School Health, Nutrition and HIV/AIDS Programming:

Promising Practice in the Greater Mekong Sub-Region

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Contents

Abbreviations and Acronyms ii
Acknowledgments iii
Executive Summary iv

Programs and Initiatives 1

Chapter 1: *Health-Related School Policies* 3

Mainstreaming HIV/AIDS in the Education Sector – Cambodia
Coordinating Implementation of School Health Activities – Lao PDR
Resourcing School Health and Nutrition Activities through the "Sin Tax" – Thailand

Chapter 2: *Safe and Supportive School Environment* 13

Promoting Gender Balance among Teachers: Scholarships for Girls – Cambodia
Inclusive Education for Children with Special Needs – Lao PDR

Chapter 3: *Skills-Based Health Education* 17

Pre-Service Teacher Training – Cambodia
Health Education for Out-of-School Youth – Cambodia and Lao PDR
HIV/AIDS Prevention Education for College Students – China
Life Skills Education and Health Promotion Materials: Blue Box – Lao PDR
Taking Life Skills-Based Education to National Scale – Myanmar
Education Services for Out-of-School Youth – Myanmar
Student Involvement in the Development of IEC/BCC Materials – Vietnam

Chapter 4: *School-Based Health and Nutrition Services* 37

Deworming for Schoolchildren – Cambodia
Educational Care Services for HIV/AIDS Affected Children – China
Deworming for Primary School-Age Children – Lao PDR
Deworming for Schoolchildren and Other High Risk Groups – Vietnam

Boxes

Box 1: School-Based Assessment in Thailand 9
Box 2: School-Based Assessment in Lao PDR 12
Box 3: Student Involvement in the Development of IEC/BCC Materials in Cambodia 36
Box 4: School Lunch Program in Thailand 44

Annexes

Annex 1: School Health and Nutrition, including HIV/AIDS, in the Greater Mekong Sub-Region: Questionnaire Responses 47

Cover image:
Tara E. O'Connell

Abbreviations and Acronyms

ACIPAC	Asian Center of International Parasite Control
ADB	Asian Development Bank
AICU	Associazione Italiana Carlo Urbani
AIDS	Acquired Immune Deficiency Syndrome
AIS	Assistant State Inspectors
ASEAN	Association of Southeast Asian Nations
ATEOs	Assistant Township Education Officers
BCC	Behavior Change Communication
CARE	Cooperative for Assistance and Relief Everywhere
CBOs	Community-based organizations
CMDG	Cambodian Millennium Development Goal
CNM	National Malaria Centre
CPC	Communist Party of China
CSCS	Cooperation for a Sustainable Cambodian Society
DFID	United Kingdom's Department for International Development
DGE	Department of General Education
DIT	District Implementation Teams
EFA	Education for All
ESP	Education Strategic Plan
ESSP	Education Sector Support Program
EU	European Union
EXCEL	Extended and Continuous Education and Learning
FFOCP	Four Frees and One Care Policy
FRESH	Focusing Resources on Effective School Health
GMSR	Greater Mekong Sub-Region
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Schools
HRDC	Human Resource Development for Community
HSE	Health Setting and Environment
ICHA	Interdepartmental Committee for HIV/AIDS
IdCF	Ivo de Carneri Foundation
IE	Inclusive Education
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IMPE-HCMC	Institute for Malariology, Parasitology and Entomology, Ho Chi Minh City
IMPE-QN	Institute for Malariology, Parasitology and Entomology, Qui Nhon
IQ	Intelligence Quotient
JICA	Japan International Cooperation Agency
JSHC	Joint School Health Committee
LSHE	Life Skills for HIV/AIDS Education
LSMC	Local Scholarship Management Committee
M&E	Monitoring and evaluation
MDA	Mass Drug Administration
MoE	Ministry of Education
MoET	Ministry of Education and Training
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MOU	Memorandum of Understanding
NAA	National AIDS Authority
NAAA	Nucleo Assistenza, Adozione, Affido
NFE	Non-Formal Education
NGOs	Non-government organizations
NIE	National Institute of Education
NIMPE	National Institute for Malariology, Parasitology and Entomology
NIN	National Institute of Nutrition
NIT	National Implementation Teams
NRC	National Rehabilitation Center
NRIES	National Research Institute for Educational Science
NSHP	National School Health Policy
OSAVY	Office of Social Affairs, Veterans and Youth Rehabilitation
PCD	Partnership for Child Development
PDR	People's Democratic Republic
PIT	Provincial Implementation Teams
PPAE	Participatory Program Assessment and Evaluation
PRA	Participatory rural appraisal
SCN	Save the Children Norway
SEAMEO	Southeast Asian Ministers of Education Organization
SHAPE	School-Based Healthy Living and HIV/AIDS Prevention Education
SHN	School health and nutrition
SIDA	Swedish International Development Cooperation Agency
SMHF	Sasakawa Memorial Health Foundation
STDs	Sexually transmitted diseases
STH	Soil-transmitted helminths
STIs	Sexually transmitted infections
TEOs	Township Education Officers
TFOSP	Two Frees and One Supply Policy
TOR	Terms of Reference
TTCs	Teacher Training Colleges
TTD	Teacher Training Department
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WFP	World Food Programme
WHO	World Health Organization
YBoE	Yunnan Provincial Bureau of Education
YBoH	Yunnan Provincial Bureau of Health

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Executive Summary

In low income countries, poor health and malnutrition are critical underlying factors for low school enrolment, absenteeism, poor classroom performance and dropout; all of which act as important constraints in countries' efforts to achieve Education for All (EFA) and the education Millennium Development Goals (MDGs). In the Greater Mekong Sub-Region (GMSR), the education and health sectors have long recognized that school health and nutrition programs can address the basic health problems faced by their schoolchildren. More recently, life skills modules and HIV prevention education are being introduced to promote positive and healthy behaviors. The currently low levels of HIV infection in the GMSR make a focus on prevention all the more timely. Delivering comprehensive, scaled, systematic and sustainable school health and nutrition programs (that include HIV prevention) based on the Focusing Resources on effective School Health (FRESH) framework is becoming increasingly more common in the sub-Region.

The aim of this document is to share emerging promising practice in the field of school health and nutrition within the GMSR and to inform governments, development partners and other organizations that recognize the need to harmonize activities and align assistance. It aims to strengthen the Network of School Health, Nutrition and HIV/AIDS Ministry of Education Focal Points and further the establishment of a sound community of good practice in the sub-Region. The document includes descriptions a wide range of different activities from the six GMSR countries of Cambodia, China (Yunnan Province), Lao People's Democratic Republic (PDR), Myanmar, Thailand and Vietnam.

The process of compiling the different accounts began during the *GMSR Workshop in March 2007 on Strengthening the Education Sector Response to School Health, Nutrition and HIV/AIDS Programs* in Siem Reap, Cambodia and was completed through remote correspondence with ministry of education teams in each of the different countries. Analysis revealed that a significant amount of activity around school health, nutrition and HIV/AIDS was already underway in the education sectors of the sub-Region (see Annex 1: School Health and Nutrition, including HIV/AIDS, in the Greater Mekong Sub-Region: Questionnaire Responses) by this time. The programs and initiatives presented here were identified as examples of promising practice in comprehensive and contemporary school health and nutrition programs by members of the GMSR Network of School Health, Nutrition and HIV/AIDS Ministry of Education Focal Points and their partners in the health sector and in civil society participating in this Workshop. The practices vary in focus, content and process but, when taken together, a number of similarities emerge across the sub-Region, suggesting that the inclusion of specific characteristics in project planning and implementation increases the likelihood of effective implementation and sustainability. These common characteristics are explored below within the five broad programmatic areas of:

- **Health-Related School Policy;**
- **Safe and Supportive School Environment;**
- **Skills-Based Health Education;**
- **School-Based Health and Nutrition Services; and**
- **Partnerships.**

Health-Related School Policy: An area of convergence amongst those programs seen as promising practice is the existence of a comprehensive and established policy for school health and nutrition (SHN) including HIV/AIDS. Those practices that were based on well-defined policy at the national, provincial, district and school levels were generally felt to be more widely supported by health and education staff, parents and students. Multi-level implementation was also found to foster much wider reach and encourage sustainability by broadening the response base.

