Jysk landsbyudvikling i Nepal

Health and learning – Village development begin with the little ones

Kantipur Health Camp 2013 - Fall 2013

Project description and report

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Jysk landsbyudvikling i Nepal

Contents

Jysk landsbyudvikling i Nepal

Reading instruction

This document holds the project description for Kantipur Health Camp 2013, the Health Team report and evaluation of actions in the villages in the autumn of 2013 and recommendations for Kantipur Health Camp 2014.

Introduction

Jysk landsbyudvikling i Nepal (Jutlandic Village Development in Nepal) is a non-profit organisation based in Silkeborg, Denmark.
Founded on principles of co-operation and self-care the organisation supports three Nepali villages in their efforts to rise above poverty. In a 5 years project the organisation supports the villages with inspiration, advice and skills development in order to establish a co-operative. During the project period, financial support is given to defined projects.

In 2009 **Jysk landsbyudvikling i Nepal** started the project in three villages - Kantipur, Ayodhyapuri and Indrabasti - in Madi, Chitwan District in southern Nepal. The project is still running and includes a School Project, a Health Project, a Drinking Water Project, a Veterinary Project and a Business Project on handicraft and tourism.

From 2009 - 2013 **Jysk landsbyudvikling i Nepal** have sent more than 50 volunteers to Kantipur, Ayodhyapuri and Indrabasti working primarily on the School and Health Projects.

The third Health Team went to Nepal in October 2013. The participants - three Danish and two Nepali participants – worked on health promotion and preventions in the schools.
Also from October 2013, for seven weeks, the ninth School Team with six participants taught more than 300 children and 15 teachers English at the three schools.

For the 2013 health and schools projects the intentions were to integrate the School and Health Projects. The Danish School and Health Team worked closely with the Nepali teachers focusing on health related subjects - such as hygiene and healthy food during the English lessons and the health sessions.

Project Description

Because healthy living and thriving lives are a prerequisite for motivation, learning, education and development the Health Project is immensely important for the success of the whole Sustainable Development Project. The Health Project helps to create and sustain coherence between the focus areas School & Education, Business development, Infrastructure and Health.
We know hygiene is a challenge in the villages and that a lack of knowledge on the significance of hygiene for the general health status exists.
Villagers in Kantipur, Ayodhyapuri and Indrabasti have expressed a need for more focus on health

- General health of school children
- Teaching on puberty (targeting girls)
- General nutrition (together with the villagers)
- (Food at school)

Including the knowledge above, the aims for the Health Project in the three villages Kantipur, Ayodhyapuri and Indrabasti are to be involved with following:

- Improvement of knowledge and consciousness of health in everyday life targeting children, women and the local health workers
- Improvement of hygiene in everyday life targeting children, women and the local health workers
- Introduction of a healthy diet involving the school and the family

The seven focus areas in this health project form a part of the Sustainable Development Project described by **Jysk landsbyudvikling i Nepal.** The seven areas are described randomly.

1. Development of cooperation with Kharkatta Health Post
The Health Post in Kharkatta plays an important role in improving the villagers' health status. The Village Development Project focuses on health promotion and prevention in the three villages and in time in the surrounding villages. For that reason, it is important to cooperate with the local health clinic. For most villagers the Health Post is the first or perhaps only contact with the health service and therefore significant - not only to the ill but also very much so to the pregnant women and entire health promotion and preventive work. Kharkatta Health Post offers a well-developed pregnancy programme. Employed are nine voluntary health workers who could be a valuable connection between the clinic, the project and the villages. Formal cooperation with the health workers will strengthen future health efforts.

Aims for Kantipur Health Camp 2013

- Health Camp 2013 adjusts expectations with health workers at Kharkatta Health Post
- Health Camp 2013 has a prosperous dialog about cooperation in the future
- Health Camp 2013 establishes a formal cooperation with Kharkatta Health Post
- Health workers and voluntary workers gain knowledge on the concepts of health promotion and prevention

Initiatives

- Visit the Chief of Chitwan District Health Office, Kehar Singh Godar, (Lone and Anne-Marie). Clarify which area of health promotion and prevention to work on e.g. health education, supervision.
- Speak with Kharkatta Health Post at project start. Clarify their needs for cooperation.
- Explain to the villagers that Health Camp 2013 focuses on health promotion and prevention and not on treatment or medication. The aim is to discover and prevent illness and through dialog supply useful knowledge on health for adults and children in order to improve health.
- Bring glasses to hand out where needed.
- Before finalising the project, agree on initiatives for Kantipur Health Camp 2014 with the villagers.
- Be aware of signs in the villages showing need for health promotion and prevention.
- On demand use health promotion and prevention to turn the focus on a need for knowledge and away from more material topics.
- Choose a person whose purpose it is to listen and look for signs showing an interest for more knowledge.
- Possibly make a small teaching programme – aimed for voluntary workers and health workers at Kharkatta Health Post.

Criteria for success

- Villagers, The Health Post and the Health Authorities are curious about and show an interest in our work in the villages.
- Questions are asked, knowledge is asked for,
- Interest for knowledge on health promotion and prevention is shown.

Evaluation

We evaluate straight after our first meeting with Kharkatta Health Post and write down important signs of commitment in order to maintain focus in coming discussions. We prepare propositions for the next Health Team.

2. Cooperation with the schools to integrate health and learning - targeting teachers, parents and school children

Health and learning are well integrated. It would be suitable to integrate health topics in the English lessons. It would make sense also to give lectures on topics from the health programme to the teachers. This might be seen as competence development of the teachers. The teachers would be familiar with health education and health would be a standard subject in school.
In this initiative, home visits could be implemented if needed.

Aims for Kantipur Health Camp 2013

- The English language and health training become an integrated part of the Teacher Training programme at the three schools.

Initiatives

- Cooperate with the School Team and match expectations relative to teaching subjects and pedagogic methods
- Plan Teacher Training in cooperation with the School team
- Match expectations with the local teachers
- Carry out and evaluate the planned teaching programme

Criteria of success

- Teacher Training runs as planned
- Teachers include health topics in their teaching programme
- Teachers at the three schools express that they find the topics relevant and wish to continue
- The lessons planned with the School Team runs as planned

Evaluation

Write down feedback from the local teachers in order to develop an accepted cooperation between School Team, teachers and Health Team. Prepare propositions for the next Health Team.

3. Cooperation between School Team and Health Team on professional development

When the Health Project coincides with the School Project, it will be logic to integrate the two projects. Synergy and better learning will evolve if health is incorporated in the English lessons and vice versa.

