CHAPTER 1

INTRODUCTION
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CHAPTER I
INTRODUCTION

1:1 Introduction

"Educating children at school on health should be given the highest priority, not for their health per se, but also from the perspective of education, since if they are to learn they need to be in good health" - Hiroshi Nakajima (1992).

"Educating children on health aims to produce a level of health consciousness in children and equips them not only to improve their own health but also to contribute significantly towards family and community health. It is equally important to provide necessary equipment and facilities to help students apply this knowledge in practice" - U. Ko Ko (1992).

Education for health is a fundamental right of every child. Health is inextricably linked with educational achievement, quality of life and economic productivity. By acquiring health related knowledge, beliefs, attitudes, values, skills and practices, children can be empowered to pursue a healthy life and to work as agents of change for the improved health of their families and communities. This goal
can be achieved in schools if the school health education programmes are strengthened.

In the declaration signed by Heads of State at the world summit for children in 1990, the world's leaders committed themselves to a 10-point programme to protect the rights of the child and improve children's lives. The 10 points include enhancing children's health, promoting optimal growth and development in childhood; strengthening the role of women and respecting the role of the family.

Health care of children who constitute about 20 per cent of the total population in any country is the most important aspect of community health (Chadha, 1979). School-age children number over a thousand million in the world. In developing countries about 80 per cent of children now enroll in primary school at ages 6 to 14, and 60 per cent complete at least 4 years of schooling (Dhillon et al, 1992). Thus the world's education systems influence millions of children in their formative years. The school years present the greatest opportunity for disseminating health knowledge, developing appropriate values and attitudes and encouraging health behaviour patterns. Since today's child is tomorrow's parent,
it is essential that before leaving school, the child should receive basic knowledge about health, how to maintain it and prevent diseases. There is a positive correlation between education and health, and as such, formal education is decisive in improving health and reducing morbidity and mortality. In addition to benefiting school children, health education has a multiplier effect in that children, properly guided could prove to be excellent health messengers and activists within their own families and communities.

1.2 Concepts of health

Before discussing school health, the concept of health should be clearly understood. Health is not perceived in the same way by all the members of a community. In a world of continuous change, new concepts are bound to emerge based on new patterns of thought. Health has evolved over the centuries as a concept from an individual concern to a worldwide social goal and it encompasses the whole quality of life.

Health has been viewed as an "absence of diseases" by Bio-medical scientists. The ecologists put forward the view that health is the dynamic equilibrium between man and his environment. Social Scientists view health not only as
bio-medical phenomenon but as one which is influenced by social, psychological, cultural, economic and political factors of the people concerned (WHO, 1986).

The holistic approach implies that all sectors of society influence health, in particular sectors like agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors (WHO, 1987). The emphasis is on the promotion and protection of health.

1.3. Definitions of health

"Health" is one of those terms which most people find it difficult to define although they are confident of its meaning. Therefore, many definitions of health have been offered from time to time, including the following:

"The condition of being sound in body, mind or spirit, especially freedom from physical disease or pain" - Webster.

"Soundness of body or mind, that condition in which its functions are duly and efficiently discharged" - Oxford English Dictionary.
"A condition or quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic and environmental" - (WHO, 1957).

"A state of relative equilibrium of body form and function which results from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response of body forces working towards readjustment" - Perkins.

The widely accepted definition of health is that given by the World Health Organisation (WHO, 1948) in the preamble to its constitution, which is as follows:

"Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity". In recent years, the statement has been amplified to include the ability to live a "socially and economically productive life" (WHO, 1978).

