotion.
4. Health education has to be improved by focussing on skill building.

Specific recommendations:

1. Knowledge Base:

This capacity area is defined as to find, disseminate, and apply the state-of-the-art knowledge base

This includes the capacity to:

- Access published documents, use the Internet, or locate experts in school health programmes (information that is current within the past 5 or 10 years)
- Produce, reproduce, and disseminate information and materials throughout the country
- Provide professional development to help practitioners apply the current knowledge base
- Evaluate knowledge and skills acquired through efforts to disseminate knowledge base

Box-1 summarizes the recommendations to improve knowledge base. Though the responses for this capacity were diverse there was consensus on the strong capacity of the State to disseminate knowledge through existing supervisory networks and modern technology such as Television and Computer networks, and the system of regular meetings through which knowledge can be disseminated. Eighty-five percent state officials and 48% of the district/block officials agreed on this account. All Important communication is done through this network. There was also agreement about availability of expert knowledge.

However it was very difficult to find consensus on whether recent research and other expert knowledge is being used systematically in spite of a good dissemination capacity. There were 53% district/block level responses showing this as weakness rather than strength.

Similarly there was consensus seen in the capacity of the state to provide training to the staff associated with school health especially the teachers. Both the health and education departments have training facilities in terms of physical infrastructure and manpower resources for training at the State as well as district and block levels. Yet there were only 16% district level respondents satisfied with the quantity of training related to school health. 38% state level and 41% district level respondents suggested that the existing training infrastructure be utilized for training teachers in school health specifically in the use of first aid box, and basics of child health.

There were 64% district level responses for the need to develop specific IEC material and communication strategies for educating the community on school health issues. Some specific suggestions for training and improving the quality of the school health programme are summarized as recommendations (Box-1).

Box-1

Knowledge Base Strengths and Capacities

- ◆ Specialist doctors and NGO's and a network of institutions like DIET, CRC, BRC, VEC, PTA and MTA which are capable of disseminating the knowledge to the schools and teachers and the potential to reach parents and the community (*28/58 at the District and block level and at the State level 9/13 respondents*).
- ◆ Research outcome and important information is disseminated through Posters, Radio broadcasts and Television (state and regional) channels (*17/58 at the District/block level and 8/13 at the State level*).
- ◆ School teachers are trained every year in checking for vision and identification of common ailments by medical officers/specialists (*10/58 at District and block level and 7/13 at State level*).
- ◆ There is good capacity of training teachers at Block level (*10/58 at District and block level and 7/13 at State level*).

Recommendations:

Training

1. The ongoing teacher training programmes at various levels to include all aspects of school health programme.
 - ◆ Training modules and skills based health education
 - ◆ Training capacities
2. The existing mechanisms and networks for dissemination has to be used to communicate relevant messages on school health programmes to the parents and the community
3. Introduce relevant sections of the school health programme (hygiene, oral health and safety) in pre school through augmentation of the training of ICDS staff /other preschools such as ECCE centres

Quality

4. Health check up and school health programme should focus on prevention and health promotion
5. The education department should use teachers to provide the components of the School health programme (Sanitation, Safe Water, Hygiene, Safety etc), which are linked but not covered under the present school health check up scheme.
6. The health department should strengthen the capacity of the school health check up to provide leadership and capacity for prevention and health promotion
7. The health and education departments should identify and promote the use of interactive methods of health education such as games, competitions, demonstrations, mobile health exhibitions, etc.

2. Create, update, and implement policy supporting school health

This includes capacity:

- Create a policy that supports school health promotion
- Assess the quality of the policy and its relationship to larger national goals
- Revise policies
- Implement policies
- Assess whether policies are implemented effectively (relative to HPS and FRESH standards)

Box-2

School Health Policies: Strengths and Capacities

- ◆ School health services were rated the highest in terms of capacity in comparison with other components of school health (scores- 3.08/4 at State level and 2.69/4 at District level)
- ◆ Policies are developed through consultations and based on local needs, implemented, revised and evaluated (9/13 at State level and 22/58 at District and Block level).
- ◆ There are specific policies for substance abuse (tobacco), mid day meal scheme, school health, health check up and water and sanitation (22/58 at District and Block level).