Aims for Kantipur Health Camp 2013

- Introduce the subjects healthy diet, hygiene, physical activity and general health in the English teaching programme as part of the School Team's teaching

Initiatives

- Healthy diet
    - Theoretical teaching: What is a healthy diet?
    - Practical teaching: Snacks, in-between meals, lunch packet
- Physical activity
    - Theoretical teaching: What is physical activity, why is physical activity important?
    - Practical teaching: Play/sport, e.g. we check how the pulse rises
- Hygiene
    - Theoretical teaching: Why is hygiene important?
    - Practical teaching: Hand wash, tooth brushing

- General health
    - Theoretical teaching: Brainstorm – what is health, family life, illness, puberty, friends, boyfriend/girlfriend, self-confidence etc.
    - Practical teaching: Draw the body
- Discuss with Headmaster Krishna Adhikari, Ayodhyapuri School, if it is possible to give information to the parents about health and the health work taking place at the school. Perhaps something to discus at a parents meeting?

Criteria of success

- The teachers have the necessary knowledge to explain to the children the reason for health education

Evaluation

- A meeting of dialog with the School Team and teachers. Ask teachers if they observe any signs of interest in health in the children. Prepare propositions for the next School Team.

4. Hygiene, incl. dental hygiene

There is a great need for improving hygiene not only in Madi but in all of Nepal. This project will focus on general improvement of fundamental personal hygiene – hand wash and dental hygiene. The intervention pays attention to hygiene at home and at the school. Hygiene is to be incorporated in the subject Health Training in the classroom and in practical training around the in water post in the schoolyard. The international Hand Wash Day takes place every year on the 18th of October. In future, the Health Project will cooperate with the voluntary workers on a local event – if possible.

Aims for Kantipur Health Camp 2013

- Contribute to an improved hygiene in everyday life in the village
- Enhance knowledge on the importance of hygiene

Interventions

- Screen all school children (height, weight, eye sight, dental status and general health)
- Hand wash by the water post and distribute hand soap
- Tooth brushing and distribute tooth brushes and tooth paste
- Offer the local teachers visual teaching materials to use from now
- Health Training

Criteria of success

- Teachers, pupils and parents continue with hand washing and tooth brushing
- Improved hygiene (compare with previous reports on data form screening)

Evaluation

- Progress compared with previous reports
- Other observations

5. Diet and distribution of lunch boxes

Previous health camps has focused on the villagers' state of nutrition and on this subject, the villagers have expressed a wish for a continuous intervention. The many cultural and religious circumstances related to Nepali cooking is a challenge the Health Team must consider. In Nepal, it is very important who prepare the food, when it is prepared and who is allowed to eat it. Consequently, the first step will be to map out all consequences of any interventions on diet. To introduce school lunch will be a complicated intervention for teachers as well as parents.

Aims for Kantipur Health Camp 2013

- Introduction of healthy food involving school and family
    - Enhance the children's energy level and will to attend school
    - Decrease school absenteeism

Interventions

- Have a meeting with Indrabasti School about their experience with the lunch box project
    - General talk
        - Improve concentration
        - Pros and cons
        - Questions
        - Contents of packet lunch, fluid, meal times
        - Attitude of the children
- Invite the directors and maybe teachers from the other schools for a discussion and exchange of experiences
- If the lunch box project works in Indrabasti, buy lunch boxes for the other two schools
- Instigate quality of the lunch boxes and why they break

Criteria of success

- The children have a lunch box with nutritious food
- The children have increased energy level and have the willpower to go to school
- Decreased school absenteeism

Evaluation

- Have a meeting with the involved parties in the lunch box project at Indrabasti School.
    - What do teachers, children, parents think about the lunch box project?
- Appoint forward-looking recommendations

6. Teaching girls and young women on puberty

We have seen a great need for teaching girls and young women on puberty. This subject is taboo. Never the less, we find it very important to focus on this, because of a general uncertainty about female rights – especially concerning menstruation

Aims for Kantipur Health Camp 2013

- Enhance the awareness of the female body and changes throughout the life

Interventions

- Follow up on the work of pervious Health Teams
- Contact Ditte og Bindiya in Denmark from Health Camp 2012 in order to discuss their experiences
- Discuss the puberty project with teacher Soma Panda from Nursery Class at Ayodhyapuri School
- Together with Soma Panda discuss menstruation and changes in the body with the eldest girls at Ayodhyapuri School, and have a general girl talk. Might use posters and drawings.

Criteria of success

- Fewer women sleep in the stables when they have their periods
- Focus on girl subjects and reduce taboos

Evaluation

- Recommendations for Health Team 2014

7. Tests of eyesight and distribution of glasses

It is a very noble story to make your friends, colleagues, neighbours, second hand shops, opticians etc. collect glasses and – based on a simple eye test - hand out glasses to the villagers in Madi. This project is a success in Denmark as well as in Nepal. It has become a sustainable project to provide better sight for many people in Madi.

News spread like wildfire when the Danes arrive with more glasses and glasses do not last forever. This project must continue.

Distribution of glasses and the entire set up of this intervention gives us valuable knowledge on Nepali culture and a deeper understanding of social life in Nepal, the caste system and the social hierarchy - an important part of the everyday life in Nepal. It has been difficult for many villagers – young and old – to cope with everyday chores like sewing, carpentry and teaching because of bad eyesight. Experiences have shown us, that this problem can be diminished by simple intervention.

Aims for Kantipur Health Camp 2013

- All collected glasses will benefit the villagers
- All in need of glasses will get a pair of glasses
- Those in need of a change of glasses will get a new pair

Interventions

- Open Clinic, one day at each school – three days in all
- All glasses are tested by an optician in **Kathmandu**
- Test of eyesight and distribution of glasses (children and adults)
- System of numbers and queue behaviour

Criteria of success

- Villagers show up and are interested in having tested the eyesight
- Experience an easier everyday life by having had glasses
- Villagers respect the rules we have for the system of numbers and queue behaviour
- Those in need of glasses will have some

Evaluation

- Distributed glasses are in use and used with satisfaction

Voluntaries at Kantipur Health Camp 2013

- **Camilla Overgaard Larsen**, Bachelor of Human Nutrition and Health
- **Marie Worm**, Medical student
- **Anne Marie Koch Jørgensen**, Health visitor
- **Arati Poudel**, Nepali Nurse and interpreter
- **Sumit Gayak,** Nepali Health Assistant and interpreter

Arati, Marie, Camilla, Anne-Marie og Sumit

Kantipur Health Camp 2013
Duration: 5 weeks from the 18th of October until the 21st of November 2013.

Report from Kantipur Health Camp 2013

Introduction

The evaluation builds on the project description Kantipur Health Camp 2013 that used the "SMTTE"-model as a reflection tool (Annex 1). Each of the 7 themes is evaluated separately followed by recommendations for Health Team 2014.
Only 3 of the 5 weeks in Nepal were actual working days for the Health Team. A week of festivities was taken into account in the planning of the Health Camp, but it was impossible to predict several days with closed schools and poor attendance due to the national election on November 19th. The election caused some disturbances in the local communities.

