THE HESAWA SCHOOL HEALTH & SANITATION PACKAGE

Zonal HESAWA Coordination Office
Mwanza, Tanzania

THE HESAWA SCHOOL HEALTH & SANITATION PACKAGE

An Effective Tool For Sensitizing and Mobilizing Communities To Participate Actively in Community Based Health/Development Projects

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THE HESAWA SCHOOL HEALTH & SANITATION PACKAGE: An Effective Tool For Sensitizing and Mobilizing Communities to Participate Actively in Community Based Health/Development Projects

INTRODUCTION

Participation of villagers in their own development is a key factor in the success of any community development project because participation is an essential part of human growth. Communities can be mobilized by the army to dig a trench for their own water supply or build better houses for their families without going through the dynamic process that leads to true community participation. True community participation must be able to release the people's own creative energies for their development.

"Participation involves organized efforts to increase control over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control."

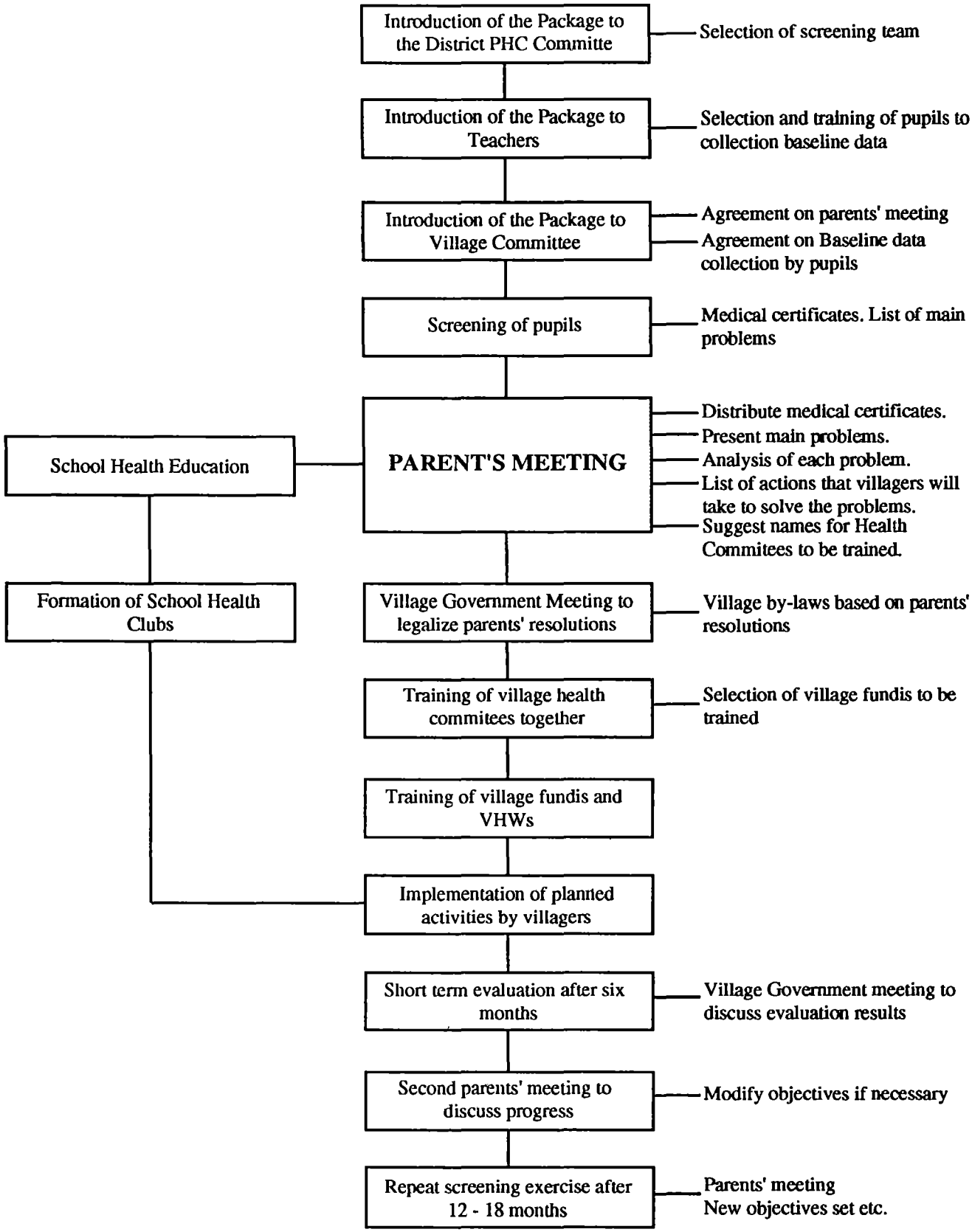
(Pearse and Stiefel, 1979.)