The concept of health as defined by WHO is broad and positive in its implications; it sets out, the standard of "positive" health. It symbolizes the aspirations of people and represents an overall objective or goal towards which nations should strive.
1.4 Dimensions of health

Health is multidimensional. The WHO’s definition envisages three specific dimensions - the physical, the mental and the social. The fourth dimension the "spiritual" has also been suggested recently.

i. Physical dimension

The state of physical health implies the "perfect functioning" of the body. It conceptualizes health biologically as a state in which every cell and every organ function at optimum capacity and in perfect harmony with the rest of the body. At the community level, the state of health may be assessed by such indicators as death rate, infant mortality rate and longevity.

ii. Mental dimension

Mental health is not the mere absence of mental illness. Mental health is the ability of an individual to adjust to the environment. Sartorius (1983) defined mental health as "a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between the realities of the self and that of other people, and that of the environment".
iii. Social dimension

Social well-being implies harmony and integration within the individual, between each individual and other members of society and between individual and the world in which they live. Donald (1978) defined social dimension as the "quantity and quality of an individual's interpersonal ties and the extent of his involvement with the community". In general, social health takes for granted that every individual is part of a family and of a wider community and focusses on social and economic conditions and well-being of the "Whole-Person" in the context of his social network.

iv. Spiritual dimension

Proponents of holistic health believe that the time has come to give serious consideration to the spiritual dimension and to the role it plays in health and disease. Spiritual health, in this context, refers to that part of the individual which reaches out and strives for meaning and purpose in life. It includes integrity, principles and ethics, the purpose in life, commitment to some higher being and belief in concepts that are not subject to "state of the art" explanation (Crew, 1965).
There are many other dimensions of health also, like cultural, educational, economic and philosophical. These dimensions symbolize a huge range of factors to which other sectors besides health must contribute if all the people are indeed to attain a level of health that will permit them to lead a socially and economically productive life.

1:5 Right to health

Historically, the right to health was one of the last to be proclaimed in the constitutions of most countries of the world. The national and international rhetoric states that health is a fundamental human right. In 1948, the WHO in the preamble to its Constitution set forth, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

In an increasing number of societies, health is no longer accepted as a charity or the privilege of the few, but demanded as a right for all. However, when resources are limited, as in most developing countries, the governments, cannot provide all the needed health services. Under these circumstances the aspirations of the people should be
satisfied by giving them equal right to available health care service (Horwitz, 1983).

1:6 Responsibility for health

Health is on one hand a highly personal responsibility and on the other hand a major public concern. It thus involves the joint efforts of the whole social fabric, namely the individual, the community and the state to protect and promote health.

1:6:1 Individual responsibility

Although health is now recognized as a fundamental human right, it is essentially an individual responsibility. No community or State programme of health services can give health. It has to be earned by intelligent and individual effort to promote one's own health. It is the individual who has to accept certain responsibilities in order to attain good health, that is, responsibility relating to food, personal hygiene, healthy habits, specific disease prevention measures, early reporting when sick and accepting treatment. In other words, health must begin with the individual at home.
Community responsibility

Health can never be adequately protected by health services without the active understanding and involvement of communities. Until quite recently, throughout the world, people were neglected as a health resource; they were merely looked upon as sources on victims of pathology and consequently as a "target" for preventive and therapeutic services. Now the emphasis has shifted from health care for the people to health care by the people. The concept of primary health care centres around peoples' participation in health activities.

State responsibility

The responsibility for health does not end with the individual and community effort. In all civilized societies, the State assumes responsibility for the health and welfare of its citizens. The Constitution of India states that health is a State responsibility. The State should regard raising the nutrition level and the standard of living of its people and the improvement of public health as among its primary duties. India is a signatory to the Alma-Ata Declaration of 1978 which aims at reaching the goal of Health For All by the year 2000 A.D. The National Health Policy,
approved by the Parliament in 1983 clearly indicates India's commitment to the goal of 'Health For All by the year 2000 A.D.' These have resulted in a greater degree of State involvement in the management of health services, and the establishment of nationwide systems of health services, with emphasis on primary health care approach.

1:6:4 International responsibility

Where health is concerned, no country is self-sufficient; each relies more, even today, on the experience of others, because health problems cannot be solved in isolation. The health of mankind requires the co-operation of governments, the people, national and international organizations both within and outside the United Nations System in achieving health goals. The WHO is a major organisation, fostering international co-operation in health, and acting as a directing and co-ordinating authority on international health work. The other international agencies like UNICEF, FAO, UNDP, UNFPA and USAID are involved in ensuring that men and women of all races enjoy the highest possible standards of health, happiness and security.
1:7 Indicators of health

Hogarth (1978) suggested that in relation to health trends the term 'indicator' was to be preferred to index, as health index is generally considered to be an amalgamation of health indicators. As the name suggests, 'indicator' is only that which indicates a given situation or reflects that situation. Indicators are required not only to measure the health status of a community, but also to compare the health status of one country with that of another in order to assess health care needs, to allocate resources, and to monitor and evaluate health services, activities and programmes. Health cannot be measured in terms of a single indicator, but it must be conceived in terms of a profile, employing many indicators, which may be classified as mortality, morbidity, disability, nutritional status, health care delivery, environmental factors, socio-economic and quality of life indicators.