In the report the local teachers are named teachers and the Danish volunteers named The School Team.
Without the help from Arati and Sumit results from our health work would be impossible to obtain. Their local knowledge and competences was essential for the project.

Results

1. Develop the existing cooperation with Kharkatta Health Post

We did not achieve our aims for this area due to logistic problems - Tihar and a strike.
Opening hours for the clinic are 10 – 14 all weekdays (Sunday - Friday). Since the opening hours collided with our schedule for the school work, we didn't visit the Health Post until week 5 of the project. Lone Petersen visited Chief of Chitwan District Health Office, Kehar Singh Godar on her return journey to Denmark. Lone informed him of the health work and volunteers of the autumn project and handed over the project description. We are always well received at the District Health Office and our work is valued highly. A proper cooperation has not yet been established.

2. Cooperation with the schools to integrate health and learning - targeting teachers, parents and school children

As Health Team we experienced a good teamwork with the teachers concerning the Teacher Training (TT). We brought with us the health pedagogic tool "The Health Flower"[1]. The Health Flower includes pictures visualising the broad health concept[2]. The Health Flower was a prototype using photographs taken by previous volunteers. It turned out to be a toll of great motivation for health talks; it awoke joy as the teachers recognised persons and places.

Due to the election, only Indrabasti did a whole week of TT on health education in cooperation with the Health Team.
Our first working day in the villages began with a large meeting to match expectations. Attending the meeting were Directors of all schools, all involved parties from the schools, the School Team, The Health Team, School Coordinator Anette and Lone. The Health Team explained that each school would receive a plan of the programme and a timetable for visits. These programmes are now in the "Black Box" in Kantipur.

[1] The Health Flower (Sundhedsblomsten) developed by health visitor Susanne Henriksen. Illustrations at page 11 and 16.
[2] The health concept is broad as it contains life style as well as living conditions. Wistoft, Karen (2009): Sundhedspædagogik - viden og værdier. København, Hans Reitzels Forlag s. 52

We hit upon the idea to bring the Health Flower to the Open Clinic in Ayodhyapuri. We put it on a table for all to look at. Arati Poudel knew the families well enough to ask the women with children attending school to stay behind to have a dialog about the Health Flower and its message. We understood that some of the women had heard about the Health Flower from their children. One mother said, "Well, my daughter came home asking after our soap".

Women from the village study the Health Flower photos.

Evaluation of Teacher Training (TT):
Indrabasti: Our team work worked well. To work with health as a subject for TT was meaningful. Even though the teachers knew of quite a number of the themes we covered, none of them were a matter of course to them. The focus was somewhat shifted from teaching the English language, a subject they could have had more of. It was still possible to teach grammar and pronunciation during the week the Health Team joined the lectures. It worked well having a health subject as basis for the teaching.
Kantipur: We had the pleasure of working with Camilla during TT. Due to national holidays our TT was limited to one week. Camilla joined us for 3 days. Our teamwork was based on a talk about the Health Flower, and Camilla was in charge of communication with the teachers. Whenever problems on the English language appeared, these were written down and used in our further cooperation with the Nepali teachers.

3. Cooperation between School Team and Health Team on professional development
We had intended to integrate teaching on health in the English lessons. This didn't happen because it never became properly coordinated and planned. Even so, in our activities with the pupils we looked into healthy diet, physical activity and general health. Especially in the higher classes (level 3, 4 and 5) we focused on these subjects by use of the Health Flower.

Our work with a new class started in the classroom with and introduction to the subjects, healthy diet, physical activity and general health, after which we introduced the programme of the day.

Our experience is that further focus on the teacher's role in the pupils' health is called for.
We saw children at school having infections, open wounds and flux from the ear without any action was taken. For the future it would be beneficial to try to impose on the teachers to ask the parents to bring their children to the Health Post more often.

The teachers are responsible for a sick pupil and also to prevent diseases from spreading.
Later on in this report we will suggest that a health ambassador is appointed in each school.
In our evaluation with the schools we have emphasized that healthy children learn better and more. Therefore, more responsibility from the schools on health matters would be of great value.

The Health and School Teams have worked together but also parallel. The Health Team's observation and impressions was evaluated with the School Directors and teachers of each school followed by a dialog on future actions and ideas.

We find it difficult to report on point 2 and 3 in our project description. We were not able to cooperate as closely as planned with the School Team – before and during the project. We had planned that the Health Team should attend the Saturday meetings in order to plan and coordinate TT. This didn't happen and now we can see it would have been desirable in order to coordinate a framework for TT.

4. Hygiene, incl. dental hygiene

All actions went as planned. We experienced that pupils in all classes, apart from nursery, knew the basic rules for hand wash. The children knew where, when and how to wash hands, but they did not act accordingly. Several circumstances might explain this e.g. lack of soap by the water posts (soap must be fetched at the office) lack of water, the children needs to be reminded of hand wash. The adults are responsible for proper conditions, and daily focus on hand wash is needed to establish new habits. Lots of posters and drawings of hand wash and other hygienic practises hang at the schools' walls.
In the future, it would be useful to discuss with the teachers their responsibility as role models for children, with a focus on water, soap and the importance of hand wash. For example, when the pupils ask permission to go to the toilet the teacher should remind them to wash their hands afterwards.

Pupils from Indrabasti washing hands

It is a really good idea that the Health Team brings tooth brushes and tooth paste to the pupils. But they seem to disappear at home. We noticed that children only start brushing their teeth long after start of school. Several Nursery Class pupils had never handed a tooth brush before. Indrabasti School had acted on this and solved the problem successfully. They had collected all tooth brushes and kept them at the school and introduced tooth brushing before the first lesson. Now and then the parents donate a small amount of money for tooth paste for common use.
At the other two schools we experienced that many children never brushed their teeth due to lack of a tooth brush.

We brought "Plaque Disclosure Tablets" to use when practicing tooth brushing. We experienced quickly that the effect of the colour tables was poor and ceased to use them. For many children the problem was not how well they brushed their teeth but whether they had a tooth brush or not. The pupils were taught how to brush their teeth and had practised this before we screened them. This biased our results and showed better dental hygiene than actually exists, but our conclusion is that quite a large number of children still have a bad dental hygiene and status[3].

While screening for height, weight, eye sight, dental status and general health a new focus area emerged – the pupils' social situation. Early on we noticed that many children live with just one parent or with another family. This interested us in view of the children's health status and therefore started to ask about the family relations.

We started a medical record system giving each pupil an individual medical record. In this way we can monitor the pupils' health status year after year, record continuous observations and supervision and effectively follow previous Health Team's activities. The medical record will make it easier to follow up on previous observations and recommendations. From previous observations we can state that the children developed in weight and height as expected. Surprisingly few children had not gained the expected weight or height. Uncertainty about the children's age can be a bias here. On the back of the growth curve of each child we have recorded notes from 2012 and 2013.

