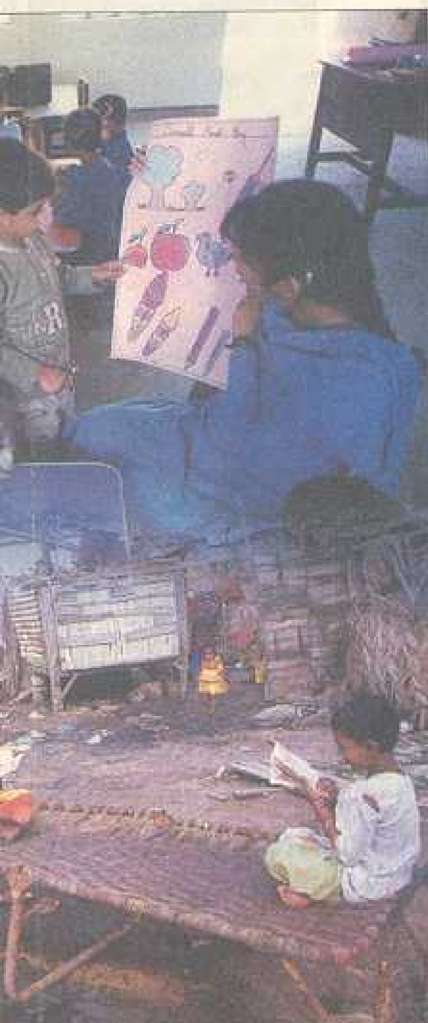
ols healthier

Haider



Throughout the implementation phase of this project many examples of health action were noted. Children were involved in making dustbins, keeping latrines and water sources clean, bringing boiled water to school, bringing healthy food for lunch and buying less snack food from street vendors, achieving a lice-free school, and making toys for younger children. In fact in one school, teachers and children supported health services by promoting a polio immunization campaign. Children also gave concrete examples of how, as individuals, they were motivated to promote new health ideas at home.

In relation to children's content of health knowledge, pre and post-test results show a significant increase in the levels of children's health knowledge. The most significant result was demonstrated in the poor semi-urban government school setting. Similarly, a comparison of children's confidence and self-esteem scores, pre- and post-intervention, showed a significant increase. Such confidence and motivation is central to children developing positive attitudes towards believing that they have the ability to develop themselves, take action on their own, and communicate their ideas and concerns to others.

In an analysis of urban government schools, it was previously seen that the bathroom behind the school was in a terrible state, breeding flies and smelling quite badly. It was overflowing with faeces and had no sink, water or soap for washing hands. Observation and analysis of the same school after HAS intervention found a vast improvement in the quality of the sanitation and water supply at this school. The latrine and surrounding area was cleanly swept. The children also had access to water and soap and were observed washing hands after using the bathroom. In fact toilet monitors were assigned, so that whenever a younger child wanted to use the toilet, the monitor would go along and assist the child with proper toilet manners.

The head-teacher of this government school also reported of a case when students and teachers tried to combat a severe epidemic of diarrhoea in their community. They recognized this issue and went from school to school giving a presentation on how to fight diarrhoea by drinking ORS. They demonstrated how to make ORS at home and presented on the common causes of diarrhoea. A few weeks after this campaign, doctors from the local community applauded the teachers and heads of this school and verified that the cases of diarrhoea in that community had, in fact, decreased considerably ever since this campaign had taken place.

The health co-ordinator of a community school mentioned that the students studied a topic on a cleaner environment after which they approached members of their community to request them to keep their surrounding areas clean and to throw trash in dumpsters. They went from home to home, pleading the people to change their habits. Although many of the community members ignored what these children said, there were quite a few who heard what they (the children) had to say and promised to change their behaviour.

In focus groups and regular interviews, children commented on how HAS had changed teachers' attitudes towards them and the way in which they were treated. In the semi-urban government school, in particular, a dramatic change was noted in the way the teachers and children related to each other. Corporal punishment was significantly reduced and an overt effort to include girls and reduce gender discrimination in class was noticed.

One of the HAS team members mentioned in her reflection that she was stunned at the marked difference in teaching methods, classroom dynamics and attitudes of the children when she visited the semi-urban government school. According to Dr Tashmin Khamis, before the HAS intervention this school was being run by one teacher and one peon, as all the other teachers were continually absent. The peon conducted the class by banging a stick on the floor, as he demanded the little children chant the alphabet loudly. The girls in this class were constantly ignored and sat in the back.

The children were too afraid to even write their names on the board when asked by the HAS worker. After the intervention, the same children shook the HAS workers hands confidently, boys and girls sat together and were enthusiastically answering as well as asking questions. The most significant change however was in the teacher-student relationship. There was a two-way communication evident and children felt comfortable approaching the teacher, discussing and enquiring of the teacher, which was so different from the fear of the teacher that was visible in the eyes of these same children some years ago.

This transformation in the social environment of the schools, and in particular in the small government schools, is one of the remarkable achievements of HAS. This can be attributed to the adoption of improved relationships between teachers and children, which the HAS team initiated. Their attitudes presented an alternative to the traditional hierarchical roles in schools between teachers themselves, and in how adults relate to children.

The results of this project show that the greatest impact of using the child-to-child approach in teaching health education is in schools where resources are few. It has proved that schools that promote a healthy atmosphere are able to provide better quality primary education. They create an enabling environment to help teachers teach better and gain greater confidence in their work. This leads to the active participation of students, a relationship between teachers and students, linkages between school and communities as well as enhancing the overall education, health knowledge and self-esteem of all teachers, students and local communities. In some cases it has also led to higher attendance of children in schools. ■

Schools interested in signing up as a Health Action School can contact the AKU's Institute for Educational Development at 021-6347611-4.