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FIT FOR SCHOOL

Keeping children 'Fit for School'

Simple, scalable and sustainable school health in the Philippines

The Essential Health Care Programme (EHCP) is a successful response to a number of serious health problems facing Philippine children. Supported financially and technically by German Development Cooperation (GDC[1]) since its beginnings, the programme uses simple, evidence-based interventions that can be delivered at low cost in elementary schools to reduce illness and missed days of school.

What keeps kids out of school?

Schoolchildren in the Philippines suffer from a high burden of preventable diseases, with hygiene deficiencies as a common cause, i.e. lack of basic personal hygiene and poor access to sanitation. The main diseases are:

- Hygiene-related infectious diseases: diarrhoea, acute respiratory infections, and pneumonia are the top three killer diseases for children in the Philippines;
- Soil-transmitted helminth (STH) infections: more than 66% of children are infested with intestinal worms;
- Dental infections and toothache: 80-90% of children have caries, and toothache is the most common reason for children missing days from school.

Individually and combined, these diseases can result in or contribute to a variety of debilitating conditions, including malnutrition.

German **Health** Practice Collection

Showcasing health and social protection for development

This Collection describes programmes supported by German Development Cooperation assessed as 'promising or good practice' by experts from German development organizations and two international peer reviewers with expertise in the particular field. Each report tells the story, in plain language, of a particular programme and is published in a short (four pages) and full version at our web site: www.german-practice-collection.org.

There is ample evidence that the main diseases detailed above can be prevented on a large scale using a few simple interventions among schoolchildren.

As in many other countries, child health in the Philippines falls under the national remit of the Department of Health, while the Department of Education (widely known as DepEd) is responsible for school health. In the past, this has resulted in unclear or overlapping responsibilities and in a lack of clear direction and leadership.

>> Children brush their teeth together under the supervision of their teacher.

[1] GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organizations Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Entwicklungsbank (KfW).

Photo: © Ivan Sarenas

Three simple interventions

The Essential Health Care Programme uses three proven interventions that can be delivered simply and at low cost:

- Daily supervised handwashing with soap;
- Daily supervised toothbrushing with fluoride toothpaste;
- Bi-annual deworming.

The essence of the EHCP lies in the everyday routines of elementary schools and day-care centres, as they apply the programme's three interventions. Underlying these routines is the guiding principle that schools can and should provide a healthy environment and establish healthy habits that last a lifetime. Institutionalising healthy habits into daily life at an early age, when children are most receptive, avoids the more complex challenges of health education and behaviour change among adolescents and adults. (This is in line with the 'settings approach' to school health, which recognizes and capitalizes the connection between health and the environment.)

Filipino elementary schools, even those in poor or rural areas, are generally well organized and pupils comparatively disciplined. Children are used to group activities such as lining up every morning for the raising of the Philippine flag and singing the national anthem. The programme approach takes this into account, making the children not only the beneficiaries of the EHCP but also its prime actors. Children are encouraged to develop leadership and to take responsibility for the daily activities.

Each class carries out the group activities of the EHCP throughout the day, according to a schedule developed by the teachers. In the first activity, the children go to the nearest washing facility where they wash their hands using soap. Older children or teachers supervise the group.

The children then brush their teeth, again as a supervised group activity. Toothbrushes for all children are stored in the classroom where the children recognize their brush by a number or a nametag. One child per class dispenses toothpaste to the other children from a container dispenser that releases a standardized amount of fluoride toothpaste on the brush. Children brush their teeth for two minutes and spit out the toothpaste into the washing facility without rinsing their mouths in order to enhance the protective effect of the fluoride contained in the toothpaste.

The deworming activity is conducted twice a year, with the ingestion of a single albendazole or mebendazole tablet. Before it takes place, parents are asked for written consent, and school health personnel carry out information meetings to inform the parents and teachers about the deworming. The deworming tablet is distributed by teachers, supervised by public health nurses visiting the school on the deworming day.

On an organizational level, providing clarity about the roles and responsibilities of each partner has been crucial. Some of these roles are very specific to the Philippines and reflect the country's governmental structure, notably the fact that while the health sector is largely decentralized, the education sector is centrally organized.