[3] Annex 2: Data over view

Health Team 2012 recommended that more pupils went to the dentist. When we asked about it this had not happened and they still had dental problems. A few pupils told us that it was hard for them to concentrate due to tooth ache. A girl with chronic ear infection found it difficult to concentrate too. During the day the pupils eat a lot of sugar. The teachers give out candy as rewards. Many children eat biscuits – also containing sugar.

During our stay in the villages we looked into the health care offered for children in Nepal. Arati and Durga helped us with this. A pregnant woman has several check-ups during her pregnancy, she is encouraged to give birth at the clinic and a volunteer health worker visits mother and child after the delivery. Twice yearly, children between 0 and 5 years visit the volunteer health worker to have A-vitamin capsules. Regularly a health worker from the Heath Post visits to immunize children at the volunteer health worker house.
There is no practice for a physical health examination of children[4].

5. Diet, establishing vegetable patches and distribution of lunch boxes

The Tiffinbox project at Indrabasti School worked really well. The project was well structured; they had a protocol of who brought a lunch box, and every pupil's lunch box had it own place in the teachers' room. The teachers kept an eye on the contents of the lunch boxes and they divided the food between the children, in case someone didn't get enough food. This was done discretely and in a very natural way. Some children only brought biscuits or puffed rice (bujai). The pupils were very proud of the lunch boxes and knew exactly where to put them.
In the evaluation of the Tiffinbox project at Indrabasti School, it became clear that the school experienced less absence from school at the beginning of the project, but this is now back to the level before project start. The teachers' explanation is that some pupils do not attend school because they have no food to put in their lunch box.

After meetings with the schools in Ayodhyapuri and Kantipur we found that the lunch box project was not the right project for them right now.
At Ayodhyapuri School they wanted to establish a school kitchen for the Nursery. This was started with support from **Jysk landsbyudvikling in Nepal**. During the strike Helga from the School Team and the teachers from Ayodhyapuri School established a school vegetable patch.
In Kantipur it was more relevant to get the toilets at the school in working order once more. The teachers were very interested in implementing the Tiffinbox project. Indrabasti School benefits from the Tiffinbox project as it is a small school with few pupils. The setting is right at Kantipur School too, but it is more difficult to start this project in Ayodhyapuri; they have fairly small rooms and a large number of pupils.

Ayodhyapuri School has promised to live up to the following demands when the school kitchen is established:

1. The kitchen must be kept clean and only contain kitchen tools
2. There must be running water and soap for washing the dishes
3. Food must be collected or donated from the parents and a list made of parents to take turns at cooking for the children in the school kitchen

[4] Look Annex 3: Tim line and Immunization programme

6. Teaching girls and young women on puberty
During the health talks and screening sessions some of the big girls asked for information on their periods and changes during puberty. It seems a good idea to take up these topics once a year with all girls in 4th and 5th class and also include girls in puberty from other classes. Because the age difference can be great in some classes it is important to be aware of mature girls in the smaller classes.

The teaching material must be quite simple and large enough for all in the room to see. Soma and Arati were very professional in their teaching; the atmosphere in the class was good, warm and confidential.

7. Tests of eyesight and distribution of glasses
A number of near-sighted persons having received a pair of glasses in 2012 came to us to have new glasses because the first pair didn't suit their sight. We observed that long-sighted people who had received glasses in 2012 used their glasses and if they came to us it was to have a stronger pair of glasses or because the first pair was broken. It was difficult for us to find the right pair of glasses for people because we had not had their strength tested before the distribution took place.
We do not recommend handing out glasses to children. They should be examined professionally first. We only found one child in need of glasses but none in need of either an eye specialist or an optician.
When we handed out the glasses we observed that many villagers were conscious of the style and quality of the glasses. Before our Open Clinics we discarded more than 100 pair of glasses. They were either of bad quality or bifocal.

We handed out 84 pair of glasses at the Open Clinics and a few more at Krishna and Durga's. All in all we handed out about 90 pair of glasses. We have left the rest of the glasses at Aratis's parents. These are for near- and long-sighted people and mostly for people in need of plus 3 glasses.

Recommendations

1. Develop the existing cooperation with Kharkatta Health Post.
To get an overview of treatments and health services offered, we recommend that the next Health Team visits the Health Post on one of the first working days and before starting screening the children. Doing this we show respect for the Health Post and our good intentions, which is the basis for a fine collaboration.

2/3. Cooperation with the schools to integrate health and learning - targeting teachers, parents and school children / Cooperation between School Team and Health Team on professional development
We recommend that the Health and Schools Teams together make preparations at home in order to plan a framework and the contents of the joint work.
We also recommend a joint evaluation on the TT in the villages, and also that a clear framework for TT has been agreed on.

It would be beneficial if the School Team had a contact person for the Health team to coordinate with.

Our recommendation is that the Health Flower becomes a permanent tool. Preferably several copies should be made with new photos from the previous Health Team to keep up the interest and motivation for the tool. An additional text on the back of the cards would be a good idea[5]. You could also make a petal with pictures of food and drink with sugar like tea, sweets and biscuits – products causing caries if the teeth are not cared for and brushed.

The Health Flower

During evaluations at the schools, we asked about their opinion on a potential health ambassador. Our idea is that each school choose a teacher to teach hygiene and health in cooperation with health ambassadors from the other schools. The health ambassadors will also be responsible for sharing knowledge with his or her colleagues and develop methods for bettering the general health status of the pupils. Everyone found the idea excellent.

We recommend a Smiley-system. The schools will get a Smiley if they live up to the following:

1. Clean toilets (not only washed down with water)
2. Easy access to water and soap after visiting the lavatory
3. A regime for tooth brushing
4. That ill pupils are taken care of

If the school live up to this they will get a large happy Smiley diploma in a frame to hang up. Later on more conditions can be added. We will underline that it shouldn't be the children's chore to clean the toilets. It should be done with help from the teachers and with proper detergents.

[5] For an example look at the back of the card for sleep and diagram for sleep pattern.

4. Hygiene, incl. dental hygiene

Together we (the Schools and the Health Team) decided that Health Team 2014 should bring equipment for a regime for tooth brushing: plastic baskets for tooth brushes (one for each class), name tacks (must be water proof), tooth brushes and tooth paste. The regime for tooth brushing works well at Indrabasti School, but the schools in Ayodhyapuri and Kantipur need help to get the regime going.

We recommend purchasing a set of dentures to use in teaching the children how to brush their teeth. It is difficult to make the children understand that they must brush more teeth that their front teeth. In order to clarify the teacher's role in the screening, we also recommend, that expectations are matched with the teacher of the class, before screening the children.