Sustainability and replicability of community based development projects depends entirely on how well the community participates in the project from the early stages of planning and phasing in to the final stages of evaluation and phasing out. The process of soliciting community participation is long, slow and tedious. Often donors press for quick results and implementers are tempted to take short cuts in order to meet pre set deadlines. There are no short cuts for soliciting true community participation. It takes time but in the long run this time will be compensated for during implementation phase because once the community is properly sensitized and mobilized, implementation becomes easier and faster.

The problem based learning (PBL) methodology on which the HESAWA School Health & Sanitation Package is based, has proved to be a very appropriate way of entering communities to start community based development projects because it presents a dynamic process which enables villagers to become more aware of their own situation, of their real health problems, the causes of these problems and the actions that they themselves can take to change their situation. This process of awakening and raising levels of consciousness constitutes a process of self-transformation through which people grow and mature as human beings.

The school health approach has been used in the SIDA (Swedish International Development Authority) supported HESAWA (Health through Sanitation and Water) project in the lake zone (Tanzania) and has proved to be a very effective tool for sensitizing and mobilizing communities to participate actively in solving their sanitation related health problems. The package consists of screening school children to identify the main health problems affecting them and calling a parents' meeting to analyse these problems by identifying underlying causes for each problem and agreeing on specific actions that they will take collectively and individually to solve the problems.

Steps for Implementing the HESAWA School Health and Sanitation Package



PRE-SCREENING PROCEDURE.

STAGE 1: The chief facilitator organizes a workshop for the district PHC (Primary Health Care) committee to introduce the main concepts contained in the package and solicit intersectoral collaboration. The necessary resources for carrying out this exercise are listed and the feasibility of implementing the package in their district is discussed in great details. At the end of the meeting the committee selects the screening team that will be taught how to implement the package practically.

Introducing the idea to the teaching staff

STAGE 2:
The district health promotion team discusses the idea of screening children with the teaching staff of the selected school, stressing the importance of health education to school children, school health clubs and intersectoral collaboration. The teachers are also introduced to simple forms that will be used by senior pupils to collect environmental sanitation baseline data from their village.

STAGE 3:
The screening team, together with the headteacher, make an appointment to discuss the program with the local village committee. This meeting should stress the community participation and prevention aspects of the program.

During this meeting the promotion team must explain clearly the importance of the parents' meeting to work out a prevention strategy for their children and the community as a whole. The success of this program will depend, by and large, on the quality of this meeting.

STAGE 4:
Ask the headteacher to appoint 20 - 30 intelligent pupils from senior classes and teach them how to fill in the special home visiting forms for baseline information on the current state of latrines, refuse pits, drying racks in the village. Teachers should assist the pupils to collect this information before the actual screening is done.

Prior to the screening exercise, the teachers will record the name, age, sex, class, weight and height of each child on a special form to be provided by the health team.
Make an appointment with the headteacher to specify the actual days for implementing the activities in his/her school. Make sure you have the following staff and equipment.