Safe and Supportive School Environment: Programs and activities were found more likely to meet with success when implemented within a supportive and inclusive school environment. The recognition of teachers as key implementers and the provision of capacity building in the form of pre- and in-service teacher training were found to be critical elements in implementation of effective HIV/AIDS programming. Due in part to cultural taboos around sexuality, many teachers in the sub-Region are reportedly reticent and ill-prepared to broach the topic of HIV/AIDS in the classroom. Pre- and in-service training focusing on teaching techniques in relation to SHN including HIV/AIDS has proven a valuable primary step in implementing curricula addressing HIV/AIDS.

Many of the programs documented here also include specific provisions to address the needs of all students, including those with special needs. In addition, the document highlights the need to provide a supportive psychosocial environment for students and staff.

Skills-Based Health Education: There is general consensus that promising practice in SHN programming in the sub-Region involves the inclusion of a life skills component that includes HIV/AIDS in school curricula. Promoting healthy behaviors related to nutrition, sexuality and a healthy lifestyle in general is regarded as key, but providing knowledge alone is not enough; young people also need to develop the skills necessary to affect behavior change. School systems present an established and efficient means through which to reach children and adolescents with information as well as training in life skills that provide the knowledge, attitudes, and values needed to make sound health-related decisions that promote a healthy lifestyle more generally.

School-Based Health and Nutrition Services: The document presents a number of promising practice examples involving the delivery of health and nutrition services to school-age children. The examples demonstrate how simple, safe and familiar health and nutrition services such as deworming or micronutrient supplements can be cost-effectively delivered through the existing network of schools to address health issues that are prevalent among the target population.

Partnerships: Creating and maintaining strong partnerships between governments and donor agencies; partnerships between the Ministries of Education and Health; and partnerships between schools and communities has proven vital to successful implementation of school health, nutrition and HIV/AIDS programming. Partnerships generally proved most effective when established in the early planning stages of activities, allowing widespread buy-in of and participation in the planning and implementation processes. Such partnerships helped drive the collaborative process, promoting innovation at the community, national and regional levels, and encouraged sustainability through shared responsibility and ownership. A particular feature of partnerships in the region has been that of enabling young people to play a role in the development of programs – and in particular of program materials. Such an approach increases young peoples' ownership and buy-in and ensures greater relevance of programs to young peoples' lives.

While the exercise of developing this document has proven useful in creating a regional community of good practice in SHN and HIV/AIDS programming, it has also aided in the identification of key challenges to successful SHN and HIV/AIDS programming in the sub-Region.

Photo: World Bank

While few of the promising practice examples elaborated in this document include monitoring and evaluation (M&E) procedures, M&E is widely recognized in the GMSR countries as a core component of the process and an area of challenge to which a much stronger response is needed. Practitioners report that evaluation of programs has been hampered by the lack of an effective plan for M&E including: identification of measurable indicators to gauge the level to which the program meets intended goals and objectives; a plan as to how data around these indicators will be collected and analyzed; an explanation as to how these data will be utilized in impacting outcomes; and an estimation of resources needed to support the M&E system. Efficient M&E systems are critical in ensuring accountability and transparency of operations.

Programs and Initiatives

***The Greater Mekong Sub-Regional Workshop on Strengthening the Education Sector Response to School Health, Nutrition and HIV/AIDS Programs*, which took place in Siem Reap, Cambodia in March 2007, offered an excellent opportunity for practitioners to share experiences and to learn from existing promising practice within the Greater Mekong Sub-Region.**

In the lead-up to the workshop, participating country teams from Cambodia; China (Yunnan province, herein referred to as China); Lao People's Democratic Republic (PDR); Thailand; Vietnam; and an observer team from Bhutan were asked to complete a pre-workshop questionnaire in order to give a snapshot of the current situation in relation to school health, nutrition and HIV/AIDS at country level.

Responses revealed that a significant amount of activity around school health, nutrition and HIV/AIDS was already underway in the education sectors of the sub-Region (see Annex 1: School Health and Nutrition, including HIV/AIDS, in the Greater Mekong Sub-Region: Questionnaire Responses). Discussion of this reality led to agreement by all participating countries and development partners that a publication documenting existing examples of promising practice in the sub-Region would be produced.

School Health, Nutrition and HIV/AIDS Programming: Promising Practice in the Greater Mekong Sub-Region is a collaborative work documenting those activities and initiatives generally felt to be examples of promising practice in school health, nutrition and HIV/AIDS programming in the sub-Region.

The program descriptions included in this document have been thoroughly vetted by government officials, practitioners, development partners and civil society groups active in school health in the GMSR. Drafts of the work were circulated widely on two occasions: the 8th International Congress on AIDS in Asia and the Pacific (ICAAP) held in Colombo, Sri Lanka in August 2007; and the UNAIDS Inter-Agency Task Team (IATT) on Education symposium on "Meeting the HIV Prevention Needs of Young People in Asia" held in April 2008 in Chiang Mai, Thailand. Useful feedback was collated and has been incorporated into this final publication.

The promising practice examples are presented within the FRESH[1] (Focusing Resources on Effective School Health) framework, which outlines the four basic components of an effective school health program, namely:

1. ***Health-Related School Policies:* including those that address HIV/AIDS issues, and gender.**

2. ***Safe and Supportive School Environment:* including access to safe water, adequate sanitation and a healthy psychosocial environment.**

3. ***Skills-Based Health Education:* including curriculum development, life skills training, teaching and learning materials.**

4. ***School-Based Health and Nutrition Services:* including deworming, micronutrient supplementation, school feeding, malaria treatment/referral and psychosocial counseling.**

[1] FRESH is an inter-agency initiative developed by United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF), the World Health Organization (WHO), Education International and the World Bank, launched at the Dakar Education Forum, 2000. The initiative now includes a large number of other organizations. The FRESH framework captures best practices from program experiences for the design and implementation of effective school health and nutrition programs.

Chapter 1:
Health-Related School Policies

MAINSTREAMING HIV/AIDS IN THE EDUCATION SECTOR – CAMBODIA

INTRODUCTION

In Cambodia, the Ministry of Education, Youth and Sport (MoEYS) is mainstreaming HIV/AIDS prevention education throughout its operations to ensure that students in public schools, out-of-school youth and its workforce can be protected from infection. This is an enormous undertaking: MoEYS is responsible for providing education services throughout the country to over 3,500,000 students and as the largest Ministry in Cambodia, it administers half of Cambodia's civil servants (120,000 staff) in over 7,000 public schools, ranging from pre-primary to tertiary levels. As well as addressing staff and students in the formal sector, activities also aim to reach more vulnerable children who do not yet access regular education.