The formal foundation of the cooperative intersectoral effort is a Memorandum of Agreement between DepEd, the League of Provinces of the Philippines, and a local non-governmental organization, Fit for School Inc., at the national level signed in May 2009. This in turn provided the basis for subsequent agreements on the provincial level. DepEd defined the roles and responsibilities of school divisions, school administrators, teachers and health personnel in a Department Order signed by the Secretary. At community level, Parent-Teacher Associations (PTAs) are highly involved, and local people contribute unpaid labour for the construction of the required washing facilities. They also participate in the tripartite EHCP monitoring with a school health personnel and local government representatives.

A notable feature is the involvement of Fit for School Inc., which focuses on activities that other partners lack the resources or remit to provide. The areas of technical support provided by Fit for School are: advocacy, social mobilisation, community participation, training/capacity building, facilitating of procurement, and monitoring and evaluation.

A number of partners from the private sector, development agencies and non-governmental organizations have also contributed to the programme in various ways. These include UNICEF and the multinational companies Procter & Gamble and GlaxoSmithKline.

The EHCP includes a monitoring component that serves two functions. First, it collects information that can be used to track the quality of implementation on school level and to correct and improve it at different levels of operation. Second, it is designed to

>> A public health nurse explains deworming to local parents at a meeting about EHCP.

Photo: © Ivan Sarenas

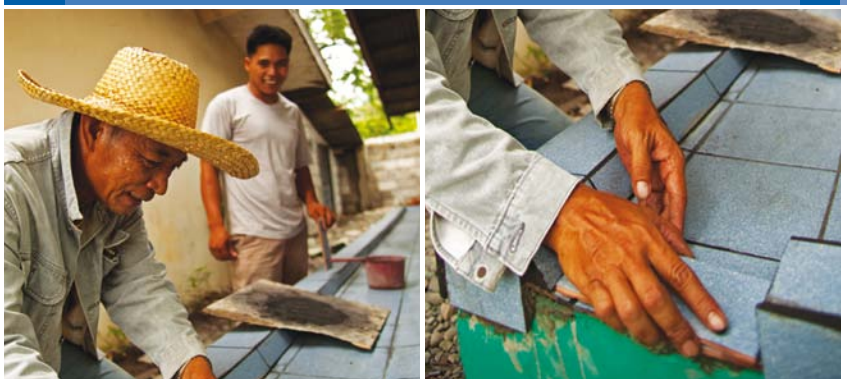

Photo: © Ivan Sarenas

>> Local community members help to construct washing facilities.

work in a participatory way that gives parents and the community a role in shaping the programme at the local level. This secures transparency and accountability while promoting local ownership in line with the school-based management principles promoted by Basic Education Reform Agenda (BESRA). Once per school year each school brings together a monitoring team consisting of three members: a DepEd health staff member, a representative from the barangay (local government), and a member of the local PTA. The team visits 'their' school together and completes the monitoring form. As well as observing the performance of EHCP activities, they assess the quality of the washing facilities, the availability of materials, the records of the deworming activities, and other aspects of the programme. Monitoring data are collected in an Online Monitoring System (OMS) designed especially for EHCP with support from Fit for School.

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Impressive increase in coverage

The EHCP started on a limited scale with pilot programmes in 2003, and received its formal launch in 2008. In the first full year of the programme, school year 2008/09, the number of children covered grew to 633,000.

In early 2009, DepEd formally adopted the EHCP as a national standard for use in schools across the country. Department orders issued during the course of the year mandated the construction of washing facilities for group activities in all elementary schools in the public education system, and called for all teachers to supervise group handwashing and toothbrushing activities as part of their daily duties.

In the following years, the programme continued to grow rapidly as it was extended to additional Local Government Units (LGUs – the basic unit of Philippine governance). By school year 2010/11, just under 1.5 million children in 27 LGUs (24 provinces and three cities) participated in the programme.

In 2010, the costs of the EHCP in Camiguin Province were analysed in a study commissioned by GIZ. The total economic cost (all resources used in an intervention, including direct money outlays and the value of resources for which no money was spent) of the programme in the province's 56 elementary schools for one year was calculated to be $68,778 or $4.78 per child. Direct costs were considerably lower at 1.66 per child. Community contribution to costs (chiefly materials and labour used to create and maintain washing facilities, plus the cost of water) was $0.40 per child.