Technical Staff (selected by the district PHC committee)

1. Clinician - one medical assistant or RMA
2. Lab technician or a trained microscopist
3. Trained nurse
4. Nursing assistant or health assistant

Non-technical Staff (selected by the screening team)

1. For weighing - one person
2. For measuring height - one person
3. For registering - one person
4. For assisting the lab technician - two persons

Equipment

1. One ream of duplicating paper or rough paper
2. Seven marking pens and two rulers
3. Three marking pens to write on slides and test tubes
4. Waterproof brown adhesive tape for marking slides and test tubes
5. Slides - 400
6. Test tubes - 200 (10 cc)
7. Spirit 500 mls
8. Cotton wool - one roll
9. Disposable prickers - 600
10. Applicators - 100 (can be made locally)
11. Gloves - six pairs
12. Antiseptic - 100 cc
13. Microscope - one
14. Hand centrifuge - one
15. Filter paper #1 - two pieces
16. Tallqist chart for Hb. estimation
17. Test tube rack for 100 tubes - one
18. Tape measure - one
19. Pair of scissors - one
20. Weighing scale - one

With the above equipment and staff the screening team can examine about 100 to 150 pupils daily for the following:

1. Height
2. Weight
3. Haemoglobin
4. Stool for immediate microscopic examination.
5. Urine for immediate microscopic examination.
6. Clinical examination which should include answering one or two specific questions, e.g. episodes of diarrhoea in the last month, eating habits, etc.
7. Quick physical examination for obvious clinical abnormalities.

Note: The non-technical staff listed in Stage 4 can be teachers from the school, senior pupils, the driver, or existing Village Health Workers (VHWs).

DETAILED SCREENING PROCEDURE

On the screening day, the teachers should give each of the 100 - 150 pupils listed for that day a small clinical form (10 x 15 cm) with the pupil's name and serial number on it. Each pupil will then carry this clinical form through the following steps:

STEP I COLLECTION OF STOOL SPECIMENS

One day prior to the screening day, the headteacher will ask the first 100 - 150 children on the roster to bring a small amount of stool specimen in an empty match box. One of the non-technical staff will collect these specimens and label them ready for immediate microscopic examination by the microscopist.

The microscopist/lab technician will record the findings on a separate urine and stool examination form to be handed over to the clinician for compilation at the end of the day.

STEP II COLLECTION OF URINE SPECIMENS

Immediately after receiving a stool specimen the nursing assistant gives a labelled test tube to each pupil and asks him/her to fill it up with his/her own urine. One of the non-technical assistants will centrifuge each urine specimen before handing it over to the laboratory staff for immediate microscopic examination. If a centrifuge is not available, the urine specimen should be allowed to settle for 30 minutes before the sediment or the last drop at the bottom of the test tube is put on a clean slide for microscopic examination. The technician records his/her findings accordingly.

STEP III HAEMOGLOBIN ESTIMATION

After handing over the urine specimen each pupil moves to the next step where a nurse estimates his/her haemoglobin using the Tallqist method. The nurse records this estimated haemoglobin on the pupil's clinical form.

STEP IV SHORT HISTORY AND CLINICAL EXAMINATION

At Step IV, the clinician takes a short clinical history, conducts a quick clinical examination and records all positive findings on the clinical form. This form remains with the clinician after the examination.

Screening of Children

DATA ANALYSIS AND REPORT WRITING

At the end of the day, the clinician, in collaboration with the other members of the technical staff, completes entering data from the technical staff on the original forms which had partially been filled by the teachers. Examination/interview results from the technical team on stool, urine, Hb, history of diarrhoea, eating habits etc. are added to these forms.

The clinician in charge, in collaboration with the technical staff, will now work on data analysis and report writing for each pupil, as well as, for the entire school as a community. The team will identify and list the top five health problems affecting the children. The health team will prepare relevant health learning materials based on these problems to be ready for the parents' meeting which should be held not later than seven days after completing the examinations.

PARENTS' MEETING

Parents' meeting

The parents'meeting is a crucial event in this program. In order to strengthen intersectoral collaboration, key actors from sectors other than the health and education departments should attend this meeting. Ward leaders and village chairpersons from neighbouring villages should also attend.