Recommendations

- ◆ The health and education departments should jointly plan implement and evaluate the school health programmes at State, District and Block levels.
- ◆ Nodal officers from education and health department at State, District and Block levels should be designated with time and responsibility to work together to coordinate and maximize resources for a school health programme which consists of
 - ◆ school health policies
 - ◆ changes in environment
 - ◆ health education
 - ◆ health and nutrition services
 - ◆ mid day meal scheme
 - ◆ school health check up

Responses in this area are summarized in Box-2. Both the State level (69%) and district level (67%) officials felt that appropriate policies are created based on local needs. There were examples of various policies such as water and sanitation, tobacco sale in school surroundings, school check-up programme, and mid day meals were given. However majority of the respondents felt that policy implementation needs to improve (84% state level, 72% district level).

3. Leadership and Management:

This capacity area includes:

- Promote a common vision and framework for school health at all levels
- Designate a person or group with responsibility for school health
- Motivate staff at all levels (from top levels for funding to school level for implementation)
- Manage human and financial resources for school health
- Continually assess and respond to leadership and management needs

Box-8 Leadership and Management

Strengths and Capacity

- ◆ Manpower, infrastructure and finance for school health available and tasks are distributed effectively to individuals and teams (7/13 at State level and 27/58 at District and Block level).
- ◆ Satisfactory management systems (6/13 at State level and 3/58 at District and Block level).

Finance and supply

■ Financing

- ◆ Dedicated financial allocation has to be provided for school health programme, which will go beyond school health check up.

■ Supplies

- ◆ Medicines for Spot treatment should be made available in the schools along with replenishment of first aid box.
- ◆ IEC materials have to be made available for health education and promotion.

Recommendations for planning and scheduling

- ◆ Dissemination of Government Resolutions on School Health to appropriate levels.
- ◆ Organization of the school health check up may be rescheduled to
- ◆ not be scheduled during the monsoon.
- ◆ be at regular reoccurring times, such as on Wednesdays, for improved follow-up and referral.
- ◆ Ensure that the dates and details of the programme are communicated in advance to all concerned and officials are following the schedule.

Rewards

- ◆ Best practices in school health can be documented and success stories projected to motivate the staff, departments, parents and the community.

There were diverse opinions for this area of capacity. The high consensus issues have been include in the table-3. Both the state level and the district/block level respondents felt that there are human resource issues, which need to be sorted out. The suggestions in this area were very innovative but diverse. There was consensus regarding the need for more budgets for school health more so at the state level (61.5%).

4. School health services:

Box-3

Recommendations for Health Services

- The policy for expanding the time period allotted for school health checkups from 1.5 months to 90 working days may be used to ensure more time for the health staff in schools.
- The policy to include doctors on internship for rural health programmes can be expanded to include school health programme with involvement of the District Education and Health officers.
- School health programme can consider the services of private specialist doctors' for referrals from school health check up, by consultations with medical bodies such as IMA, IAP, and community based organizations.
- The policy to have preliminary screening by paramedical staff and teachers before the school health check up by medical officers should be communicated, implemented, enforced and monitored.
- School health check up can consider additional tests such as blood group determination

School health check-up had the highest score. It had the highest visibility (93% district level respondents talked about the programme), and yet most of the suggestions for immediate actions were related to the check-up programme (Box-3). As seen in table-3, 38% state level and 74% district/block level respondents have suggested that the check-up programme should be more frequent/ that it should be made a regular programme rather than a campaign once a year. Other specific suggestions were related to scheduling, the need to increase manpower and utilize the existing manpower by looking for alternatives such as have the preliminary screening done by the paramedical staff, involve intern doctors, involve private practitioners etc.

Water and Sanitation:

School environment more specifically water and sanitation has the lowest mean as seen in the score sheet and yet it did not figure in the list of weaknesses (41% district level, state level none). Moreover there were very few suggestions (33% district level, state level none) (Box-4)

The reason could be that water and sanitation does not come under the responsibility of the health department. The education department has administrative control of the schools and is responsible for providing the physical infrastructure required for providing water and sanitation. But there lacks a clarity of who will provide water and maintain the sanitation units in schools. This lack of clarity is reflected in the responses.

Box-4
Recommendations-School environment

- ◆ There should be a policy to maintain the cleanliness of the sanitation facilities in every school through creating appropriate mechanisms.
- ◆ There should be a mechanism to monitor school environment, availability of safe drinking water, adequate sanitation facilities and maintenance of the same.