When we realised that the several pupils live in broken up families we considered how this affected the pupils' health status. Already we can find the answer to this in our notes, log books and screening data, but have not jet cross checked these data. It might be a focus area for the next Health Team as it looks as if these children need special attention (e.g. distribution of clothes)

We recommend continuous screening of the children and other health work at the schools. We get in touch with most children at the schools and the schools have a valuable impact in the local societies.
For the future we recommend exercises in tooth brushing and hand wash in Nursery and Class 1. It might be beneficial to let a pupil from an older class demonstrate this. There is still a need of theoretical teaching in the higher classes, but we recommend that the pupils demonstrate for each other. It would be recommendable to use the Health Flower when teaching in the older classes.

For the older classes, we suggest that lectures on hygiene and hand wash include how diseases spread; for example let the pupils rank how to wash their hands with the risk of spreading a disease[6]. Results from research back up this recommendation; the spreading of faecal pathogens are better prevented if the spreading is blocked from direct contact (hand wash) than by preventing spreading through the contact with food (Annex 4)
We realised that many children and adults lacked knowledge on how diseases spread. Let the pupils brainstorm on situations, when hand wash is important and let them rank it with the risk of spreading a disease, might therefore be an idea.
We underline the importance of not questioning the children in plenum on who has brushed their teeth and who has had breakfast. This should be talked about during the individual screening - a job for the health ambassador?

It was valuable for us to evaluate our work by the end of each day. We kept a detailed log book of the day's experiences, findings and what we found necessary to recommend.

According to our timeline (Annex 3), we recommend visiting families with children ready to attend school. The focus of these visits is; a good start and the time at school. The following subjects can be discussed: sleep, diet, illness, spreading and treatment of diseases etc. For children with a lunch

[6] Attachment 4: F-diagram and a list of situations where hand wash is relevant

box, the talk can also be about the importance of a healthy lunch.

"Healthy children are happy children and they will learn better"

5. Diet, establishing vegetable patches and distribution of lunch boxes
We recommend that Health team 2014 look into how the school kitchen at Ayodhyapuri School is used and whether the contract, described in point 5, is followed.

6. Teaching girls and young women on puberty
Speak to Arati about the best illustrations to bring to the lessons on puberty. We can help finding these materials. Keep Arati and Soma on as teachers.
Because of great interest, we recommend that the girls are invited twice during our stay; one session for all the girls in the first week and a follow up session for girls interested. The girls will have had time to absorb the new knowledge from the first session and be able to ask further questions in the second session.

7. Tests of eyesight and distribution of glasses
We suggest only bringing glasses with strength 0.5-3 to hand out and a maximum of 150 pairs.
If we distribute glasses we need a professional who can test the eye sights etc. The glasses must be sorted before leaving Denmark. If we collect glasses only ask for glasses with documented strength and of good quality. The budget for the Health Team should cover the test of the remaining pair of glasses in Nepal.
We recommend that the Health Team is taught how to make an eye check before leaving Denmark.

Do not bring glasses for children or near-sighted persons.

We recommend a queuing system for the Open Clinics – either use tickets with numbers or take down names when people arrive.

Logistical recommendations for screening and health education
On arrival, at the large meeting where expectations are matched the Health team explains that each school receives a plan on the programme and a timetable for visits and which classes to visit.

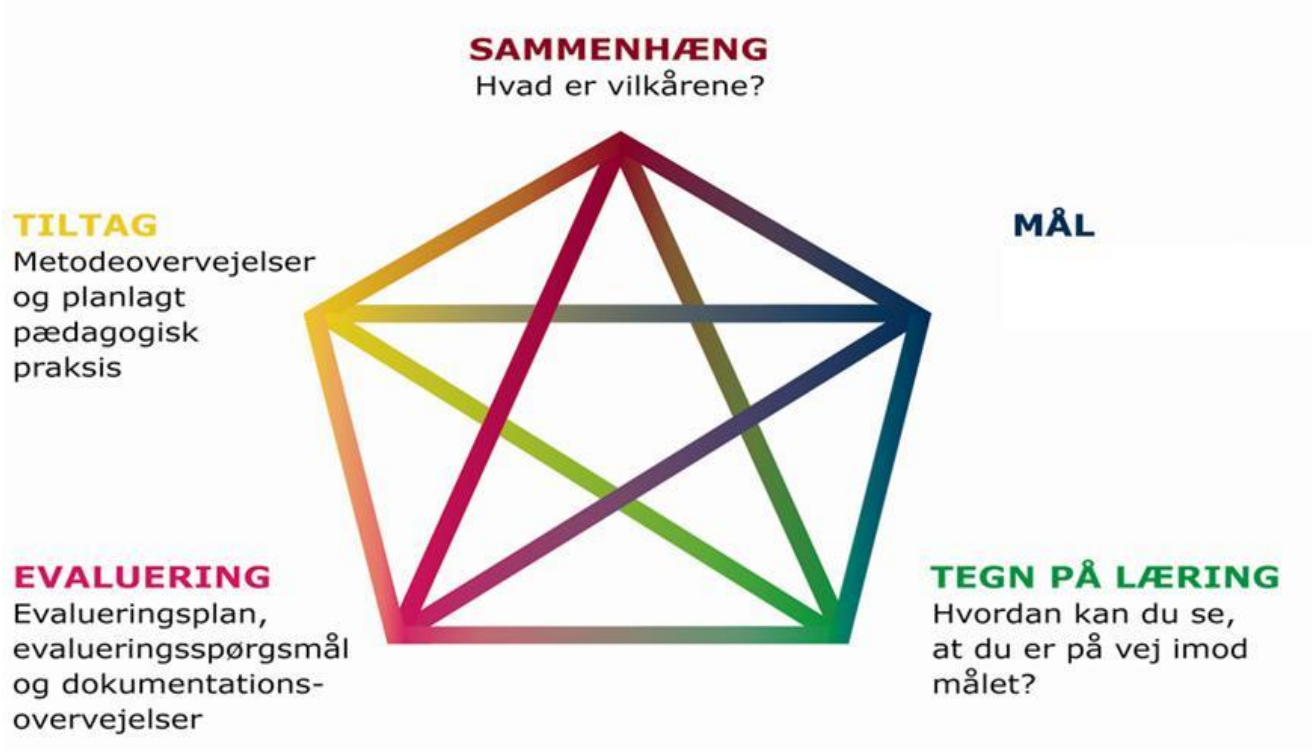
On the day of screening, we recommend a match of expectations with the teacher of the class on our different roles and also to explain the programme of the day.
Get a protocol of the class to give a better overview of the pupils (available in English). In this protocol each pupil has a number; we have a positive experience from working from these numbers. It calmed the pupils.