The first activity during this meeting is to present a written medical report to each parent. This report should list the health problems affecting each child. It should also state clearly what action the parent should take to solve the child's problem as soon as possible. The health team must see to it that medical ethics are observed when communicating individual reports to parents. The parents whose children have no medical problem should be congratulated and encouraged to maintain their children's good health.

Having done this, the district team, which should include the District Medical Officer (DMO) and other members of the district health promotion team, will now go over the top five medical problems affecting the children and discuss them in detail with the parents. Problem Based Learning (PBL) and other learner centred adult teaching techniques should be used. The health team members will act as facilitators rather than lecturers. At the end of this meeting, parents should be able to:

- State the top three to five health problems in the school.
- Describe underlying causes of each problem.
- State/list possible solutions for each problem.
- State what they have agreed to do to solve each problem.

During this meeting, the parents will be facilitated by the health team, under the chairmanship of the village chairman, until they have worked out a detailed plan of action specifying:

- What is going to be done?
- Who is going to do what?
- When it is going to be done?

SELECTION AND TRAINING OF A VILLAGE HEALTH COMMITTEE

The parents' meeting should elect a village health committee if it does not exist. This new or re-inforced committee should consist of (VHC) about 8 - 12 people, of which half should be women. The committee should be empowered to deal with all health and sanitation problems in the village. The village chairperson and secretary should be ex-officials in this committee.

Soon after the parents' meeting the overall village government should meet to discuss all parents' resolutions to legalize them while re-enforcing existing village by-laws on sanitation when and if necessary. District and sub-district trainers should organize a six-day seminar for the (VHC) not later than 30 days after the parents' meeting. Recommended are four hours of training three times a week for two weeks. This seminar should cover, among other topics, the following:

1. Detailed health education on the main health problems affecting their children.

2. More detailed plans for implementing the parents' resolutions.

3. The role of Village Health Workers(VHWs) and Village Fundis in implementing their plan of action including recruitment, selection, supervision and motivation of these key workers.

4. Write their own constitution to outline how they will run their affairs.

5. Other program specific concepts like HESAWA Concept,and Gender Issues.

SELECTION AND TRAINING OF VILLAGE HEALTH WORKERS (VHWs)

At the end of the seminar the VHC should be given two weeks to work with the village government and villagers to select VHWs and Village Fundis for training. Ideally, they should select one VHW/VF for every 50 households. It is recommended that training of the selected VHWs/VF be done within the village by sub-district trainers.

Six hours of training per day, three days a week for three months should be enough to cover the Ministry's syllabus for VHWs.

Training of VHWs

HEALTH EDUCATION AND SCHOOL HEALTH CLUBS:

Organize a workshop for the teachers in the village primary school where the screening was carried out. Two hours a day, two days a week for three weeks running concurrently with VHW training within the village would be ideal.

This workshop should aim at equiping the teachers with the knowledge and skills for implementing an effective health education campaign in the school. It should be based on the health problems found among the pupils. The teachers will be provided with the necessary books and other materials for health education. Pre and post tests will be given to pupils to assess the amount of knowledge transferred to them. AIDS shall be included in the health education curriculum as a special subject for all schools.

Formation of school health clubs can be discussed in detail during this workshop. The following steps will be discussed and adopted:

1. Teachers select 20 - 30 pupils (from Std V and above) who are always clean and smart.

2. One teacher accompanied by a trainer will visit the homes of each of these 20 - 30 pupils to certify whether they have a good latrine, refuse pit and drying rack. Those who qualify are then officially declared the founding members of the school health club. Each one is given a school bag, mathematical set, T-shirt or any other incentive that will raise the other children's interest to join the club. The founding members should then elect a chairperson, a secretary and a treasurer. The health teacher or domestic science teacher should be their patron/matron.

3. Each group should establish specific and detailed criteria for joining the club. They will take over the role of inspecting other pupils' personal hygiene and homes for qualification to join the club.