AIMS AND OBJECTIVES

- To protect and prevent students, out-of-school Cambodian youth and MoEYS labor force from being infected and affected by HIV/AIDS.
- To contribute to increasing knowledge, skills and safe behaviors among Cambodian students and out-of-school youth, and the education sector's employees.
- To support the Royal Government of Cambodia's effort towards reaching Education for All (EFA), by strengthening the MoEYS capacity to respond to HIV/AIDS.

PROGRAM OVERVIEW

Background

HIV/AIDS is a key priority for the Royal Government of Cambodia which considers that responding to HIV/AIDS is critical to the socioeconomic development of the country. Education and Health are essential pillars of the Government's strategic development plans; for example, Cambodian Millennium Development Goal (CMDG), Rectangular Strategy and the National Strategic Plan for Poverty Reduction. In February 2006, the Government launched the new 5-year National HIV/AIDS Strategic Plan (2006 to 2010), coordinated under the auspices of the National AIDS Authority (NAA). HIV is likely also to be having an immediate impact on MoEYS' ability to deliver quality education – according to the latest estimates of the prevalence of HIV/AIDS in Cambodia, it is estimated that some 2,000 MoEYS employees (teaching and non-teaching staff) could be HIV-positive.

HIV/AIDS Law

Article 3 of the HIV/AIDS Law states that the responsibility of the Ministry of Education, Youth and Sport is to:

- **Integrate HIV/AIDS education in the school curriculum;**
- **provide preventive education programs for in- and out-of-school youth;**
- **train teachers as resource persons; and**
- **cooperate with the civil society and non-government organizations (NGOs).**

Program Implementation

The Ministry's HIV/AIDS program is coordinated through its Interdepartmental Committee for HIV/AIDS (ICHA, see diagram below) and implemented as part of the Education Sector Strategic Plan (5 years), its Education Sector Support Program (ESSP) and the Ministry's HIV/AIDS Strategic Plan.

The ICHA was established in 1999 in response to the decision of the Royal Government of Cambodia to strengthen Cambodia's response to HIV/AIDS. The committee is chaired by the MoEYS Secretary of State and comprises 15 departments and institutes. These include School Health, Finance, Information and Association of Southeast Asian Nations (ASEAN) Affairs, Personnel, Teacher Training, Non-Formal Education (NFE), Pedagogical Research, Primary Education, General Secondary Education, Higher Education, Planning, National Institute of Education, Student Physical Education and Sport, Youth and Inspectorate of Education. The ICHA structure is as follows:

- ***Policy Board:*** composed of the Secretary of State and the 15 Directors in the departments.
- ***Technical Working Group:*** composed of 15 departments with 2 Focal Points per department.

- ***ICHA Secretariat:*** composed of 3 full-time and 5 part-time officers responsible for facilitating the implementation and coordination of the Ministry's HIV/AIDS strategy and program. In addition, a finance team oversees financial management, procurement and contractual matters.

The ICHA program is implemented by the Ministry's 15 central departments, the Provincial and District Education Authorities, contracted NGOs, and other development partners and institutions.

Target Groups

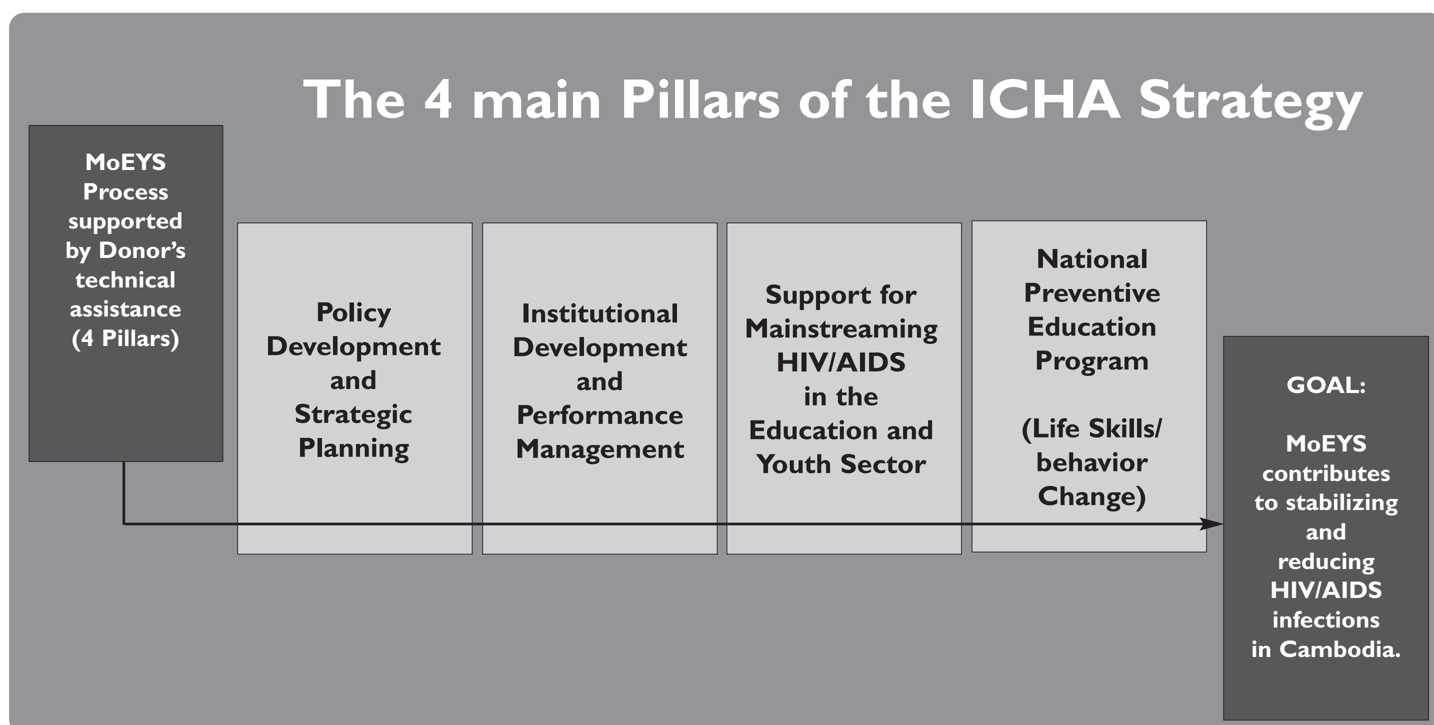
The ICHA program has nationwide coverage in the Kingdom of Cambodia and operates with the following beneficiaries:

Primary Target Group(s): Cambodian youth: primary schoolchildren, secondary schoolchildren and literacy learners; vulnerable youth; out-of-school youth; orphans and vulnerable children; and street children. MoEYS teaching and non-teaching staff: central Ministry staff; teachers and literacy trainers; and administrative and technical staff at provincial, district and school levels.

Secondary Target Group(s): parents and community representatives; religious authorities; local authorities; NGOs; community-based organizations (CBOs) and political leaders in Cambodia.

Program Activities

Program Components: The ICHA program consists of 4 pillars (see diagram below).



Pillar 1: Policy Development and Strategic Planning: Policy and strategy are developed to ensure that HIV/AIDS (and other related topics) remains a priority for the MoEYS, and that relevant goals and aims are established.

Pillar 2: Institutional Development and Performance Management: Institutional development, capacity building and training activities are organized to strengthen the Ministry's capacity to plan, implement and monitor HIV/AIDS programs. Financial management, procurement, human resource management and merit-based incentive schemes are also addressed.

Pillar 3: Support for Mainstreaming HIV/AIDS in the Education and Youth Sector: Pillar 3 aims at mainstreaming HIV/AIDS across the MoEYS. It mainly focuses on integrating HIV/AIDS in the national curriculum, pre- and in-service training of teachers, developing curriculum and Information, Education, Communication (IEC) tools, research, and monitoring and evaluation (M&E).