After matching expectations with the teachers, give a joint briefing in the class on today's programme. When the classes are large divide the pupils into two groups. We used the Health Flower in our general talks on health from level 3. After lessons we had skill training and then the screening.

During screening we were two groups. One group took care of weight, height, eye tests, dental check-ups and check for lice. The other group (with Arati) did a little health talk with the pupil. After this talk we gave the pupil a piece of soap.

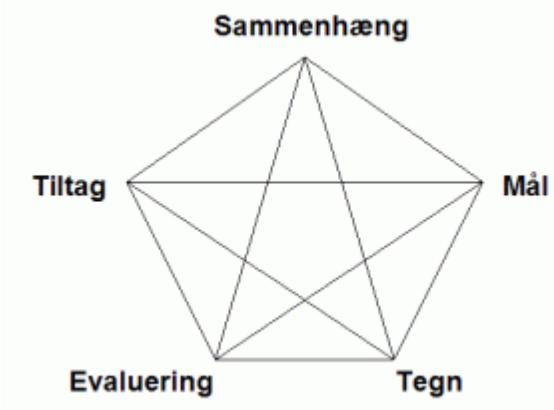
We recommend keeping the log book daily and a daily evaluation. For structure, see the log books from 2013.
We have produced Medical Records that follow each child. The record is kept in a locked cabinet at the school. Remember to bring empty growth curves for new pupils (photocopies can be made in Kharkatta).
We recommend that the Health Team stays for one week at the two small schools and two weeks at Ayodhyapuri School because of its large number of pupils. It does not have to be two weeks in a row. On account of offering two sessions of puberty teaching, it would make sense to spend week 1 or 2 at Ayodhyapuri School and again week 4 or 5.

Annex 1 – the "SMTTE"-model



The SMTTE model – a reflectionsmodel for the pedagogical field

The letters in **SMTTE** stands for: **Sammenhæng (Context), Mål (Aims and objectives), Tegn (Signs), Tiltag (Actions) and Evaluering (Evaluation)** (the english translation of SMTTE is my way of translating the words) The SMTTE model was originally developed in Norway for public schools and the educational field. The SMTTE model consists of a pentagon. Each of the 5 peaks contains elements associated with the four other. The model should be seen as a dynamic tool, where you can jump back and forth between the five elements.



When working with SMTTE, you must define your *aims* and focus on the process.
With the concept of *signs* you can concretise your *aims* by considering what to keep an eye on the path to the *aims* and when the *aims* are reached. The *signs* will be both a help in the planning and during the course, where you can adjust if you do not register what you desired.

When planning and setting *aims* and goals for the SMTTE model, it is useful to jump back and forth between the various points in order to see things in a *context*.
During the implementation of the *actions*, you can also adjust them if you do not find the desired or expected *signs*.

Context/Sammenhæng
Any development takes place in a certain context. Therefore it is important clearly to identify origin and background of the aims. It's a good idea to describe the students and what conditions and needs they have before defining aims.

Aims/Mål
Aims concretize what teachers want to achieve with the students, meaning what the students have to gain from the educational intervention. To work with the aims and objectives they must be concrete and realistic, i.e. match the opportunities we have in everyday life.

Signs/Tegn
Sign is a definition of what to look for on your way to reach the target. Signs can also be called success criteria.
Signs can be defined as indicators of a desired development, and these indicators should be recorded and observed in practice.

Actions/Tiltag
Actions are a description of your intervention in order to achieve your aims. That is a concretization of what you will do to achieve your aims – the content of the lesson for example.

Evaluation/Evaluering
Evaluation can cover a variety of assessment methods that can help us to describe and reflect on the development of the students. Evaluation is a part of the development process, and therefore the evaluation should be done continuously to follow up on the intervention. It is also an opportunity to reflect, and finally make status of the progress achieved and define the steps that must now be taken.

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Annex 2 – Summery of screenings from the schools in Indrabasti, Ayodhyapuri and Kantipur

Indrabasti School week 43 (21/10-24/10 -2013)					4 classes with 48 pupils in all and 4 teachers		
Level	No. of pupils	Age	Height	Weight	Findings	Referral	Eye sight
Nursery	Total: 17 Screened: 14	2-4	84-103 cm	9-15 kg	2 pupils live at grandparents 2 pupils live with the father only 1 pupil with a blind eye 4 pupils very dirty	0	All pupils were eye tested, all OK
Class 1	Total: 10 Screened: 9	5-7	105-118 cm	14-21 kg	2 pupils with lice 2 pupils very dirty 1 pupil had not gained height 2 pupils live with just one parent 1 pupil lives at grandparents 1 child with tooth ache and caries	0	
Class 2	Total: 9 Screened: 9	7-10	113-134 cm	16-28 kg	2 pupils live at grandparents 1 pupil lives with just one parent 1 pupil with caries in the lower part of the mouth	0	
Class 3	Total: 12 Screened: 12	7-15	106-145 cm	15-48 kg	Generally bad dental health 1 pupil had not gained weight 1 pupil had gained a lot of weight 4 pupils live with only one parent 1 pupil with lice 2 pupils with caries 2 pupils attend 3rd grade twice 1 pupil with a cleft palate (going for re-operation)	0	

All the screened pupils were taught hand wash and tooth brushing. All children had been given soap, a tooth brush and tooth paste.
Class 3 talked about health using the Health Flower. They remembered a lot from last year.
All children had a tooth brush at school and brushed their teeth before the first lesson.
All children brought and had lunch at the school.

Conclusion: Small classes. Pupils in the lower classes are generally more dirty that the older pupils. Maybe being less conscious about self-care can account for this.

44 out of the 49 pupils at Indrabasti School were examined
14 pupils had dental problems

Observations
Fairly good toilet facilities with running water next to the toilet.
The pupils only used soup if they had had their bowl open. They got soap from the office.
Good teachers who kept an eye on the children and cared for them.