4. The district health promotion team will facilitate and encourage health clubs from different schools in a given ward to compose health songs, stories and short plays, or design posters to educate the public on health and sanitation related problems. The best performers will be rewarded accordingly.

   The Health team will also be expected to facilitate health clubs to run mini projects like rabbits farming, vegetable gardens and raised stoves.

EVALUATION

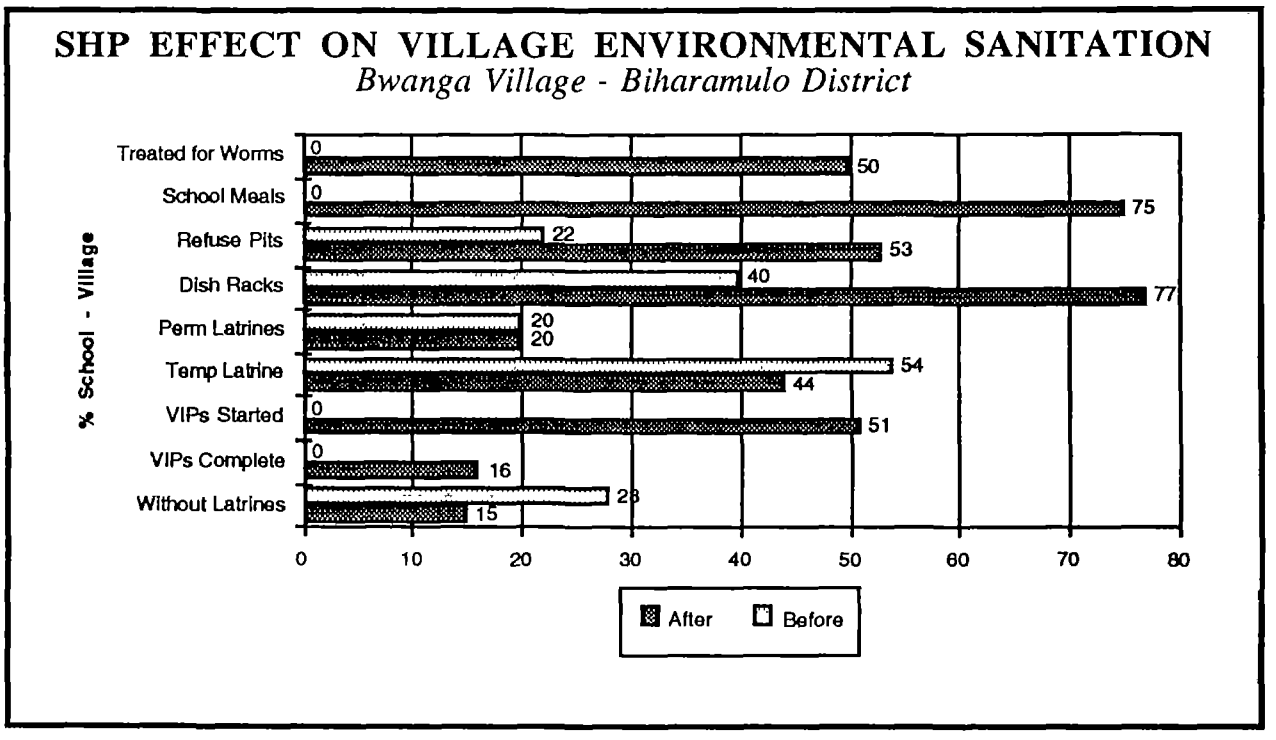
The teachers will keep copies of all data related to this program for the purpose of monitoring and evaluation. The district team will conduct KAP studies from time to time to evaluate changes in knowledge, attitude and practices related to school health and environmental sanitation activities in the village as a whole.