Pillar 4: National Preventive Education Program (Life Skills/Behavior Change): Pillar 4 supports the planning and implementation of the 'National Life Skills for HIV/AIDS Education' program that targets Cambodian in- and out-of-school youth (approximately 6 million youth).

Program Resources and Finance

The ICHA annual budget is approximately US$2.3 million. Besides national budget allocations, ICHA receives its main support from DFID and from the United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and other development agencies. ICHA closely cooperates with international and local NGOs and coordinates its program activities with NAA, other line Ministries and the donor community.

Program Materials (MoEYS materials on HIV/AIDS)

- Education Strategic Plan (ESP).
- Education Sector Support Program (ESSP).
- HIV/AIDS strategic plan.
- Workplace policy.
- ICHA log frame.
- Monitoring and evaluation plans.
- Manual for conducting 'Participatory Program Assessment and Evaluation' (PPAE).
- Seven fact sheets:
  - i. *Education sector's national response.*
  - ii. *Monitoring and evaluation.*
  - iii. *Life skills for HIV/AIDS education.*
  - iv. *Financial management.*
  - v. *Institutional arrangements.*
  - vi. *Staff performances (output-based incentive scheme).*
  - vii. *Contracting NGOs.*
- Teacher training manuals for primary, secondary and NFE.
- Life skills for HIV/AIDS manuals, with 2 separate sets of manuals for teachers and students.
- Set of IEC tools, including posters, games, television spots, etc.
- ICHA documentary film.

PARTNERSHIPS

Support was received by DFID, UNDP, UNESCO, UNFPA, UNICEF, local NGOs and the donor community.

KEY OUTCOMES AND LESSONS LEARNED

Recent achievements of the MoEYS are:

- The new curriculum framework now integrates HIV/AIDS topics in primary, secondary and NFE.
- HIV/AIDS is part of the new Students Performance Minimum Standards.
- HIV/AIDS is integrated in the National Examination plans.
- All pre-service teachers attend a 5-day training course on HIV/AIDS.
- In-service teachers are progressively trained on HIV/AIDS.
- HIV/AIDS manuals and IEC tools have been developed.
- The 'National Life Skills for HIV/AIDS Education' program has been launched in 14 provinces.
- The Ministry reaches out to out-of-school youth and street children.
- HIV/AIDS-related topics (such as reproductive health and drugs) are integrated in the program.
- The DFID Monitoring and Advisory Team suggested that the model and experience of MoEYS in the area of HIV/AIDS be used for other line Ministries and in other countries.

This holistic approach used by MoEYS to mainstream HIV/AIDS is today recognized as good practice in terms of capacity building, political/individual commitments, sustainability and technical/managerial expertise.

Program Evaluation

As a key cross-cutting issue, M&E is entirely integrated in the Ministry's HIV/AIDS program. The MoEYS and M&E system address both process and impact(s). With the support from DFID, MoEYS has opted for a combination of quantitative and qualitative/participatory approaches. This dual system focuses on implementation and quality of processes/operations as well as on end results. In addition, while a centralized system was required in the early phase, the Ministry is now moving towards greater decentralization and involvement of local authorities. Co-operation with local actors (e.g. community leaders and youth groups) and NGOs is therefore essential.

FURTHER INFORMATION

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COORDINATING IMPLEMENTATION OF SCHOOL HEALTH ACTIVITIES – LAO PDR

INTRODUCTION

Effective coordination of different stakeholders is essential if school health and nutrition activities are to occur within countries. In Lao People's Democratic Republic (PDR), clear mechanisms have been established between the education and health sectors that outline the roles and responsibilities of each and their interaction with one another. Such coordination has enabled the establishment of a school health and nutrition program that is being implemented across the country.

AIMS AND OBJECTIVES

- To increase children's knowledge on basic health issues.
- To empower and motivate children to adopt basic healthy practices in daily life.
- To strengthen collaboration between the Ministry of Education (MoE) and Ministry of Health (MoH).
- To increase the capacity of the main partners in program management and in providing technical support to program implementers.
- To strengthen the capacity of schoolteachers in health messages that are delivered and implemented through a child-to-child approach using existing and new materials.
- To develop a package of school health materials.
- To strengthen the system of monitoring and supervision of the school health program.

PROGRAM OVERVIEW

Background

In Lao PDR, a number of agencies have been involved in implementing health activities in schools. Previously, no comprehensive or systematic process existed to strengthen cooperation between the Ministries of Education and Health, or to introduce and expand health subjects in the school curricula with effective, participatory and interactive pedagogical systems.

Since 2002, a number of steps have been taken to improve coordination. The first was a meeting held among education and health officials which drafted a Memorandum of Understanding (MOU) between the two Ministries. It was agreed that the MoH would support the MoE in institutionalizing, expanding and improving health promotion in schools. The MOU was a significant achievement that created a basis for collaborative activity for future activity between the Ministries of Education and Health. It includes both vertical and horizontal co-ordination mechanisms to encourage collaboration and co-ordination between the education and health sectors. The concepts and vision of school health that support education outcomes were subsequently introduced to provincial and district education and health administrators.