Family relations
1 pupil; the mother is dead; the father is in India – no contact, lives at his grandparents. The boy is often ill and absent from school.
9 pupils live with only one parent, the other parent is abroad.
1 pupil; the mother is abroad, father remarried, lives at grandparents
2 pupils; no contact with parents, live at another family
1 pupil; both parents abroad, lives at grandparents
1 pupil; mother abroad, father ill, lives with grandparents

Open Clinic: Glasses **25th of October**
37 persons from 11-81 years were eye tested
20 persons got glasses; 19 adults and 1 child
3 persons with eye problems were referred to a doctor
Glasses handed out: 18 for correcting for long sight, 2 for correcting for short sight

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Ayodhyapuri School Week 44 and 46 (27/10 – 31/10 og 13/11 - 2013) 6 classes with 177 pupils in all and 5 teachers

Level	No. of pupils	Age	Height	Weight	Findings	Referral	Eye sight
Nursery	Total: 40 Screened: 18	2-6	83-109 cm	10-18 kg	7 pupils do not brush their teeth 1 pupil lives with only one parent 1 boy with a large wound by the ear and a body-infection ➔ Referred to the Health Post 1 pupil was given clothes 1 pupil with fever how was sent to school to be fed	1	Not eye tested
Class 1	Total: 39 Screened: 35	4-9	98-121 cm	12-20 kg	29 pupils had never brushed their teeth 3 pupils had not gained weight 13 pupils live with only one parent 1 pupil lives at another family 4 pupils had lice 1 pupil had symptoms of asthma ➔ Referred to the doctor 1 pupil with a nail infection 1 pupil with infected wounds on the scalp 1 pupil with fungal infection on the scalp 2 pupils with ear infections Many pupils had not eaten	1	All pupils were eye tested, 1 had a bad eye sight
Class 2	Total: 24 Screened: 22	6-12	104-138 cm	15-30 kg	15 pupils do not brush their teeth 6 pupils had lice 2 pupils live at another family 8 pupils live with only one parent 1 pupil had neither gained weight nor height 1 pupil had a fungal infection on the elbow 1 pupil with a wart on a finger 1 pupil had a tumour operated on	0	
Class 3	Total: 16 Screened: 16	8-12	117-141 cm	16-33 kg	8 pupils never brush their teeth 5 pupils have caries, 1 pupil with a lot of pail 1 pupil with a nasty wound by the nose 1 pupil with ear infection (the same infection as last year) 3 pupils have lice 1 pupil lives at another family 1 pupil lives with only one parent	0	
Class 4	Total: 33 Screened: 33	8-14	117-158 cm	17-44 kg	3 pupils never brush their teeth 4 pupils have their periods 10 pupils live with only one parent 3 pupils live with another family 1 pupil had bad hearing and eye sight, too shy to wear glasses 1 pupil had not gained weight 1 pupil was retarded 2 pupils had lice	0	
Class 5	Total: 25 Screened: 19	10-14	124-166 cm	23-50 kg	Everyone brushed their teeth 2 pupils have their periods 1 pupil lives at grandparents 1 pupil lives with another family 1 pupil lives with just one parent 1 pupil was very dirty	0	

All the screened pupils were taught hand wash and tooth brushing. All children had been given soap, a tooth brush and tooth paste.
Class 3-5 talked about health using the Health Flower. They remembered a lot from last year.
Girls from Class 4-5 had lessons on puberty with Arati and Soma
Conclusion: Very big classes. Pupils in the lower classes are generally more dirty that the older pupils. Maybe being less conscious about self-care can account for this.
143 out of the 177 pupils at Ayodhyapuri School were examined

Observations
The toilets were very smelly – the smell was in the classrooms too
There was not always running water by the toilets. Nursery children got soya bean gruel at the school

Family relations
31 pupils live with just one parent, the other parent works abroad of somewhere else in Nepal
4 pupils live with father or mother, the other parent is dead
1 pupil lives with father, mother had remarried
2 pupils with one parents dead, the other remarried, live at grandparents or another family
3 pupil live with another family, both parents work away from the village
3 pupils with father abroad, mother remarried live at grandparents or another family
2 pupils with father dead mother abroad, live with aunt
1 pupil with father dead, mother abroad, lives at elder brother
1 pupil with both parents abroad, lives with elder brother of 14 years

Open Clinic: Glasses **1st November**
55 persons from 16-90 year were eye tested
47 persons got glasses: 46 adults, 1 child
1 person with eye problems was referred to a doctor
Glasses handed out: 41 for correcting for long sight, 6 for correcting for short sight

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Kantipur school week 46 (10/11- 11/111 – 2013)					4 classes with 53 pupils in all and 4 teachers		
Class	No of pupils	Age	Height	weight	Findings	Referral	Sight
Nursery	Total: 16 Screened: 12	4-5	89-104 cm	11-19 kg	9 pupils never brush their teeth 1 pupil with a chronic ear infection 1 pupil lives with just one parent 1 pupil lives at grandparents 2 pupils were given clothes 4 pupils were very dirty	O	Not tested
Class 1	Total: 13 Screened: 9	5-8	102-125 cm	14-25 kg	10 pupils never brush their teeth 3 pupils were very dirty 1 pupil with lice 1 pupil lives at grandparents 1 pupil lives with just one parent 2 pupils attend Class 1 twice	0	All pupils were eye tested, all OK
Class 2	Total: 12 Screened: 8	7-11	106-124 cm	16-25 kg	5 pupils never brush their teeth All pupils had had breakfast 2 pupils live with just one parent 2 pupils with lice 2pupils with caries All pupils were very dirty	0	
Class 3	Total: 12 Screened: 10	8-13	117-145 cm	20-47 kg	4 pupils never brush their teeth 2 pupils with cariese All pupils had had breakfast 1 pupil have her periods 1 pupil live at a teachers, parents in another town 1 pupil lives at grandparents 1 pupil lives with just one parent	1	
All the screened pupils were taught hand wash and tooth brushing. All children had been given soap, a tooth brush and tooth paste. All children had had breakfast before school. **Conclusion:** Small classes. Pupils in the lower classes are generally more dirty that the older pupils. Maybe being less conscious about self care can account for this. **39 out of the 53 pupils at Indrabasti School were examined**							

Observations

Not very nice toilets. School Director Krishna Thapa has promised to sent for people to make repairs.
Two month ago they got running water by the toilets. They get soap from the office, if they have any (The school says they can't afford it).
Quite few pupils in the classes. Many interruptions from people with no proper errant.

Family relations

2 pupils live with one parent, other parent works abroad.
1 pupil with both parents abroad, lives at grandparents.
2 pupils with father remarried, 1 pupil lives with mother, 1 pupil lives with a remarried mother.
1 pupil lives with a teacher, parents work in another town
1 pupil with father in India, mother remarried, lives at grandparents.