1:8 Education, health and development

There are two ways in which education and health have a bearing on development. First, education and health are necessary pre-requisites for quality of life. If this is so then health care and education must also be seen as the
important constituents of the development process. There are
evidences to show that healthy and educated people are two
significant pillars of development. There is a vicious circle
wherein low productivity, lack of income, poor nutrition,
deteriorated environment and the like, constrain
development. Secondly, development is restricted by social
institutions in such a manner that neither education nor
health can follow a path of progress. It is well known,
particularly in the context of developing countries, that
expansion in the network of health and educational facilities
has not resulted in increasing the degree of accessibility to
a large section of the population. Practically modern health
programmes and better educational facilities remain the
preserve of a few. If this has to be changed, then education
will have to enlarge its base so that social institutions
lose their rigidities. Better health care will have to be
provided so that it develops physical human capabilities in
order to face the problems of underdevelopment.

1:9:1 Health services

The health care system in India, provides health
services to meet the health needs and demands of the
individuals and the community. It is represented by the five
major sections or agencies which differ from one another in the health technology applied and in the source of funds for operation (Park and Park, 1978). These are:

i. Public agencies: Primary Health centres (PHC), Hospitals - rural, Taluk, District specialist and Teaching hospitals, Health insurance schemes - ESI, Central Government Health Schemes, Other agencies - Defense services, Railways.

ii. Private agencies: Private hospitals, poly clinics, Nursing homes and dispensaries, General practitioners and clinics.

iii. Institutions of indigenous systems of Medicine: Ayurveda, Siddha, Unani and Tibbi, Homeopathy and Unregistered practitioners.

iv. Voluntary health agencies

v. Vertical health programmes

1:9:2 Primary health care institutions in rural areas

India is a signatory to the Alma Ata Declaration of 1978 and is committed to attaining the goal of "Health For All" by the year 2000 AD through Primary Health Care approach. The National Health Policy adopted by the Parliament in 1983, "Health For All - Principles and Strategies" was also incorporated in the sixth (1980-85) and
the seventh (1985-90) Five year plans. The Government has started concentrating on the development of rural health infrastructure so as to provide primary health care services to about 74 per cent of the rural population which had by and large remained neglected. Primary health care is essential health care made universally accessible to individuals and acceptable to them through their participation and at a cost the community and country can afford.

In rural areas, services are provided through a network of integrated health and family welfare delivery systems. The primary health care services are provided through a three-tier system.

i. **Community health centre (CHC)**

Community health centres are being established and maintained by the State Government under the Minimum Needs Programme. Each CHC serves a population of 80,000 - 1,20,000 and is situated at the block level. It is manned by four medical specialists, supported by 21 paramedical and other staff. It has 30 in-door beds with one operation theatre, x-ray, Labour room and Laboratory facilities. It serves as a referral center for 4 Primary Health Centres. At present (1996) there are 2,424 CHCs functioning in India.
ii. Primary health centres (PHC)

In India PHCs were started, as part of the community development programme in 1952, in each community development block having a population of 60,000 to 80,000. To bring the health services closer to the rural people, Government of India in 1988, started the PHCs for an average of every 30,000 rural population in general and for every 20,000 population in hilly and tribal areas. These centres are established and maintained by the State Government under Minimum Needs Programme. A PHC is manned by a medical officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 sub-centres. It has 4 to 6 beds for patients. There are 21,854 PHCs functioning in India (RHD, 1996). Each PHC is providing a group of functions essential to the health of the people. These are medical care, maternity and child health, family welfare, school health, improvement of environmental sanitation with priority for providing safe drinking water and disposal of human wastes, control and surveillance of communicable diseases, collection and reporting of vital events, health education and national health programmes.
iii. Sub-centres

It is the most peripheral contact point between the primary health care system and the community. It is manned by one male and female multipurpose health worker. At present 1,32,730 subcentres are functioning in India (RHD, 1996).