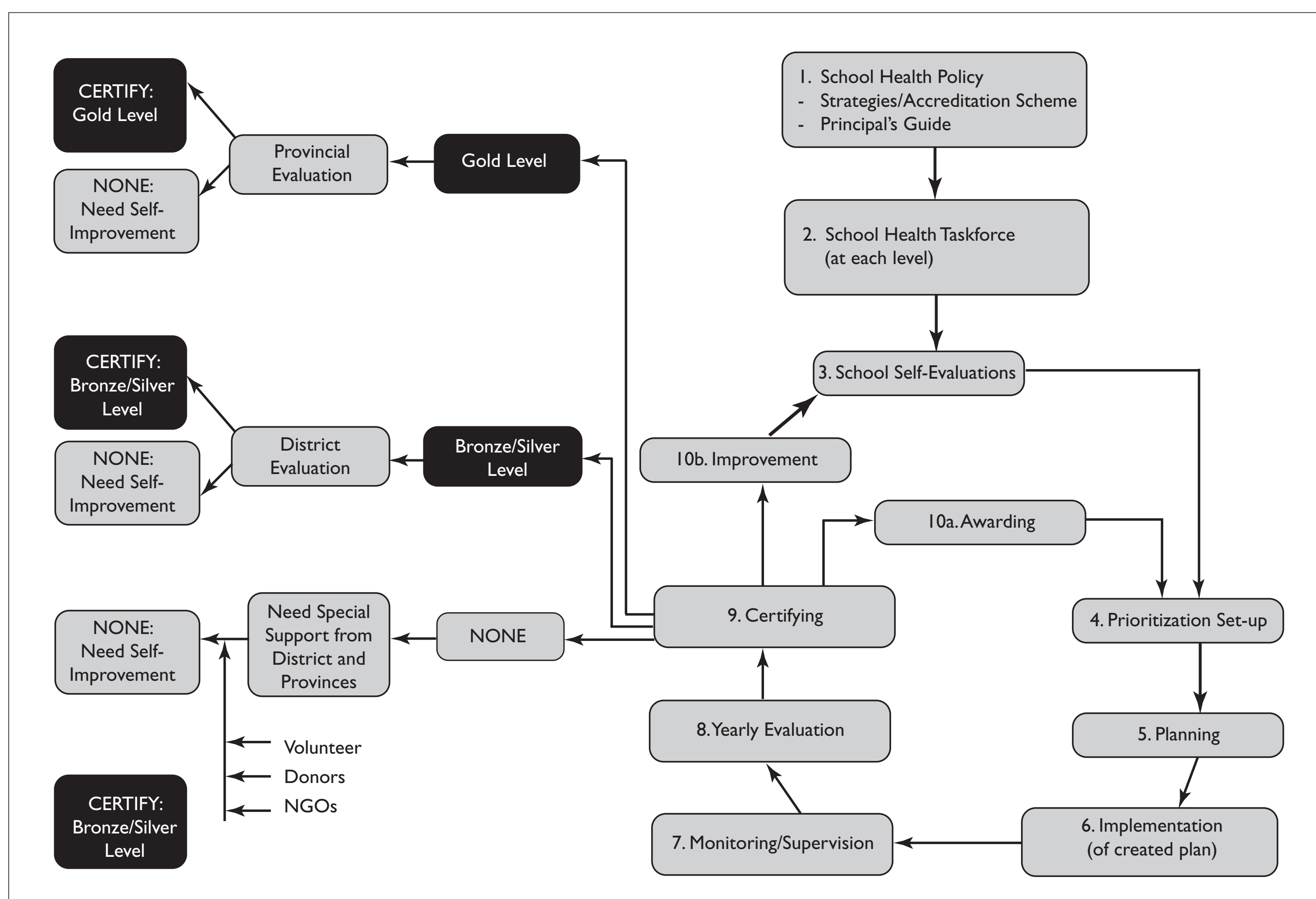
Photo: UNICEF

More recently, a Joint School Health Committee (JSHC) was established in central and lower administrative levels to oversee the school health implementation in certain schools. A National School Health Policy (NSHP) was formulated by JSHC with key development partners. Both of these coordinating mechanisms serve to align efforts and to encourage the promotion of a common platform on school health and nutrition activities and initiatives.

Program Implementation

The program is implemented by the National School Health Taskforce which consists of staff from related departments of the MoE and MoH and plays multiple roles in a cycle of school health implementation (see Figure 1: School Health Education – Implementation Approach). The approach follows a step-by-step process unique to developing a school health education intervention. The approach begins with the development of program materials, continues with the dissemination of materials and then proceeds to school self-assessments; situation analysis; planning; implementation; monitoring and assessment; and review and re-planning of activities and materials. Finally, the 'award' intervention is carried out to recognize outstanding school achievements. Education and health staff were identified as Focal Points to facilitate school health activities at all levels.

Figure 1: School Health Education – Implementation Approach



Program Duration

The program will run from 2003 until 2007.

Target Groups

Primary Target Group(s): all primary schoolchildren in 450 'complete' schools in 450 primary schools in 17 provinces throughout Lao PDR[2]. In-service teachers in targeted primary schools are also included as primary targets for improvement in a professional capacity. Each province has decided to initially invest in 'complete' schools before expanding to 'incomplete' schools. It has been acknowledged that not all schools share the same point of departure towards reaching desired health standards and that some have little chance of gaining one of the programs 'awards'. Rather than setting such schools up for failure, they are therefore excluded, during the first few years, from the criteria of formally participating in the school health program.

Secondary Target Group(s): pre-service teachers in 8 Teacher Training Colleges (TTCs) in Lao PDR.

Program Activities

Since 2005, the National School Health Taskforce has performed a national school deworming campaign for all primary school-age children throughout Lao PDR under the framework of school health. The task force also enables the adoption of modern pedagogic systems and interactive participatory learning for health promotion.

Program Resources and Finance

Data not available.

Program Materials

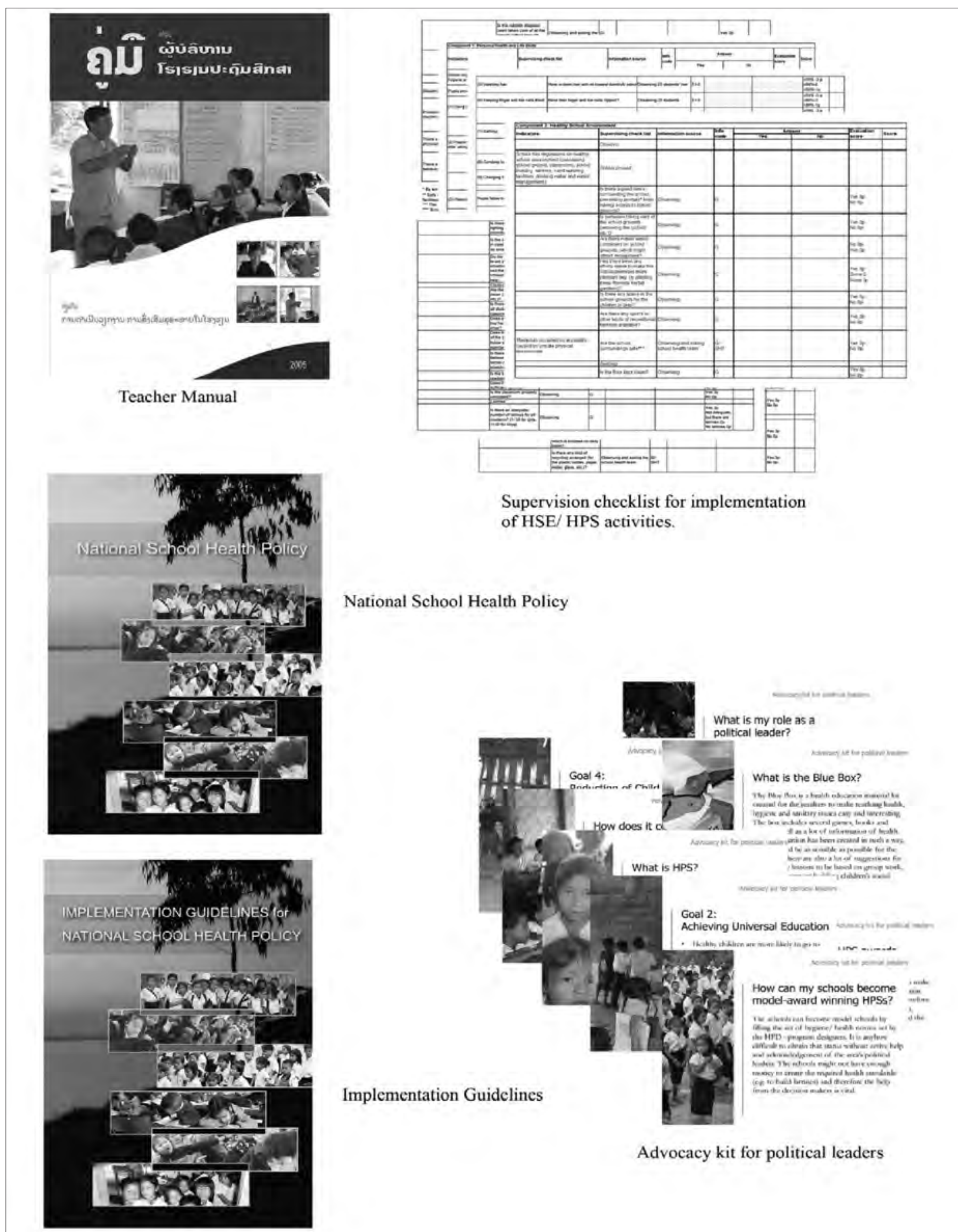
The materials for the program are:

- A National School Health Policy.
- A National Strategic Implementation Guideline.
- A Principal's Guide on school health education interventions.
- Educational materials such as the Blue Box.
- An advocacy kit for political leaders.
- A supervision checklist for implementation of Health Setting and Environment (HSE) and Health Promoting Schools (HPS) activities.