Recommendations for structuring and organization

- ◆ The ministry of education and health should structure and allocate resources as necessary for the settings to ensure that the school health policies relating to safe water and sanitation can be communicated, implemented and enforced.
- ◆ Primary responsibility of school health programme to be given to education department.

There was one urban area selected to understand the issues in towns and cities. The mean scores of Ahmedabad zone-3 are the lowest in all components amongst all districts. This is because urban areas have fewer infrastructures and space is a problem.

Nutrition services-Mid Day Meal:

More than 50% of the district level officials felt that quality of the meal provided in the Mid Day Meal programme should improve.

Box-5
Recommendations for Nutrition programme

- **Mid day meal scheme can be enhanced and made more appealing by**
 - Transferring the responsibility to Village Education Committee/Ward Education Committee with specific guidelines
 - Improving taste and quality of ingredients
 - Ensuring hygienic practices in storing, cooking and serving
 - Monitoring the nutrition content

Most of the suggestions indicated the need to decentralize the implementation so that the local village leaders/village education committee, voluntary organizations could adapt the programme as per the local needs (Box-5).

Skill based Health Education:

Skills-based health education, which includes the following:

- Curricula that improve students' understanding of factors that influence health and enable them to make healthy choices and adopt healthy behaviours throughout their lives
- Curricula that include critical health and life skills, a focus on promoting health and well-being as well as preventing important health problems, and information and activities appropriate to children's intellectual and emotional abilities
- Training and education for teachers and parents

This had second after school environment amongst the lowest rating of mean score. This was also the most frequently mentioned demand by the parents as revealed from the responses in the focus group discussions. Fifty percent of the district level respondents suggested the use of innovative methods of health education such as games, health projects involving children, specific slots in the school timetable for physical exercise and yoga.

Box-6
Recommendations- School Health Education

- ◆ Health education has to be improved by focussing on skill building relating to important public health issues such as prevention, protection and psychosocial support and education issues such as schooling, ability to learn and a quality-learning environment.
- ◆ All schools should support policies on school health with appropriate rules and requirements.
- ◆ One day a month may be observed as School Health Day
- ◆ Parents to be sensitised to the nature and scope of school health programmes
- ◆ NGO's should be involved in creating awareness about school health in the community.

5. Collaborate across sectors

This includes capacity to:

- Identify common ground in priorities and unique contributions of different sectors Coordinate in order to leverage resources that can contribute to school health programmes
- Encourage participation of a range of stakeholders at different levels in the planning and implementation of school health programmes

As seen in table-3 the majority of the respondents felt that collaboration is not a strength in school health programmes. Only 46% respondents at the state level felt that there is collaboration between the two major departments directly involved with school health i.e the health and the education department.

Sixty nine percent of the state level respondents felt that collaboration with NGOs was weak. The district/block level respondents did not comment a lot on this area- 26% said it is strength and 12% said it is a weakness. However 57% said there is a need for more collaboration.

There is a strong demand to improve communication, and collaboration with the community and parents for school health programme – 77% of the state respondents and 79% of the district/block respondents suggested that there need to be planned special strategies to educate and involve the community in school health programme.

Box-7 Collaboration

Strengths and Capacities:

- ♦ The ministry of education enjoys good collaboration with the ministry of health (4/13 at State level and 9/58 at District and Block level).
- ♦ There is collaboration among multiple stakeholders including PTA, MTA and NGO's (6/13 at State level and 30/58 at District and Block level).
- ♦ NGO's are involved in creating demand and mobilizing the community (2/13 at State level and 15/58 at District and Block level).

Recommendations

- ♦ The school health programme needs to be jointly planned, implemented and evaluated by multiple stakeholders at each level.
- ♦ Innovative communication strategies should be used for Panchayat Raj system, communities and NGO's to make the school health programme a people's programme.

1. Monitor and evaluate processes and outcomes in school health

This includes capacity to:

- Regularly monitor determinants of health and educational outcomes
- Evaluate implementation and effectiveness of school health programmes
- Document, disseminate, and use monitoring and evaluation results to publicise achievements and improve efforts

Box-8

Strengths and capacities-Monitoring and Evaluation

- ✓ Programme monitoring carried out through regular visits and meetings and statistics generated (7/13 at State level and 27/58 at District and Block level).
- ✓ Monitoring leads to corrections (5/13 at State level and 5/58 at District and Block level).