DepEd is the largest contributor, covering 65% of costs (mostly the teacher's salaries). LGUs provide 12%, and the Department of Health 0.4% (for procurement of the deworming drugs). The community contribution is 9%. GIZ and GlaxoSmithKline contributed the remainder of the economic costs through their support to Fit for School Inc.

A four-year study was begun in 2009 to assess the efficacy of the respective interventions of the EHCP. Data have been collected at the 12-month and 24-month mark. At time of writing (mid-2012), preparations are being made to carry out the 36-month data collection, which will allow definitive conclusions to be drawn about the efficacy of the program.

At time of writing, the EHCP is benefiting more than 2 million children. It is notable that more than 20 of the 42 provinces currently implementing EHCP – out of the country's overall 80 provinces – have allocated regular budgets to cover the majority of (and in some cases all) material costs involved in delivering the EHCP interventions.

Following interest from other countries in the Southeast-Asian region, GIZ – on behalf of BMZ – has established a Fit for School Regional Programme, in partnership with the Southeast Asian Ministers of Education Organization (SEAMEO). The three-year programme, started in late 2011, will provide capacity and technical assistance for school health on a regional level, with specific programming for schools in Cambodia, Indonesia and Lao PDR.

Lessons learned

The process of creating and rolling out the EHCP has taught a number of important lessons:

Simplicity

The EHCP focuses on three basic interventions implemented by teachers rather than health professionals in order to make implementation as easy as possible for all partners. Clear, concise and reader-appropriate training material and guidelines help in instructing schools and their staff on how to implement the programme.

Scalability

Interventions follow a modular structure and are based on uniform templates. For example, supplies come in a pre-packaged set of soap, toothpaste and toothbrush sufficient for eight children for an entire year. Depending on the availability of resources, facilities can be extremely basic at first and be improved later.

Sustainability

The four most important contributors to sustainability are: (a) DepEd's inclusion of the EHCP activities in policy ordinances (b) alignment with existing school management principles (c) long-term financing of consumables (soap, toothpaste, etc.) by local governments, not donors or the private sector (d) the participation of the community in various ways.

Overcoming institutional barriers

It is essential to invest in promoting intersectoral collaboration between the health and education sectors and between education and health professionals – not just at the beginning, but throughout the implementation of the programme.

The value of a 'kick-start' mechanism

During the first year of implementing the EHCP in a new province, the financial and technical 'kick-start' from GIZ or other donors is very important. This period helps the local decision makers to understand the process, costs and benefits of the programme better.

An independent support structure

The creation of the NGO Fit for School Inc. responded to a need for an independent and highly flexible organization, which could support DepEd, the LGUs and other implementing partners as the EHCP was rolled out.

Peer Review

The two expert reviewers of this report have concluded that the initiatives described here are worthy examples of current practice in school health.

Although the definitive measure of the programme's effectiveness will only be known once results of the four-year study are published, the EHCP was judged **effective** in terms of rapidly reaching a large number of children in a short time 'with time-tested interventions that are well-recognized as effective in preventing the relevant health problems.' The reviewers also noted its success in overcoming institutional barriers between the health and education sectors that had previously been major constraints on the effectiveness of previous school health interventions in Philippines. They commented that EHCP interventions and approach are transferable, being easy to replicate and scale up in many different contexts. Both reviewers stated that the **participatory** aspect of the EHCP was one of its particular strengths, particularly in that it 'empowers the parents and community stakeholders to be involved in ensuring healthy school children.' The reviewers were impressed with 'well developed tools for **monitoring and evaluation** of the programme,' including the online monitoring system. They concurred that the innovative nature of the programme was not in the interventions themselves but 'in the sense that it brings the three interventions together into a single, low-cost strategy that addresses the commonest health issues among elementary school children.' The creation of an NGO to partner with the public sector was also seen as innovative. The lack of comparable programmes in other countries to use as benchmarks made it difficult for the reviewers to comment definitively on **cost-effectiveness**. Finally, it was suggested that DepEd's adoption of EHCP as flagship programme was a hopeful indicator of future **sustainability**, along with the fact that many provinces were now allocating regular budgets to cover the majority of the programme's material costs.

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