Open Clinic: Glasses **8th November**

27 persons form 16-90 year were eye tested.
17 adults got glasses.
1 person with eye problems was referred to a doctor.
Glasses handed out: 15 for correcting for long sight, 2 for correcting for short sight

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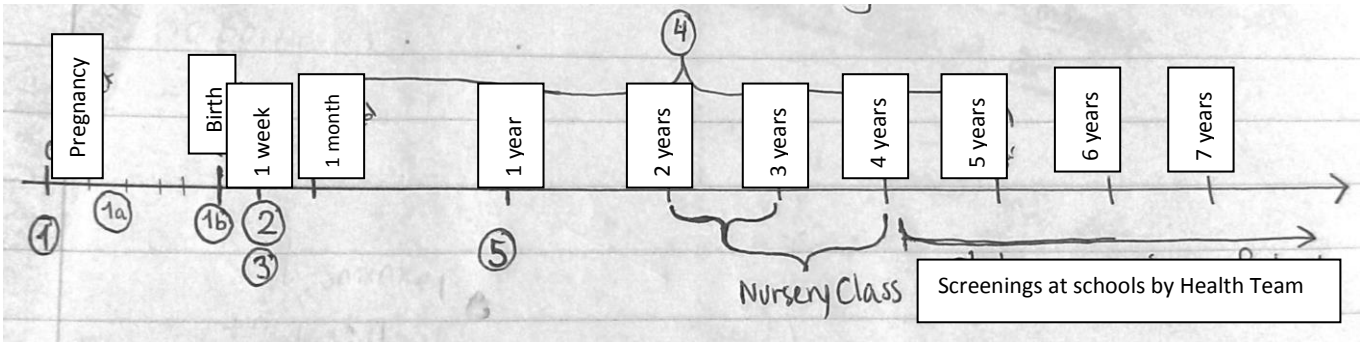
Annex 3 – Time line for children's health check in Madi



1) The Village Health Worker (a trained volunteer) visits the pregnant woman 3 times during the pregnancy and gives information on:

- How to stay healthy during pregnancy
- The importance of following the pregnancy programme, meaning 4 checkups at the Health Post before the delivery (1a).
- The importance of giving birth at the Health Post (1b).
- Preparation for parenting

2) When the child is 1 week old, it is examined at a home visit by the Village Health Worker. Mainly the head and stomach is examined and she has a talk with the parents. The visit is repeated when the child is one month old.

3) A TB vaccination (intradermal BCG- vaccine) is given during the first month.

4) All children have A-vitamin capsules twice a year. The children have A-vitamin and immunizations from age 0-5 years. If the dispensing of A-vitamin correspond with an immunization this is done at the same time. No health talks or health examinations are done.

5) From the child is 1 month till it starts Nursery Class there is no health visits or other initiatives for health promotion – apart from dispensing A-vitamin.

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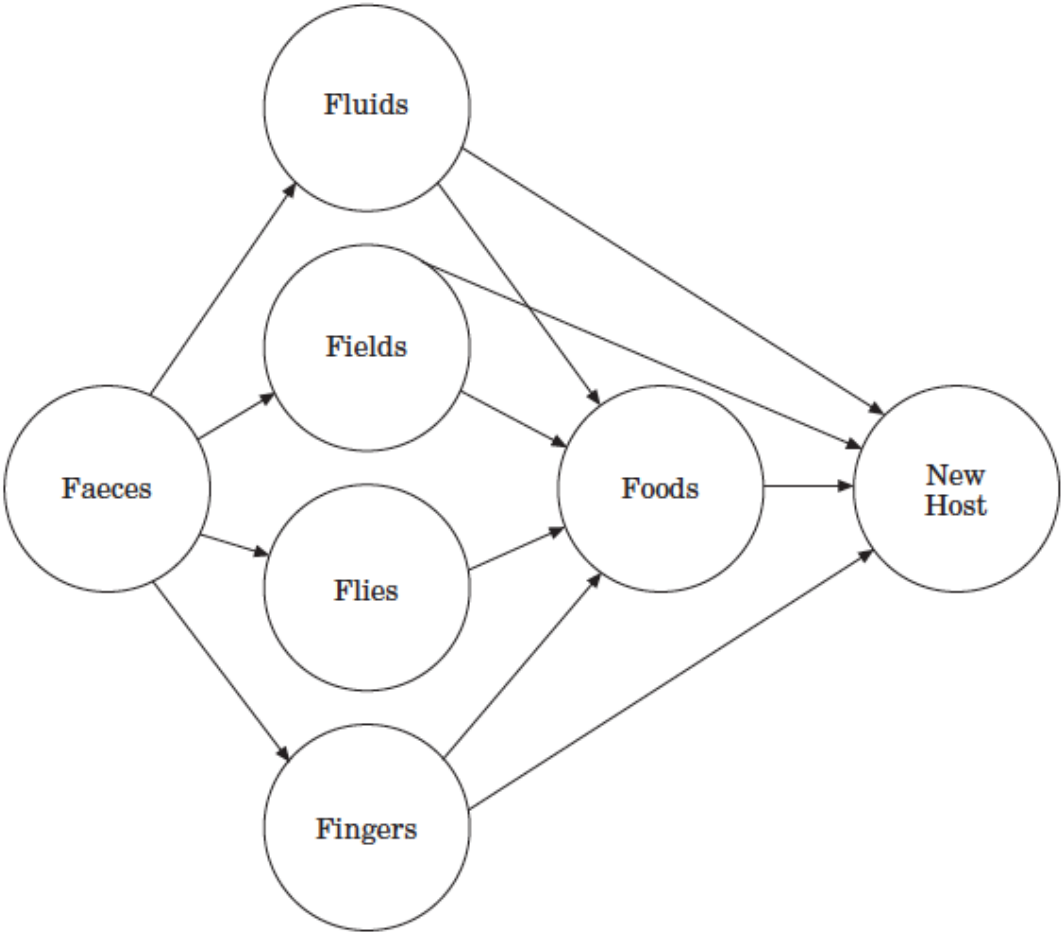
The Nepali immunisation programme for children

Name of vaccine:	Dosis:	Time for vaccination:	Prevents:
1. BCG	0,05ml	From birth and until 1 month of age. Intradermal.	Tuberculosis
2. Di-Te-Ki	0,5ml	Vaccine no. 2 and 3 are given at the same time.	Diphtheria, pertussis and tetanus
3. Polio	2-3 drops	1st dose at 45 days (6 weeks). 2nd dose 1 month after 1st dose. 3rd dose 1 month after 2nd dose.	Polio
4. Maesles	0,5ml	From 10 months of age	Maesles
5. MMR	0,5ml	After 1 year of age	Maesles, mumps and rubella

Source: Arati Poudel.

Annex 4 – F-diagram of spreading of faecal pathogens

Kilde: Curtis, V. et. al., (2000), Review: domestic hygiene and diarrhoea – pinpointing the problem, *Tropical medicine and international health vol. 5, no. 1, pages 22-32*



The F-diagram shows the road of spreading of faecal pathogens. You talk about the primary road from ”faeces” to ”fluids”, ”fields”, ”flies”, ”fingers” and the secondary road from ”fluid, fields, flies” and ”fingers” to the ”new host”. The logic behind this is that it is more efficient to block the primary road that the secondary road. This means that it is far more important to wash hands after being in contact with faeces that when in contact with food

List of situations when hand wash is relevant

- After all visits to the toilet!
- Before contact with food
- After changing a little brother or little sister
- After contact with animals or their excrements
- After playing
- When there is visible dirt on the hands
- After touching open wounds (we observed children touch other children’s infected wounds)