1:10 School health

School health is an important branch of community health. School health service is an economical and a powerful means of raising community health, and more importantly, in future generations. The school health service is a personal health service. It has developed during the past 90 years from the narrower concept of medical examination of children to the present day's wider concept of comprehensive care of health and well-being of children through the school years.

1:10:1 Objectives of school health

The objectives of school health programme are as follows (CHEB 1965):

1. Promotion of positive health
2. Prevention of diseases
3. Early diagnosis, treatment and follow-up of defects
4. Awakening health consciousness in children and
5. Provision of healthful environment.

The school health programme includes the four major areas of activity through which the health of pupils is protected and promoted. Learning experiences in health education occurs in all the four areas.

i. Healthful school living

Healthful school living comprises

a) an environmental sanitation to guarantee a safe water supply, good sewage and refuse disposal, adequate ventilation, heating and lighting, appropriate seating, ample equipped playgrounds and building maintenance.

b) a hygienically organized school day, which takes into account from the health standpoint, such items as the length of the school day, the number of periods, play period, the sequence of subjects, the amount of home work, the number of pupils per room, discipline and punishment, extra curricular activities, the weighing and measuring of pupils, daily observation of individual pupils, and the school lunch, and

c) Maintenance of a healthful emotional environment through sound teacher-pupil and intergroup relationships,
recognition of individual differences, and curricular adaptation.

ii. Health services

It includes examination and procedures necessary to determine the health status of each child, the follow-up treatment of children to get the deficiencies corrected, the maintenance of health guidance for all children according to their special needs. Referral to special classes of those selected children whose health would be injured in the regular programme, emergency care and the control of communicable diseases.

iii. Health Instruction

This includes, direct health teaching at specifically allotted hours, to health, correlated instruction where material is presented in connection with Science, Social studies, or other subjects, integrated health instruction covering health learnings and individual health instruction.

iv. School, Home and Community relations

This includes the teacher and school personnel meeting the parents, parents' observation and participation in school health activities and school's relation with
health educational activities carried on by agencies in the community.

1:10:2 Development of school health programme

Interest in school health and the earliest development of organized health programmes may be attributed to the American Systems of health and education. The initial interest and concern was focussed on school buildings and the overall physical facilities. However as the knowledge on communicable diseases and their transmissions grew, the emphasis was shifted to the control of communicable diseases. This went on till World War II when a significantly high proportion of the armed forces recruits showed physical health problems. As a result physical education and physical aspects became the focus of attention during the subsequent years. Based on the results of the screening of armed forces' recruits, during World War II, mental health took the centre stage during the post-war period. However, the nationwide School Health Education Study of the 1960's and the School Health Curriculum Project initiated in 1974, became the two outstanding efforts, that brought about changes and new directions in the curricula of the American School System.
On the international scene, interest in School Health Education (SHE) began with UNESCO and the WHO recognized health education in schools as an important part of general education and a vital means of health promotion. This joint concern was translated into a framework for action with the publication of the book "Planning for Health Education in Schools", by Turner in 1968. A global review on SHE was done in 1985, by WHO / UNICEF International Consultation on Health Education for school-age children. Both WHO and UNESCO as well as a number other international agencies also held a number of Regional Consultations from time to time. The focus on School Health Education in this Regional Consultation was on Health Education strategies in South East Asia. It is yet another indication of WHO's continuing interest and commitment for School Health Education. A number of Member countries in the South East Region have already implemented School Health Education with varying degrees sophistication and success. 

1:10:3 School health education in India

Since the early 1960's there have been a series of projects which attempted to improve the delivery and
effectiveness of health education. As early as 1961, the School Health Committee was established. Its mandate was to create a comprehensive school health programme which linked health and educational institutions. The programme was to include the delivery of health services within schools as well as impart basic health education.