See also Figure 2: Samples of Project Materials.

[2] In Lao PDR, a fully functioning 'complete' primary school is one that consists of grades 1 to 5. However, there are still many 'incomplete' primary schools (grades 1 to 2 or 1 to 3 only). Although good hygiene standards should be the goal for all schools in Lao PDR, it is understandable for 'incomplete' schools to first improve their scale of grades.

Figure 2: Samples of Project Materials



PARTNERSHIPS

JSHC has received support from key development partners such as Japan International Cooperation Agency (JICA), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

KEY OUTCOMES AND LESSONS LEARNED

The key outcomes to the program were:

- *Needs Assessment:* In 2002, the 'Rapid Knowledge Attitude and Practice Survey' was conducted to identify gaps and review project implementation.
- *Establishment of Focal Points:* Focal Points consisted of education and health staff to facilitate school health activities at all levels.

- *National School Health Policy (NSHP):* The policy addressed several components such as improving the current health education curriculum on prevention skill-orientation, school environment, health and nutrition services, disease control and prevention, and promoting partnerships and participation from the community to school development.
- *National Strategic Implementation Guideline:* The guideline contains the general strategy for co-ordination, implementation, monitoring and evaluation, and reporting based on NSHP.
- *Principal's Guide:* A guide to head teachers on school health education. The guide presents a worksheet to support head teachers in creating a school health team and a school health plan.
- *Teaching-Learning Materials:* The materials used originated from UNICEF's Blue Box (for further details on the Blue Box see pages 24 and 25). All materials (13 items) in the box were revised to create new materials so that they matched the health topics in 'The World Around Us' curriculum. A total of 20 items were now in the Blue Box (see Figure 3: Samples of Materials in the Blue Box). The materials are tools to support the implementation of the NSHP.

The lessons learned from the program were:

- In recent years, Lao PDR witnessed substantial progress in implementing school health programs. However, to translate the NSHP into effective action requires powerful leadership and a strong support system at the central, provincial and district levels to move the initiative forward and strengthen the implementation of school health policy in primary schools.
- To manage the school health program, JSHC needs to improve leadership and identify clear mechanisms on coordination and collaboration with all related development partners for effective information sharing, planning and implementation, to avoid duplication and ensure effective sector-wide collaboration.
- Strengthening the development of an initiative framework by supporting health promotion activities between schools and teacher training institutions is necessary. The limited support on school health activities for pre-service teachers in TTCs may harm the sustainability of health promotion in schools. Since TTC students will become teachers in the future, they must be familiar with issues on health promotion in primary schools.
- Integrating appropriate monitoring and supervision frameworks into the regular monitoring system in the education sector is advisable.

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BOX 1

School-Based Assessment in Thailand

SUMMARY

The Ministries of Public Health (MoPH) and Education (MoE) established an award system for health promoting schools nationwide. According to the results of the self-assessment conducted in schools, supervisors have re-assessed school activities and upgraded their standards. In 2007, more than 90% of schools maintained the highest standard of health promoting schools.

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RESOURCING SCHOOL HEALTH AND NUTRITION ACTIVITIES THROUGH THE "SIN TAX" – THAILAND

INTRODUCTION

Attaining the resources needed to implement school health and nutrition activities is a major challenge in many countries. In Thailand, an innovative "Sin Tax" levied on alcohol and tobacco products enables the Thai Health Promotion Foundation or ThaiHealth to disburse funds needed to finance health and nutrition activities to a wide range of different actors, including the MoE allowing a wide range of different health problems to be addressed.

AIMS AND OBJECTIVES

- To reduce sickness and death and to promote general improvements in the quality of life of Thai people through the education sector.
- To support, rather than replace, groups and organizations that are already working on public health issues.
- To act as a catalyst, maintaining a neutral position that will allow ThaiHealth to promote collaboration between many different partners.

PROGRAM OVERVIEW

Background

In Thailand, the major causes of death and health problems are due to preventable causes such as smoking, alcohol abuse and road accidents. According to the World Health Organization (WHO), these issues should be addressed by public health organizations with the aim to achieve complete physical, mental and social well-being. In response to international statements on public health, the Royal Government of Thailand created a strong public health movement establishing, through the Health Promotion Foundation Act in 2001, the Thai Health Promotion Foundation or ThaiHealth. The philosophy of ThaiHealth is that "all Thais can attain better lives, in a self-reliant way, through increased cooperation." The vision of ThaiHealth is "the sustainability of health for Thai people" and its mission is to support and develop a movement to establish and promote health that will lead to a state of well-being among Thai people.

Program Implementation

The program is implemented by ThaiHealth which receives revenue of US$35 million annually through a special excise tax of 2% imposed only on tobacco and alcohol known as the "Sin Tax" (for further details about how this is collected, see "Program resources and Finance" below). ThaiHealth then distributes the monies collected to a wide range of different stakeholders, including the MoE, for the financing of different health and nutrition activities.

ThaiHealth enjoys considerable autonomy as it is the only organization that reports directly to the Cabinet and Parliament, and the only organization that receives revenue outside of the normal budgetary processes. The MoE is one of 21 members in the Governing Board, chaired by the Deputy Prime Minister. The board has the role of: policymaking, general budgetary allocation, specification of important rules, provisions for project management and the assessment of expected results.

Photo: UNICEF

Program Duration

The program is ongoing.

Target Groups

With respect to the education sector, ThaiHealth channels its efforts to establish and promote health among young populations in school settings. The program operates at all education levels to children and young people aged between 4 to 18 years in Thailand of whom more than 8.5 million are currently enrolled in education from pre-school to high school levels. Under Thai law, every child has access to free compulsory education for 12 years.

Program Activities

ThaiHealth supports a wide range of different activities in schools undertaken by a number of different stakeholders.

Program Resources and Finance

Previously, producers paid a standard 30% excise tax on sale of tobacco and alcohol but, with the enactment of the ThaiHealth Bill, an additional 2% excise tax was added to the sale of these products. Products previously valued at 100 Baht, for example, would have been subject to a 30 Baht excise tax but are now taxed to a total of 30.6 Baht.

The 2% excise tax is only imposed at the sale of the product, as no tax is payable if products remain in the factories. The producers are required to buy the excise duty stamps from the Excise Office (under the Minister of Finance) and affix them to each bottle of alcohol and cigarette packets. The levy is collected when the producer submits to the Excise Office documentation on how many units of alcohol or tobacco were distributed to the dealers and wholesalers.

The Excise Office sends daily summary reports to ThaiHealth and directly transfers the collected tax to ThaiHealth's account. The Customs Department collects the tax on imported products, for ThaiHealth. The Finance Department cross-checks the total amount transferred, at the end of each month, from both the Customs and Excise Departments. ThaiHealth then allocates monies to the education sector as well as to other selected organizations and agencies.

The budgetary provisions to the education sector, institutions and organizations were as follows:

- According to the annual report in 2006, ThaiHealth spent (in the fiscal year October 2005 to September 2006) a total of 2,233 million Baht (US$676 million, with an exchange rate of 33Thai Baht for US$1).

The percentage distribution of funding according to target organizations and institutions were as follows:

- Government agencies and public benefit organizations – 38%;
- community (temple and village) – 37%;
- network organizations – 30%;
- **schools and educational institutions – 16%;**
- private agencies – 9%;
- community/civic organizations – 8%;
- professional associations – 7%;
- other organizations – 6%;
- hospitals and nursing homes – 4%;
- the media – 4%; and
- business and enterprises – 3%.