Recommendations for monitoring and evaluation

- **Reviews**
 - The school health programme should be reviewed in the meetings of district and block level officials of health and education departments.
- **Reports and Reporting**
 - Indicators for monitoring components of school health programme such as skill based health education to be developed.
- **Evaluation**
 - Beneficiary satisfaction to be included in monitoring.
 - Evaluation should be objective and to be carried out by a neutral outside party,

Majority of state/district/block level (69% State level & 65% district/block level) respondents felt that monitoring and evaluation is a weakness rather than strength. Seventy one percent of the district

respondents suggested a need for improvement but not many suggested involving beneficiary satisfaction as part of evaluation. However 69% of the state level respondents felt that beneficiary feedback is important. Some 31% of state level and 41% of the district level respondents suggested ways to make the monitoring process more objective through use of indicators, and involving a neutral agency for evaluation.

Table-3: SWOT on issues seen across Districts and State respondents						
	Strengths		Weaknesses		Suggestions	
Summary of responses	State % Responses	District % Responses	State % Responses	District % Responses	State % Responses	District % Responses
1. Knowledge Base						
Research/important information is disseminated through posters/ meetings/T.V/Radio through supervisory network/The state system gives information to districts/Districts disseminate information to village level	85	48	-	53	-	-
Teacher training on use of first aid box/orientation to health issues	54	16	-	-	38	41
2. Leadership and Management						
Appreciation of work /Strategies for staff motivation	-	12	77	47	23	45
Budget / Infrastructure	-	28	54	45	61.5	31
3. School Based Health Services						
School based health & nutrition services	31	93	-	-	-	-
Health check-up more frequent/ A regular periodic event	-	-	-	-	38	74
Quality/quantity of food provided in Mid Day Meal Programme (vegetables, dry food packets, leafy vegetables/should be area specific/Families should be provided raw foodstuffs)	-	-	-	29	-	52
Implementation of the Mid day meal by community level organizations such as Village education committee	-	-	-	-	-	21
4. Healthy School Environment						
Schools should have own source/safe drinking water/There should be sanitation units with sufficient water and should be clean/Appropriate technology requiring less water/Schools should be clean/Schools				41		33

Table-3: SWOT on issues seen across Districts and State respondents						
	Strengths		Weaknesses		Suggestions	
	State % Responses	District % Responses	State % Responses	District % Responses	State % Responses	District % Responses
Summary of responses						
should have health environment						
5. Policies for school health						
Appropriate policies are created, implemented and revised –as per the local needs	69	67	-	-	-	-
Policy implementation	-	-	84	72	-	-
6. Collaboration						
Coordination between departments dealing with school health	38	-	46	38	31	43
Collaboration with NGOs	-	26	69	12	23	57
The needs and opinions of the community are taken in school health programme/Women participate/The community has adequate information about school health especially people of lower socio-economic status/ discussed in meetings/The programme is discussed with parents.	-	24	7	55	77	79
Specific strategies for communication with community and IEC material should be made available/Increased role of parents.	-	-	-	-	23	64
7. Skill based health education						
Innovative teaching methods for change in behaviour & health in schools needed- personal hygiene, safe handling of drinking water/Modules should be prepared for school health/There should be physical exercises/yoga/games in schools for children.	-	-	-	-	-	50
8. Monitoring and Evaluation						
Regular monitoring done	46	45	69	65	46	71
Beneficiary feedback / Involvement of beneficiaries in monitoring.	-	-	-	-	69	36

Table-3: SWOT on issues seen across Districts and State respondents						
	Strengths		Weaknesses		Suggestions	
Summary of responses	State % Responses	District % Responses	State % Responses	District % Responses	State % Responses	District % Responses
Objectivity in monitoring and evaluation/Through measuring performance on indicators /through outside agency/neutral party / In collaboration with other organizations.	-	-	-	31	31	41
Monitoring leads to action.	38	-	-	23	15	26

GUJARAT RAAPP: DRAFT ACTION PLAN FOR IMPROVING STATE CAPACITY FOR PROMOTING HEALTH THROUGH SCHOOLS

Gandhinagar, May 6-7 2005

RAAPP Capacity Area: Policy

OBJECTIVES:

1. JOINT PLANNING

- Initiate joint planning, implementation and evaluation of the school health programmes at State, District and Block levels of departments of health and education.

2. REVISE POLICY FOR HEALTH CHECKUP PROGRAMME

Make the School check-up programme a periodic event instead of a campaign once a year.