The Kangazha Project, introduced in the mid-1970s in 30 schools in central Kerala, is one example of a project developed under this mandate with the objective to strengthen the teacher's role as a health worker. An evaluation of the project proved beyond doubt that school teachers were a great resource for the delivery of health care. However, no structure had been created to ensure collaboration between health and education for a full implementation of the project.

It was recommended that the Central Health Education Bureau (CHEB) be strengthened to enhance the health education component. Its mandate was to review syllabi for the inclusion of health messages, assist in teacher training, and develop appropriate supportive material.

It was advocated that health education be included as a part of the general education programme in primary
schools. Surveys of the health education content of school syllabi were conducted to begin with. While these indicated that health topics were, in fact, included in every syllabus, it was also found that health education was of secondary importance to teachers.

In order to overcome this difficulty, Nutrition, Health Education and Environmental Sanitation (NHEES) project was created in 1975, with assistance from UNICEF. The NHEES project represented an attempt to weave priority health concerns into the primary school curriculum and teacher training. To support the effort, NCERT established four regional centres. These had two responsibilities. The first was to develop health education curricula and material suitable for primary school children. The second was to train teachers in the use of these material. An evaluation completed by Nutrition Foundation in India, indicated that the NHEES programme was very effective in bringing about a significant improvement in the awareness of the community with regard to health and nutrition matters and effective change in related practices. One of the weaknesses of the programme, was inadequate co-ordination
between school children, teachers and health workers. As a result, the programme gradually lost its momentum.

Another health education effort was begun in 1981 by Task Force on School Health with mandate to strength health education in schools. Their work resulted in the creation of the Intensive Pilot Project for School Health Services, whose purpose was "to raise the capability of primary school teachers to impart health education to their pupils". A feature of this project was that health education was not incorporated into the main stream of primary school curriculum. But health personnel, and sometimes teachers, were expected to educate school children on health, during the extra-curricular sessions.

The quick review cycle of health education project in India, reveals that, to some extent, health topics are already a part of the primary school curriculum. The issue has been how to get teachers to pay more attention to this material in order to ensure that children have both practical and book knowledge about health. There has been an attempt within the various projects to highlight the health information that exists in the curriculum and devise some
method to increase the teachers' interest in health education.

1:10:4 Need for school health services

Children are the most valuable asset of a nation. Any investment in their health care and related development will yield rich dividends in the long run. Healthy children will be the greatest resource of the country as future citizens, strong and prosperous. Although the school children are considered to form the healthiest segment of the total population, they do experience certain health problems and have certain health needs, although the nature and extent of such problems and needs may vary from one community to another. Health problems generally bring about problems in learning and school performance, affect personality, self-esteem and behaviour of the individual or groups of children. It is estimated number of children below the age of 16 years is about 42 per cent of the population. As such even a low incidence of any of the health problems can contribute to the development of a serious public health disorder. Moreover the effects of some of the childhood problems often get carried forward into the adolescent stage, affecting the physical, mental and emotional development and social
relationships. In this struggle to individuality and freedom, the children may experiment or even indulge in risk-taking behaviours. Hence it is essential that knowledge on health matters is provided to give them the right perspective. The estimated number of students attending the primary schools in India is around 90 million. Realising the importance of these children's health, the Government has launched many programmes to improve their health and welfare. School health programmes aim at protecting and promoting the health of the school-going population through health education and school health services.

In this context, the school children form a captive audience at an impressionable stage of their lives. School children together with the school personnel form an important manpower resource for community health, particularly in the context of Health For All by 2000 AD and Primary Health Care. School children react favourably to child-to-child or peer group health education in and out of school. Their involvement and participation usually is more effective in dealing with the sensitive needs of the adolescent and the youth.
School health education should be geared not only to develop desirable knowledge pertaining to health but also attitudes and skills within the context of local cultural and social values. It should enable the students to understand the needs, problems, and issues, the various behavioural options available to them and arrive at responsible decisions within the context of promotive, preventive, curative and rehabilitative aspects of health. Health education, therefore must be provided before the onset of the risk behaviour or the development of the health need or the problem concerned. School-age children are more receptive to new information and are enthusiastic to be assigned new responsibilities. If children are empowered with their knowledge, their future will be bright and prosperous. By mobilizing majority of families through these school children with new power of knowledge, the task of promoting Primary Health Care seems achievable.