The percentage distribution of funding on health issues ranged from 1% to 9%. Among these were:

- Accident and safety promotion – 9%;
- alcohol consumption – 8%;
- exercise – 6%;
- tobacco consumption – 6%;
- narcotics – 2%; and
- sexual relationships/behavior – 1%.

Program Materials

Not available.

PARTNERSHIPS

The MoE receives support from various organizations and institutions.

KEY OUTCOMES AND LESSONS LEARNED

Some key outcomes to the program were:

- The findings from the research, funded by ThaiHealth on 'the effects of increased exercise towards increased bone mass in girls' (2005) resulted in the implementation of a policy (by the MoE) of increasing physical education in the school curriculum from 1 hour a week to 2 hours a week.
- Networks of people who work with children/youth/families have vigorously started working on health issues and have recognized around 1,000 model schools that teach approximately 500,000 schoolchildren. The networks have supported the national censorship movement (2005) against the portrayal of violence on children in the public media.
- Collaboration between the MoE and Thai Webmaster Association in 2006 launched a reliable knowledge-based website (www.panyathai.or.th) which serves both schools and public interest.

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BOX 2

School-Based Assessment in Lao PDR

SUMMARY

The Lao People's Democratic Republic (PDR) School Health Taskforce established a system of self-assessment and an award system based on national policy and implementation guidelines. The standard level was set under the situation analysis in Lao PDR. The World Health Organization (WHO) Laos; the Japanese consulting team, Japan International Cooperation Agency (JICA); Tokyo University; and the Asian Center of International Parasite Control (ACIPAC) have offered support to expand this system

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Photo: Tara E. O'Connell

Chapter 2:
Safe and Supportive School Environment

PROMOTING GENDER BALANCE AMONG TEACHERS: SCHOLARSHIPS FOR GIRLS – CAMBODIA

INTRODUCTION

In many countries, the recruitment of female teachers to schools can be problematic. When female teachers are lacking, the impact on the school environment can be substantial – both girls and boys are deprived of strong female role models, and girls in particular may be unable to address health issues at school that they are reticent to discuss with a male teacher. In Cambodia, the Human Resource Development for Community (HRDC) project was begun in order to support human resource development in particular areas of Cambodia that lack teachers. The project particularly focuses on females. As part of this project, selected female students receive scholarships for schooling in addition to training and mentoring for capacity development, enabling young women to realize their full potential and contribute to the development of their communities.

AIMS AND OBJECTIVES

- To support students, particularly females, to graduate from high school and to continue this support until they obtain qualifications with which they can get a job to contribute to community development.
- To ensure that scholarship students obtain knowledge and skills necessary for community development.

PROGRAM OVERVIEW

Background

The HRDC project is being implemented in an area of Cambodia that lacks teachers and other human resources, especially with regard to females. This is largely because there are few female students who advance to higher education and have the skills necessary to obtain employment. Teaching and other professions have attracted females from outside the communities involved, but they do not stay long due to the difficulties of adapting to village life far away from their families and support structures. To solve these issues, HRDC aims to develop female human resources within the communities themselves.

Program Implementation

The program was implemented by the Ministry of Education, Youth and Sport (MoEYS).

Program Duration

The program ran from October 2004 until September 2007.

Target Groups

The program is carried out in Hun Sen Kampong Phnum High School in the Leuk Daek district, Kandal province and includes the following beneficiaries:
Primary Target Group(s): 65 scholarship girls who progressed from grade 10 through to grade 12.

Secondary Target Group(s): parents of the scholarship girls, local scholarship management committee members, lower and upper secondary schoolteachers and community members in 7 communes of the Leuk Daek district in Kandal province.

Program Activities

The selection criteria used to decide who receives scholarships were based on girls who:

- Have passed grade 9 school exams;
- want to continue their studies;
- have families who support their education;
- are from families of low socioeconomic status;
- have high numbers of siblings;
- are orphaned or from single parent households; and
- have parents/guardians with little or no education.

The selection process involved 4 stages to decide scholarship recipients:

- ***Preparation of Scholarship Candidates List:*** The Local Scholarship Management Committee (LSMC) announced the up- coming scholarships (organized by the LSMC) in secondary schools. Directors of the secondary schools obtained a list of students who had passed grade 9 and referred them to LSMC.
- ***Short-Listing of Candidates:*** LSMC organized meetings with village chief/elders to shortlist candidates by using the standardized selection criteria above. Any candidates who failed to meet at least one of the short-listing criteria were disqualified from the candidate list. The LSMC organized interviews (based on the same selection criteria) when potential candidates were borderline or when LSMC were uncertain as to whether the selection criteria had been met.

- ***Selection Process:*** LSMC review the scores from the short-list and select candidates.
- ***Public Announcement of Scholarship Recipients:*** After the selection process, a list of successful candidates was posted in all public places, including secondary schools, commune council and local markets. Successful candidates were then asked to complete an application form and sign a student/parent contract.

Once selected, girls who enter the program receive scholarship assistance such as tutoring payments, school materials, lunch allowance and boarding allowances. In addition to scholarships, girls also receive training beneficial for community development. This includes home economic life skills, gender awareness and peer educator training. Girls are also involved in various educational support activities such as 'study clubs.'

Program Resources and Finance

The program has been funded by Cooperative for Assistance and Relief Everywhere (CARE) Friends Okayama and CARE Friends Tokyo, through CARE International Japan.

Program Materials

- Awareness manual on facilitation skills
- Alcoholism
- Safe migration and gender

PARTNERSHIPS

The program has been supported by CARE Friends Okayama and CARE Friends Tokyo, through CARE International Japan.

KEY OUTCOMES AND LESSONS LEARNED

The scholarship program successfully implemented the following activities:

- Awarding scholarships for vulnerable students in upper secondary school, especially girls.
- Establishing a Senior Management Team in collaboration with MoEYS and provincial level authorities to monitor and support scholarship implementation, and establish the LSMC programs.
- Creating local bases to manage boarding assistance and follow-up with teams at community level.
- Delivering decentralization workshops at local, provincial and national levels on community development support for girls' education.
- Developing youth groups (i.e. 'study clubs') through their involvement in various aspects of the education program (e.g. planning, monitoring and management).
- Promoting gender awareness campaigns on the benefits and importance of education, the realities of trafficking, environmental protection and domestic violence.

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The lessons learned from the program were:

- Girls staying at the boarding house were more comfortable in sharing their concerns when a female teacher was assigned to welfare support.
- Study support provided through a 'study club' activity (coordinated and encouraged by LSMC members) resulted in girls' improved understanding and academic achievement.
- Timely provisions of scholarship materials such as notebooks, pens and school uniforms alleviated unnecessary financial burdens likely to jeopardize the girls' ongoing pursuits of formal education.
- Frequent monitoring of scholarship implementation through household visits, checking attendance lists, observation of tutoring classes and in-class performance facilitated higher levels of achievement.
- Strong support from both parents/guardians and members encouraged girls to perform well at school and to behave appropriately in the boarding house.

Program Evaluation

An evaluation of the program was due to be conducted in August 2007.

