SCHOOL HEALTH IN RURAL NEPAL: WHY AND HOW?

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Abstract. School health has been regarded as a high priority intervention in developing countries from the perspective of donor organizations. This paper aims to show why school health is important from the community perspective as well, and how school health programs should be implemented based on a case study by the School and Community Health Project (SCHP) in Nepal. SCHP conducted a needs assessment using a participatory rural appraisal in 28 rural communities (mean household number: 51; mean population: 352) in rural Nepal. As a result, SCHP found 70% of the target communities regarded schools as the most important institutions in their communities. Then, SCHP initiated two school health programs to meet their needs, a Supportive Healthy Environment Program and Child Initiative Program. The community members welcomed them, and all the schools successfully built toilets and water supply systems, and initiated child club activities, even though the school teachers' commitment was limited.

INTRODUCTION

Although the World Bank has included school health as one component of its essential public health package for cost-effective health programs (World Bank, 1993), the nutrition and health of school-age children in the developing world has received little attention. Year by year, the health sector has broadened its concern to include the school-age population (Rosso and Marek, 1996). WHO, in 1997, developed 10 recommendations for school health, and initiated a Global School Health Initiative in ten countries, of which 8 were developing countries (Kolbe *et al*, 2001).

Despite such initiatives, school health has not been prioritized in Nepal for many years and donor-initiated school health projects have come and gone sporadically over the decades. A responsible administrative unit, such as a department of school health, has not existed in either the Nepalese Ministry of Health or Education for many years.

This paper aims to identify school health needs based on input from the communities themselves, and to evaluate the school health programs implemented by the School and Community Health Project (SCHP) (Sato *et al*, 2000; Shimobiraki and Jimba, 2002) in rural Nepal.

Background

The target area consisted of 15 village development committees (VDCs: minimum local government bodies in Nepal) with approximately 50,000 villagers. These VDCs are located 2 to 16 hours by foot from the nearest motor vihicle road, and have neither telephones nor electricity. The area included 84 target schools and 14 health institutions in 1997.

To implement school health programs, SCHP initially targeted teachers as key players for health promotion activities. However, SCHP soon found that most teachers came from urban areas and frequently took extended leaves. Erratic teacher attendance caused the SCHP's initial school health activities to fail.

These failures led SCHP to change work partners from teachers to indigenous schoolchildren and their parents. Then, SCHP initiated two new school health programs: the Supportive Healthy Environment Program in 1997 and the Child Initiative Program in 1998.

Through the Supportive Healthy Environment Program, SCHP aimed to create a sup-

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portive environment for health in schools and local health institutions, based on WHO's recommendation for health promotion (Haglund *et al,* 1996). Its major activity was to establish safe drinking water and toilet facilities in these buildings. Then, through the Child Initiative Program, SCHP aimed to promote the health and well-being of school children and community members through the child initiative for health-related activities in schools and communities based on the Child-to-Child approach (Pridmore and Stephens, 2000). To implement the Child Initiative Program, SCHP helped each school form a child club with 7 to 9 members and facilitated various activities, such as school toilets and drinking water management, health quiz competitions, and immunization campaigns.

MATERIALS AND METHODS

A participatory rural appraisal (Melville, 1993) was carried out with villagers from 28 communities (mean household number: 51; mean population: 352) in 1997. For the needs assessment, SCHP used group discussion and verbal ranking in each community and asked community members for their general needs before asking health needs. To identify the important organizations within each community, a Venn diagram was used with different sizes of circles according to its priority. Three to four years after the initiation of two school health programs, we evaluated them using project reports and collecting data from the field.

RESULTS

The participatory rural appraisal revealed that health was not the highest priority in the target area. Out of 28 communities, only 20% placed a high priority on health, and more than 50% ranked it 4th or lower in their list of priorities. Overall, education ranked first, followed by irrigation, road construction, water supply, and then health. As for education, the majority of the communities were interested in school infrastructure development rather that the quality of education. The results also showed that 70% of the target communities regarded their schools as the most important institutions in their communities. During the participatory rural appraisal, SCHP observed that most target communities used school grounds as places for mass meetings where decisions were made for overall development. Thus, SCHP identified schools as centers for health promotion and community development.

The target communities welcomed the new school health programs. For the Supportive Healthy Environment Program, the villagers made significant contributions of their existing resources and labor. Installing one school toilet and water supply system cost approximately 80,000 NRS (US$ 1,100), which included 65% cash support from the donors and 35% contribution from the community as labor cost. In 1998, UNICEF began supporting this program. In 1995, only 20% of the target schools had both toilets and a water supply system, while 100% of the target schools had set up them by 2001. UNICEF has also supported the Child Initiative Program since 1999. Before initiating the program, no child organization existed in the target schools in 1998, but in 2001, all the schools formed the child clubs. The clubs have participated in the above-mentioned health-related activities. They have also come to work as agents for delivering health messages to their families and communities.

DISCUSSION

Our study revealed that rural Nepalese communities expressed their need for school health even when it was not yet prioritized by the Government of Nepal, as shown in the participatory rural appraisal survey.

However, such needs vary from community to community. For example in the target area, many drinking water projects had already been implemented, so that clean drinking water was not a high priority. In other communities where water projects had not been implemented, clean water was given a much higher priority than education. Donor agencies should be sensitive to such community needs, and consider conducting a general needs survey prior to a health needs survey.

As for the specific school health programs,

our first intervention using teachers was not very successful. However, two newly initiated school health programs did succeed. It is important to identify the best parties to work with to make school health programs successful. Where school teachers are reliable, they may be the best resource; under other circumstances, it is better to work directly with schoolchildren and their parents, since they are rooted in the community as long as they live there.

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