As stated earlier, each village will be encouraged to discuss their progress regularly. At the end of each year, the whole exercise will be repeated from Steps 1 through 6. The parents will be congratulated for any improvements achieved during the year and new problems will be dealt with accordingly. This will lead to appropriate modification of their plans of action to be implemented in the following year. This process will be repeated until the villagers are satisfied that the problems in question have been reduced to an acceptable level.

RESULTS FROM IMPLEMENTATION IN PILOT DISTRICTS

In 1993 this methodology was tried in three districts in the program area, and the following results were obtained:

- Over 80% attendance at parents' meetings.
- Active participation by all parents during meetings.
- Action oriented meetings - implementation of village action plans effective up to 75% within six months in some villages (see Bwanga results below).
- Villagers were willing to use locally available materials for latrine construction.



In October 1993, the Department of Health Behaviour and Education of AMREF was asked by SIDA to evaluate this approach and make recommendations accordingly. AMREF came up with the following main conclusions.

1. The school health package (SHP) has succeeded in creating awareness on environmental sanitation related health problems, their causes and solutions among the target populations.

2. Communities have been motivated to participate actively in implementation of environmental sanitation activities.

3. The school health strategy has made remarkable progress in promotion of the use of available materials and in increasing sanitary facilities (latrines, dish racks, refuse pits and bathrooms). There is a high potential for sustainability of construction of these facilities.

4. The SHP has promoted interaction between government extension workers, teachers and community members in finding solutions to prevalent health problems, especially at the community level.

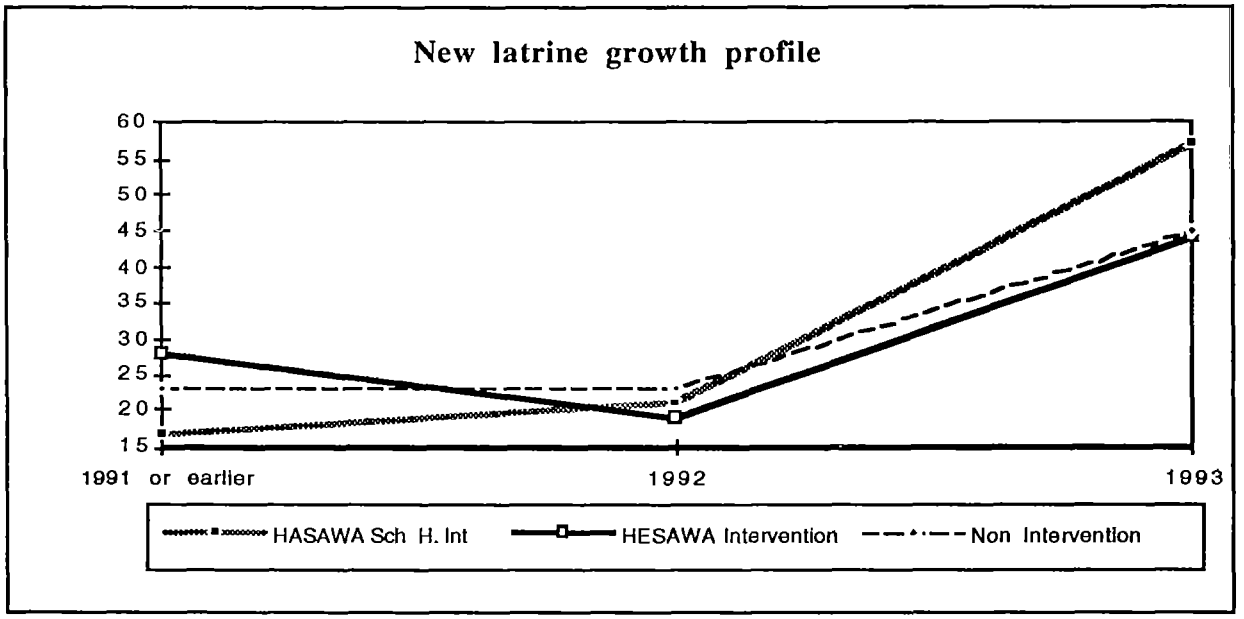
5. There exists a high potential for replication of environmental sanitation activities promoted through the SHP.