ACTIVITIES	RESPONSIBIITY	RESOURCES	TIME TABLE	M & E INDICATORS
JOINT PLANNING 1. Initiate process for appointing / designating a nodal person for school health in the education dept. <ul style="list-style-type: none"> - Advocacy: Advocate for a joint group at various levels- Ministers, Secretaries and directors and DDOs. - Permission etc. 2. Appoint/Designate a nodal person/s for school health in the education department with exclusive responsibility for school health at the State, district and block levels. <ul style="list-style-type: none"> - Prepare for getting approval - Get approval 3. Nodal person of education and Health Education Bureau plan school health programmes together 4. Establish Core group for school health at district level consisting of: <ul style="list-style-type: none"> ◆ Chief District Health Officer, ◆ District Primary Education Officer, ◆ Officers of training of both departments. 				Communication for advocacy, minutes of meetings etc Name of the designated person Communication/minutes of meeting. List of core group members. Document of roles and responsibility- modules describing role.

ACTIVITIES	RESPONSIBIITY	RESOURCES	TIME TABLE	M & E INDICATORS
<ul style="list-style-type: none"> ◆ Supervisors ◆ IEC Officers <p>5. Draft/Develop roles & functions of core group to plan, implement evaluate school health programmes and communicate to all stakeholders.</p> <p>REVISE POLICY FOR SCHOOL HEALTH CHECKUP</p> <p>6. Study the feasibility of making the school health check-up programme a regular programme (Periodic throughout the year)</p> <ul style="list-style-type: none"> ◆ Workload of Medical Officer and paramedical staff. ◆ Discuss possibility with the department of education & their possible role. ◆ Budget implications <p>7. Prepare a draft proposal for discussion and approval</p>				<p>Feasibility report</p> <p>Minutes of steering committee meeting</p> <p>Draft proposal</p>

RAAPP CAPACITY AREA: LEADERSHIP AND MANAGEMENT

OBJECTIVES

- ♦ Dedicated financial allocation for school health programme, beyond health check up.
- ♦ Possibility of pooling in budget for school health of both the health and education departments.

1. SUPPLIES

- ♦ Ensure medicines for Spot treatment & replenishment of first aid box.
- ♦ Provision of IEC material for health promotion

2. DOCUMENTATION OF BEST PRACTICES

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>1. Initiate discussion:</p> <ul style="list-style-type: none"> – The need for dedicated financial allocation for all the components of school health. – For pooling in resources of both the departments for effective use. <p>2. Communicate to the Primary Health Centers and the Schools</p> <ul style="list-style-type: none"> – <i>Replenishment of first aid box through the health workers.</i> – <i>Include this point in the monthly meetings of the PHC</i> <p>3. Health promotion IEC material:</p> <ul style="list-style-type: none"> – Develop a dissemination system for IEC material through the district administrations of health and education. – Need assessment for future requirements. – Review and revise existing health information in textbooks. – System for measuring effectiveness <p>4. Identify areas for documentation and</p>				<p>Financial allocation:</p> <p>Replenishment of first aid box:</p> <ul style="list-style-type: none"> ♦ Communication letters to Schools, PHC ♦ Minutes of PHC meeting <p>IEC material: Documents of signatures for material received exchanged in meetings- of CRC, BRC, and Principals.</p> <p>Documentation: Prepared documents</p>

the methods/type of documentation				
5. Identify professional to document				
6. Disseminate effectively				
RAAPP CAPACITY AREA: COLLABORATION OBJECTIVES				
<ol style="list-style-type: none"> 1. Increase collaboration between the departments of health and education 2. Planned involvement of the Village Education Committee, the MTA/PTA in the school health programme. 3. Planned involvement of the local Voluntary Organizations in school health programme. 				
ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<ol style="list-style-type: none"> 1. In addition to activities listed under <i>POLICY</i> the following would be done immediately: <ul style="list-style-type: none"> – Initiate the practice of inviting professionals of health and education departments in each other’s meetings at district and state levels. – Share important documents, Government resolutions (GR) such as the health checkup programme, the VEC etc with all concerned departments. – Mechanisms of linking GCERT and SIHFW and their district centers (DIET & DTT) for training for school health- share faculty, resource material. 2. Identify/spell out specific areas and roles for VEC/MTA/PTA in School health. 3. Develop mechanisms for regularizing their role. 4. Training to VEC/MTA/PTA members 5. Develop monitoring indicators 6. Identify/spell out specific areas and roles for NGO involvement. 7. Develop mechanisms. 				<p>Collaboration of departments of health and education:</p> <p>Communication about directive to invite professionals in meetings.</p> <p>Minutes of meetings</p> <p>Modules prepared jointly by GCERT & SIHFW, DIET & DTT.</p> <p>VEC/MTA/PTA:</p> <p>Document describing roles and responsibilities.</p> <p>Training reports/list of members trained.</p> <p>Minutes book of VEC/MTA/PTA in schools</p>