1:10:5 Case for school health education

There are important practical grounds on which to make the school health education of children and youth a high priority. These are based upon the size and accessibility of
the population, the impact that health education can make on both health and education, and the existence of a rich tradition of success and innovation in school health education. The population as well as the health problems, of school-age children and youth have grown enormously in recent decades. Children are receptive to learning and are at a formative stage where important health practices can be influenced. Because many attend school, they may be reached readily and cost-effectively. By reaching these school-age children, comprehensive school health education can provide benefits to all levels of society (WHO, 1992). For example:

The children benefit by gaining self-reliance and by obtaining knowledge, beliefs, attitudes, values and skills that may be needed to live a healthy life and to avoid a broad range of important health problems. They also benefit by gaining experience in participating in collective actions to create conditions that are conducive to health and well-being.

The family benefits because the child possesses a broad range of health-related information and skills that can be used to improve knowledge, practices and conditions at home. It also benefits from opportunities for interaction
with school and health authorities and the support for health related actions.

The school benefits by having important health related learning experiences efficiently organized and institutionalized as part of the school curriculum, and not as a series of special programmes that compete with each other for school time and attention. The school also benefits from enhancements to the school environment and from the opportunity to obtain resources in support of school health education from a broad range of agencies and organizations, as part of a comprehensive approach to school health education.

The community benefits by the increased awareness among community members for health problems and their solution. It benefits also from an increase in health-related projects conducted in the community by students and teachers.

The health challenges facing school age children and youth, and to which comprehensive school health education must be directed, are complex and challenging. Their complexity arises because health status is largely a product of the physical, social and economic conditions in which

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children live, and the life-styles they adopt. Among the health and nutritional conditions that have been linked with failure to attend school or poor academic performance in developing countries are nutritional deficiencies, recurring helminthic infections, physical and mental disabilitie. All of these problems pose important questions for the development of Comprehensive School Health Education (CSHE) programmes as well as for their management and administration.

1:10:6 Concept of comprehensive school health education (CSHE)

School health programmes include several related components, namely school health services, school counselling and guidance, a healthful physical, social and psychological environment, food services, physical education, health promotion for school staff, community participation, school health administration and management and school health education.

A CSHE programme include a broad spectrum of activities that take place within or outside the schools in their surrounding communities. They are designed to enable children and youth to enhance their health, and to develop
their fullest potential by acquiring health and education. CSHE is reinforced by, and in turn reinforces community health and education programmes.

1:10:7 The current status of school health in India

The Central Health Education Bureau (CHEB), Directorate General of Health Services, Ministry of Health and Family Welfare, have been monitoring the National School Health Service Programmes in 25 States/Union territories in India. The major thrust of this programme has been to provide school health services including health education to students in primary schools of rural areas with a view to reducing morbidity and mortality among them and to inculcate healthy life style.

A National workshop on school health promotion held in New Delhi (1995), identified the following obstacles in school health programmes in India (John Hubley, 1995).

1. The low priority given to health promotion with the school and community: The low commitment made by policy makers and educators to health in schools is a major contributing factor for poor implementation.
2. The adoption of a narrow medical view of health: emphasising disease and cure, dominated by doctors rather than a broader section of people including teachers, social development and community level health workers.

3. The marginalisation of health in the curriculum: The Nation Curriculum for all levels of schooling, developed by NCERT lays down that 50 per cent of the time given to Health and Physical Education (which is allocated ten per cent of total school teaching time) should be spent exclusively on health education. However, in reality very little of this time is actually spent on health education.

4. The overemphasis on factual didactic learning methods: The health content taught at present mainly emphasises examination - oriented learning, formal lessons and learning of facts. At the end of this process the child may have health knowledge but this is not translated into decision-making and action.

