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Primary school health education: a practical project for a small hospital community health department

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SUMMARY
A pilot project in a rural district of Tamil Nadu, India in which health is taught as a subject in primary schools by hospital-based staff is described.

INTRODUCTION

The child-to-child programme of the Institute of Child Health, London, has pioneered health education of children as an effective means of improving community health. In Tamil Nadu, South India, there has been a sharp increase in the number of children enrolled in primary schools, perhaps due to the Chief Minister's noon meal programme, which attempts to give young children a free nutritious meal at lunch using schools as a part of the distribution system. However enrolment in middle and secondary schools remains poor for the low income family children, who are the important targets of health education.

The Christian Fellowship Hospital is a Government Registered Charitable Hospital in a rural area of Tamil Nadu concentrating mainly on hospital-based medicine. It has limited funds as it receives no foreign aid or Government aid.

The Department of Community Health of this hospital is relatively new and has few personnel. The department chose primary school health education, where health is integrated as a subject into the school curriculum, as a priority in 1986 because:

(i) A high percentage of target low income group children are enrolled in primary schools.
(ii) Schools presented a ready and available structure to teach health.
(iii) The concept of making children into 'health workers' is both practical and effective because they are not only future adults but often care for younger children at home. If taught enthusiastically they can readily influence adults at home.
(iv) The costs of the programme are limited and require few materials and personnel, who nevertheless must be both enthusiastic and possess innovative ideas in teaching health to young children. Success depended very much on the teaching methods being effective.

METHODS

Primary schools were chosen according to (i) rural location, (ii) acceptable class size, i.e. up to 30 children in each class (this includes the majority of rural schools) and (iii) cooperation given by school authorities whether Government or private, after discussions with the headmasters and relevant management.

Each school was visited fortnightly for a 90 minute session. Quizzes were held to evaluate the programme every three months. Parent meetings were held in one school to involve the parents in this programme. A total of 10 schools were involved in the programme during the pilot study, although the project will be expanded as staffing allows.

Staff used in the programme were employed by the hospital. They had to be carefully chosen to deliver the sessions enthusiastically and in a manner acceptable to children. They were a trained nurse, a trained Balvady (nursery) school teacher, a health worker and a social worker, all of whom also helped in other activities in the Department of Community Health.

The programme was designed by the staff members with the help of interested hospital doctors, and tested and modified in each school with the advice of the school teachers. The school teachers were given a 7-day orientation course for the programme.

A two-year syllabus was designed and covered the topics in Table 1. Forty visits were made to each school during the two years.

The subjects had to be delivered in a manner which the children understood and found exciting. Usually this meant the idea about a topic was given by a drama, story, game or a puppet show and the children were involved in an activity to hold their interest. These activities included:

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Table 1. Subjects taught and number of lessons

Subject	*Number of lessons*
Introduction	1
Germs	2
Immunization	3
Drugs and medicines, medical malpractice	2
Personal hygiene	2
Wounds	1
Dental hygiene	1
Diarrhoea and its treatment	2
Latrines	1
Clean water	2
Nutrition	
(a) Balanced diet	1
(b) Breast feeding and weaning	1
(c) Identifying malnutrition and monitoring	2
(d) Good cooking methods (energy rich food and preserving nutrients)	1
Kitchen garden and use of pesticides and fertilizers	2
Fevers and coughs	2
Tuberculosis	1
Leprosy	1
Hearing	1
Eyes and vitamin 'A'	1
Accidents	1
Dangers of smoking and alcohol	1
Quizzes	4
Total	37

(i) answering simple appropriate questions. For example, to reinforce the idea that straining cooked rice in too much water wastes carbohydrates, we asked 'which of you notices your mother doing this at home?'
(ii) making practical items such as immunization records for babies, or making oral rehydration fluid in the classroom.
(iii) enrolling students to be in charge of wound dressing for a class after lessons on first aid etc.
(iv) acting out dramas.

For example immunization was taught over three visits. The first visit included a filmstrip on immunization produced by the Tamil Nadu integrated Nutrition Project. This introduced the concept of germs as green monsters which are in duel with handsome white cells. In the film the germs often win but immunization trains and arms white cells with exciting weapons which they use to destroy any invading germs. The second lesson involved a contemporary village story given as a puppet show illustrating the many reasons why vaccinations are refused by mothers. The third visit included simple descriptions of the main immunizable diseases using slides and actors. Each child is then encouraged to make an immunization record for a related or a neighbour's baby (Figure 1). Children were encouraged to bring the babies whose vaccinations were due to the next visit or to the health clinic if one is available in the village. The result was that all the children learnt the schedule and were enthusiastic in bringing several relatives to be vaccinated. The teaching thus produces immediate and long-term results.

Figure 1. A type of immunization card produced is illustrated. The germ is coloured green and other bright colours are used to make the card interesting. The local language, Tamil, is normally used

DISCUSSION

We have found that organized school health education is a cheap, relatively easy and effective way of achieving short- and long-term improvements in community health. Moreover, it can be done by a small community health department that is just beginning its programmes. Our programme will be modified and redesigned as our experience improves. We found the most important factor was the enthusiasm and innovative abilities of the staff who need not be highly trained. At present these qualities are more easily centralized by having the staff hospital-based and visiting individual schools in turn. However, as teachers learn about the programme and its methods we hope they will become more activity involved in delivering the message.