RAAPP AREA: KNOWLEDGE BASE OBJECTIVES

1. COMMON VISION FOR SCHOOL HEALTH

Establish a common vision for a school health programme that recognizes the following components

- a. School health Policy
- b. Changes in the school environment
- c. Skills based health education
- d. Health and nutrition services

2. TRAINING FOR SCHOOL HEALTH PROMOTION

Include all aspects of school health programme in the ongoing teacher training programmes at various levels.

3. QUALITY OF SCHOOL HEALTH CHECKUP PROGRAMME

- a. Refocus Health check up and school health programme to prevention and health promotion.
- b. Teachers to provide the components of the School health programme (Sanitation, Safe Water, Hygiene, Safety etc)
- c. Promote the use of interactive methods of health education such as games, competitions, demonstrations, mobile health exhibitions, etc.

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>COMMON VISION:</p> <ol style="list-style-type: none"> 1. Develop a short concept note/Presentation/points for discussion about school health in English and Gujarati. 2. Disseminate this resource material to all stakeholders in the health and education department, municipal corporations. <ul style="list-style-type: none"> ♦ Ministers ♦ Secretaries ♦ Steering committee members ♦ Directors and others 3. Presentation in steering committee meeting. 4. Presentation in meetings of: <ul style="list-style-type: none"> ♦ Chief District Health Officers ♦ Medical Officers, ♦ RCH Officers ♦ IEC officers ♦ Health workers ♦ Supervisors of the health department ♦ District Primary Education Officers, ♦ Cluster Resource Coordinators ♦ School Supervisors ♦ School Principals ♦ Teachers 5. Disseminate the note to related NGOs, and other organizations involved with school health. 6. Develop specific plan to communicate the vision for school health with the Panchayati Raj system, the community and parents of school children 				<p>Common vision:</p> <p>Copy of note/presentation/ in English and Gujarati. Minutes of steering committee meeting/other meetings where presentation was made.</p> <p>Training:</p> <p>Approval letter</p> <p>Documents:</p> <p>List of topics identified</p> <p>List of resource</p>

¹ WHO guideline for LOCAL ACTION for schools available

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p style="text-align: center;">TRAINING</p> <ol style="list-style-type: none"> 1. Obtain approval from both the departments of health and education. 2. Identify areas/topics for training 3. Prepare training strategy with the help of GCERT and SIHFW. 4. Prepare modules for training 5. Identify trainees including trainees from other related departments. Such as ICDS/ECCE. 6. Prepare training plan 7. Identify resource persons 8. Conduct training. 9. Evaluate effectiveness <p style="text-align: center;">REFOCUS SCHOOL HEALTH CHECKUP FOR HEALTH PROMOTION</p> <ol style="list-style-type: none"> 1. Analyze and utilize health check-up data to plan activities for health promotion. 2. Get approval to include health promotion as part of school health checkup. 3. Prepare guidelines for health promotion through schools for PHCs/Schools¹ 4. Help Primary Health Centres and Municipal corporation health centres to plan and implement health promotion activities based on data with the help of school staff. 5. Disseminate check-up results to schools and parents MTA/PTA, VEC. 				<p>persons</p> <p>List of trainees</p> <p>Training strategy, plan, document</p> <p>Training modules</p> <p>Training reports</p> <p>Follow-up report</p> <p>Refocus school health checkup:</p> <p>Approval letter with additional budget allocation for additional supplies and IEC material.</p> <p>Data Analysis report</p> <p>Guidelines for PHC/Schools.</p> <p>Plan for health promotion prepared by PHC and Schools</p> <p>Report of activities conducted by school/community/PHC</p> <p>Involvement of teachers:</p> <p>Report of activities in the health week</p>