5. Lack of training and support for teachers: The quality of School Health Programmes is mainly dependent on the amount of time and effort that teachers are willing to put into health education and their understandings and skills in
health education. Teachers are often too busy, lacking in interest. They feel uncomfortable dealing with health issues, lacking the skills to adequately teach the subject. Teacher training institutions do not give enough attention to health education.

6. The poor state of the school surroundings: The school surroundings are often inadequate with overcrowded class-rooms and lack of water and sanitation facilities. Children cannot be expected to learn about health if they are unable to put into practice what they have learnt.

7. Insufficient links with health care staff: Health is usually seen as a matter for health workers and not for teachers. The lack of active interfaces between the education and health sectors for joint planning and action is a major drawback for development of school health in India today.

8. The need to build links between the school and the community: The involvement of parents and the community is essential if the knowledge and skill acquired at school are to be translated into action at home. Links between school and community are very weak where links do exist, for
example, parent teachers' association, where they are not involved in discussing school health issues.

9. Lack of materials: Educational materials such as books and teaching aids are scarce. When they are available they are often of poor quality and out of date. Distribution mechanism for getting material out to schools is not well developed.

10. The situation of the girl child: Girls have poorer health than boys yet are less likely to benefit from existing health education activities. Millions of children in India, and significantly girls, never attend schools they are drop-outs in the first five years after enrollment due to a variety of factors.

1:10:8 The teacher - his crucial role in school health programmes

The Directorate General of Heath services brought out, A Guide for Primary School teachers, on school health (CHEB 1984). The teacher occupies a central position with regard to the implementation of the school health education programme. The document identifies the following tasks:

The teachers' main task is to provide health instruction to school children and promote healthful
practices among them. They should supervise the students' hygiene-related habits and the school environment including in-school food sanitation practices, plan relevant and need-based health educational activities, plan and organise in-school and in-community/home projects.

The other tasks include detection of deviation from normal health, provision of first aid in accidents, and referral of children to health workers at the nearest health centre. The teacher is also expected to assist in health check-ups and the immunization of school children as well as in the maintenance of health records. The objective is not for teachers to replace health workers but to act as a first point of detection and referral.

Thus, apart from imparting health education in the academic sense, teachers are expected to play a vital role in influencing the daily behaviour of their students, intervening directly and indirectly in minor and major health problems, and creating a bridge from school to home and school to community by creating linkages between students, parents and professional medical services.
Facilities for health education

Facilities required for proper implementation of health education in schools may be in terms of physical facilities, manpower and money. At present there is a wide disparity in the resources available in rural and urban schools. One of the prerequisites of upgrading the school health programme and activities is to provide basic essential facilities for creating healthful school environment (CHEB, 1990). These include:

- safe drinking water
- proper drainage and sanitation arrangements
- adequate water for cleanliness
- sanitary latrine
- arrangement for rest, relaxation, recreation and exercise
- adequate shelter with proper light and ventilation
- environment free from possible accident hazards
- adequate food, and
- primary health care facilities.

The facilities such as first aid kit, weighing machines, measuring tape, available with ICDS, PHC and other agencies may be shared by the schools. In terms of community resources, the medical and para medical personnel in the community may be utilized for delivering health education messages. These personnel may help the teachers in the observation and treatment of minor ailments and in improving the school health education programme and health services.
The community support may also be obtained for providing proper sanitary and safe water facilities in the school. At the District and State levels, appropriate health agencies should provide resource material for health education, such as enrichment material, handouts, pamphlets, and other A.V. aids to schools and training centres. They should also provide manpower and technical support, needed for handling and maintaining these material.

1:10:10 Content areas

The following content areas may be included in health education at primary school level suggested during the National Workshop on Health Education for School-age children (CHEB, 1988).

- external parts of human body
- structure and function
- care of external body parts
- personal cleanliness and personal health practices
- Food types, values, sources, consumption, desirable practices, avoiding wastage and spillage
- environmental cleanliness and sanitation
- communicable diseases, causes, transmission, prevention and control
- accidents/first-aid care of the sick
- harmful effects of smoking or chewing tobacco, consuming alcohol.
Need for the present study

Since independence, considerable progress has been achieved in promotion of the health status of people. In spite of significant achievement, the health scenario in the country appears to be a cause of serious concern. This is mainly because the ever-high increasing pressure of population growth continues to exert an adverse effect on the health status of people.