6. To some extent, the SHP has promoted community participation in decision making through parents' meetings.

The following graphs are extracts from the AMREF evaluation report that was submitted to the SIDA/HESAWA annual review mission in November 1993. Based on this report, SIDA accepted the HESAWA school health and sanitation package and recommended that this approach be used throughout the HESAWA program area with effect from July 1994.

VIP Latrine Melam Type

The growth of latrines since 1991 was investigated. Results are shown in the graph below:

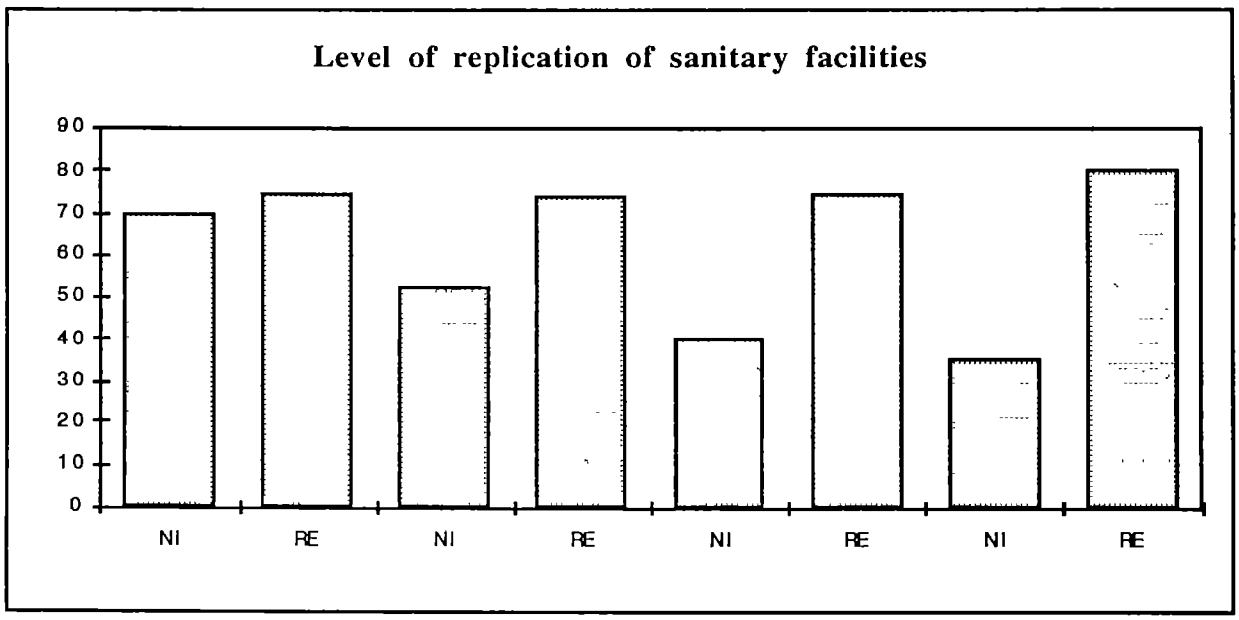


In all the three sites, there is a remarkable growth in the number of new latrines during the year 1992/93. However, the school health intervention villages registered better performance compared to other sites.

Construction and use of new dish racks, refuse pits and bathrooms showed similar growth profiles and the following conclusion was made by AMREF:

"Overall the assessment of the construction of latrines, dish racks, refuse pits and bathrooms shows a better performance in the HESAWA school health intervention villages compared to the control villages. The better performance of the HESAWA school health intervention villages can be attributed to the influence of the problem based learning approach."

A comparison was made on existing facilities in the non intervention and villages neighbouring the school health intervention area. The results are shown in the graph below:



NI - Non intervention village
RE - Village where replication was expected to occur.

As shown on the graph, the villages neighbouring the school health intervention areas (RE) have performed much better than the non intervention areas.

The

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Hesawa

PROGRAMME

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