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>INVOLVEMENT OF TEACHERS:</p> <ol style="list-style-type: none"> 6. Celebrate a health week in all schools once a year. <ol style="list-style-type: none"> a. Provide guidelines b. Minimum IEC material such as charts/posters/ mobile health exhibition. 7. Train teachers as per topics identified 8. Include activities for sanitation, safe water and basic hygiene in the teaching timetable for teachers. 9. Teachers should organize programmes on <ul style="list-style-type: none"> ◆ Cleanliness of school and school surroundings, ◆ Sanitation <p>INTERACTIVE METHODS OF HEALTH EDUCATION/PROMOTION:</p> <ol style="list-style-type: none"> 1. Prepare training modules for interactive methods for health education. 2. Develop games, competitions, demonstrations, mobile health exhibitions –an “Interactive health education kit” with the help of GCERT, SIHFW and HEB with inputs from experienced NGOs other experts. 3. Train teachers and supervisors in using interactive methods. 4. Include indicators in the supervisory checklist for monitoring. 				<p>celebrated in school.</p> <p>Timetable of teachers, which include health activities.</p> <p>Interactive methods:</p> <p>Modules</p> <p>Training report</p> <p>Reports of field activities</p> <p>Supervisory checklists</p>

RAAPP AREA: HEALTH SERVICES OBJECTIVES

1. Improve the management of the school health checkup programme.
2. **Ensure optimum utilization of First aid box provided to schools**
 - a. Train teachers
 - b. Replenishment of supplies
3. **Improve management of distribution and quality of food in the Mid Day Meal Programme**
 - a. Role of VEC MTA/PTA

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>HEALTH CHECKUP:</p> <ol style="list-style-type: none"> 1. Communicate plan to district administration of education of checkup programme well in advance. 2. Preliminary screening by paramedical staff & teachers before health check-up by medical officers. <ol style="list-style-type: none"> a. Develop specific guidelines/checklists b. Train PHC supervisors, workers and schoolteachers. 3. Advocacy with medical colleges for including school health in the internship programme of Doctors for rural health under the supervision of CDHO.members 4. Improve Referrals <p>FIRST AID TRAINING FOR TEACHERS: Prepare training plan and strategy Develop resource material. Conduct training. Formalize the responsibility of the Medical Officer/ PHC supervisor/Health worker to replenish supplies once a month from the PHC.</p>				<p>Health checkup: Guidelines Training reports List of teachers/paramedical staff trained</p> <p>Approval letter to include school health in the internship programme</p> <p>Plan to involve intern doctors in school health</p> <p>Mid day meal:</p>

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>MID DAY MMEAL PROGRAMME:</p> <p>a. Get approval for creating a role for VEC/MTA/PTA in monitoring the quality of food under the MDM programme.</p> <p>Check the feasibility and prepare a draft strategy for the purpose</p> <p>Get directive from Commissioner Mid Day Meals to arrange dialogue between</p> <ul style="list-style-type: none"> ♦ Collector mid day meals, ♦ District primary education officer ♦ Chief District Health Officer of each district <p>For specific authority/role for VEC in mid day meal programme.</p> <p>Develop mechanisms/guidelines to increase the role of the VEC/MTA/PTA after approval/agreement between all stakeholders.</p>				<p>Approval letter to involve VEC/MTA/PTA in monitoring food quality</p> <p>Copy of guidelines</p>

RAAPP AREA: SKILL BASED HEALTH EDUCATION

OBJECTIVES:

Improve Health education by focusing on skill building relating to:

- ♦ **Important public health issues**
- ♦ **Education issues such as schooling, ability to learn and a quality-learning**
- ♦ **Environment.**

ACTIVITIES	RESPONSIBILITY	RESOURCES	TIME TABLE	M & E INDICATORS
<p>a. Identify responsible persons from the department of health and education for the task.</p> <p>b. Identify specific focus areas for skill based health education</p> <p>c. Identify training needs for these areas</p> <p>d. Prepare a list of people to be trained (Training teachers, health workers, block extension educators etc)</p> <p>e. Prepare modules for training</p> <p>f. Prepare low cost health education material for school children.</p> <p>g. Estimate and arrange resources required for all these activities</p> <p>Pilot test in some districts.</p> <p>a. Implement training</p> <p>b. Develop monitoring indicators</p> <p>c. Identify partners and their roles- health professionals, teachers, NGOs etc.</p> <p>d. Plan for their systematic participation</p> <p>e. Create a mechanism using the current supervisory network to monitor the activities.</p> <p>f. Document process/lessons learnt for up-scaling</p>				