The Government of India, in National Health Policy (1983) fixed broad indicators for the achievement of certain basic health and family welfare objectives. They appear to be quite ambitious, therefore demand concerted efforts for achieving them. The indicators, demand a bold health education policy and its vigorous implementation at all levels of education. Emphasizing the importance of the school health programme, the National Health Policy has recommended that organized school health services integrally linked with the general, preventive and curative services would require to be established within a time-limited programme. The policy further states that health, nutrition and population education programmes should be implemented in all educational institutions at various levels. This view
was also emphasized in the National Policy on Education (NPE), recognizing the holistic nature of child development, namely nutrition, health, social, mental, physical, moral and emotional development. Early Child Care and Education programme is to receive high priority and be suitably integrated with the existing programme, wherever possible, which would strengthen the primary education and human resource development in general.

Attention to health is central to the objectives of general education. Children need good health for effective learning, and the educational careers offer various opportunities to teach about health. Health education is an important component of health programmes for the school children, as it promotes the physical, emotional, intellectual and social development. Properly planned, the school health service can act as a powerful means of improving community health and contribute to the health of the future generation. Next to home, school is the effective place where attempts could be made to provide all the requisite means for the child with regard to the physical, mental, emotional and social aspects.
For a child, the school is the first experience of group life, outside the cloistered home environment. Children are constantly undergoing changes physically, mentally, emotionally and socially. Living together in groups in the school increases the dangers of communicable diseases. Health in the course of the study in a school becomes a part of the child's way of living. He can be motivated in matters of health and can influence his parents, family and peers in the cultivation and practice of healthful habits.

In inculcating such health habits and imparting health knowledge among school children, the teachers can play a vital role, since they are very close to them during the school hours. The teacher is in a unique position to carryout the daily 'inspection' as he is familiar with children and can detect changes in their appearance or behaviour that suggest illness or improper growth and development. The teacher can also provide health education to the students. The teacher's role in school health is of particular importance in India, because of the limited number of trained personnel for school health programmes. To carryout the health promotional activities in the schools, the teacher
should be adequately trained in health promotion, so that he can play a meaningful role in the school health programme. Hence there is a need to study the level of awareness of teachers and students in health promotion and suggest suitable teacher intervention strategy for developing a school health programme.

1:12 Scope of the study

It is a great matter for regret that in this modern age, more than a quarter of a million small children should still be dying every week of malnutrition and easily preventable illness. Everyday measles, whooping cough and tetanus, all of which can be prevented by an inexpensive course of vaccines, kill almost 8,000 children. Everyday diarrhoeal dehydration, which can be prevented at almost no cost, still kills almost 7,000 children. Everyday pneumonia, which can be treated by low cost antibiotics, kills more than 6,000 children. Death and suffering on this scale are simply no longer necessary and it is therefore no longer acceptable (UNICEF 1990). Children in developing countries are at great risk. They are at risk because they are susceptible to diseases that, in fact, can be prevented, and they are at risk, because their caretakers, frequently older siblings,
lack the knowledge, skills and experience to keep themselves and the younger ones safe and healthy. In recognition of these realities, the school health education was first chosen as an approach and the children were the focus group. The supposition was that these children would be able to learn basic health measures and they would be able to apply what they had learned in their lives. The children may be safer and healthier and have more cognitive stimulation. They can improve their psycho-social and motor skills, receive more attention and do more appropriate activities.

In spite of efforts to improve school health, it must be stated that in India, the school health programme provided are hardly more than a token service because of shortage of resources and insufficient facilities. Teachers' participation in school health is of particular importance in India, because of the limited number of trained personnel for school health. Moreover the existing health staff are providing curative services rather than health promotional activities in school health. To promote health among school children, the teachers can play a useful role, if they are adequately trained in school health education. This study attempts to discuss the integration of health promotional
components with the existing curricula of teacher education and the provision of in-service training for teachers at various levels. In turn these teachers once trained can help the students and the community to acquire health knowledge and can inculcate health habits among them, which may in turn help to improve the health of the future generation.