INCLUSIVE EDUCATION FOR CHILDREN WITH SPECIAL NEEDS – LAO PDR

INTRODUCTION

Many children with special needs have no access to basic education due to families not sending them to school or to non-acceptance from schools. In addition, there are many children with special needs who attend schools but experience discrimination, bullying and failure. These children are eventually pushed out of the system where exclusion becomes the norm. In order to address these issues in Lao PDR, the MoE has introduced Inclusive Education (IE), a system through which children with special educational needs attend their local schools and study alongside their peers. The program seeks to address the problem of exclusion by making changes needed in schools, classrooms and the education system to enable disabled children and all children with special needs to learn successfully. The program is an important part Lao PDR's efforts to achieve its Education for All (EFA) goals.

AIMS AND OBJECTIVES

- To protect and ensure the right to quality education for all children in Lao People's Democratic Republic (PDR) by focusing on children with special needs.
- To establish simple, effective systems of access for quality education in designated schools nationwide for children with disabilities.

PROGRAM OVERVIEW

Background

The IE program acknowledges the rights of all children to receive education as enshrined in the United Nations Convention on the Rights of the Child (UNCRC), and confirmed by the international agreements on EFA, and on the Statement and Framework for Action on Special Needs in Education.

The program is based in the further recognition that most disabled children can study in ordinary schools which should adequately provide education for all local children. In Lao, traditional systems have sought to limit access to children with special educational needs, creating a segregated system. They have also been found to ignore children with special needs, excluding them from the education system. Barriers to learning have been found not to occur because of disability but because of the methodology used in schools and organizations in the education system. These barriers also affect other marginalized groups of children, such as poor children (who have no books or time and space to study); ethnic minority children (who cannot understand the language taught in school); and children below average ability (who need changes in pace and content). The IE program further seeks to ensure that children with disabilities are not removed from their homes to attend special schools which can violate children's rights to their home, family and involvement in the community, and where separation can confirm society's prejudice against children with disabilities.

Program Implementation

The IE program was initiated by the Ministry of Education (MoE), with the Ministry of Health (MoH), through the National Rehabilitation Center (NRC).

Program Duration

The program will run from August 2005 until July 2008.

Target Groups

The program beneficiaries are:

Primary Target Group(s): children with special needs in Lao PDR.

Secondary Target Group(s): non-disabled children, parents and community members in Lao PDR.

Program Activities

Program activities included the following:

- Establish Implementation Teams at the National (NIT), Provincial (PIT), District (DIT) and school levels.
- Build the capacity of the Implementation Teams. NIT trained PIT and DIT, while PIT trained head teachers and schoolteachers.
- Build the quality of standard in classrooms, schools, districts and provinces.
- Create an evaluation tool for school self-evaluations.
- Annually plan review meetings and training for teachers, supervisors and administrators including PIT. The NIT and DIT plan their own activities.
- Integrate the UNCRC using appropriate methods such as the child-to-child approach.
- Set parameters for inclusion by welcoming all learners, regardless of their characteristics/ differences, background, disadvantages or difficulties.

- Integrate UNCRC content in the IE training workshops at all levels. At present, integrated training on UNCRC in IE workshops is extended to 2 days.
- Ensure that head teachers and schoolteachers explain to all schoolchildren the diverse backgrounds and abilities of individual children and to discourage children from discriminating against and bullying each other.

Program Resources and Finances

Not available.

Program Materials

Not available.

PARTNERSHIPS

The IE program works in partnership between the MoE and MoH, through the NRC and Save the Children Norway (SCN). The Swedish International Development Cooperation Agency (SIDA) is the major donor to the program.

KEY OUTCOMES AND LESSONS LEARNED

The program found that when children of different abilities grow up together and learn from each other, differences are acknowledged and accepted. Inclusion was believed to bring benefits to all children, not only children with special needs; when schools sought to be inclusive, they were enabled to increase responsiveness to the range of abilities, skills and learning styles of all children. Inclusion did not require high levels of resources and materials. Rather, what it needed most was changes in the relationship between teachers, children and communities.

Essential to the smooth running of the program were found to be:

- A long-term commitment from the MoE.
- Good technical advice.
- Excellent monitoring and support systems.
- Sensitive and common sense approaches.
- Flexibility.
- Good practice in development, such as sustainability and local ownership.
- Involvement by parents and community members.

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Chapter 3:
Skills-Based Health Education

PRE-SERVICE TEACHER TRAINING – CAMBODIA

INTRODUCTION

Chapter 1 of this publication described Cambodia's aim of mainstreaming HIV education among its 3,500,000 students, 120,000 staff and 7,000 public schools. The sheer scale of teacher training required to undertake this task is immense and the resources required to provide in-service HIV training for all existing teachers would be enormous. In addition, for existing teachers, the pedagogy required to teach about HIV/AIDS in a participative fashion would be, in many cases, highly novel and, in certain cases, hard to acquire. Over time, a much easier way to ensure that all staff of the MoEYS is trained in HIV/AIDS would be to ensure that the subject is covered adequately in pre-service training – reaching both large numbers of trainees and also touching them at a time when their teaching approach has not been formed. In this chapter, Cambodia's experience of providing such in-service teaching is described.

AIMS AND OBJECTIVES

- To provide training for teacher trainees in primary schools (provincial Teacher Training Colleges), in lower secondary schools (regional Teacher Training Centers) and in upper secondary schools (National Institute of Education).

PROGRAM OVERVIEW

Background

As has been discussed, pre-service teacher training in HIV/AIDS is occurring as part of Cambodia's efforts to mainstream HIV/AIDS throughout its education sector (see Chapter 1).

Program Implementation

World Education Cambodia and the Teacher Training Department (TTD) worked together to develop the curriculum and Information, Education, Communication (IEC) materials for a pre-service program. This also included inputs from relevant departments in the Ministry of Education, Youth and Sport (MoEYS).

Program Duration

The program is ongoing.

Target Groups

HIV/AIDS has been integrated into the pre-service teacher training curriculum at all levels. For primary school teachers it is taught through four subjects: Khmer, Science, Maths and Social Studies. For the lower secondary school-teachers, it is included in regional Teacher Training Centers, and at the National Institute of Education (NIE) it is included in training to become a secondary schoolteacher.

Photo: UNICEF

Program Activities

For 2 years the program was implemented in partnership between World Education Cambodia and TTD. After endorsement from the Ministry, the program was implemented in 8 provinces and was later expanded to all 18 Teacher Training Colleges (TTCs) around the country. A training team consisted of 1 staff member from World Education Cambodia and 1 staff member from TTD. This team designed the training plan and implemented the program in the provinces. Continuous feedback was given within the team. This capacity building process made it possible for TTD staff to implement the program on their own after 2 years.

Since the start of the 2005/2006 school year, TTD has implemented the pre-service program without technical support from World Education Cambodia. During the 2006/2007 school year, 3,069 lower secondary schoolteachers (grades 7 through 9), 4,521 primary schoolteachers (grades 1 through 6) and 905 upper secondary schoolteachers were trained in life skills for HIV/AIDS.

Program Resources and Finances

The MoEYS receives technical and financial assistance from the United Kingdom's Department for International Development (DFID) through a 5-year program implemented by the ICHA (budgeted at US$2.3 million).

Program Materials

Life skills teacher manuals have been developed for teaching HIV/AIDS and prevention of sexually transmitted infections (STIs), reproductive health and drug abuse.

PARTNERSHIPS

The pre-service teacher training program started as a partnership between World Education Cambodia and TTD with funding from the United Nations Children's Fund (UNICEF).

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KEY OUTCOMES AND LESSONS LEARNED

Cambodia's experience of undertaking pre-service training of teachers in HIV/AIDS is aiding enormously the country's efforts to mainstream the issue throughout the education system. Pre-service training has a number of distinct advantages:

- Over time, it results in the exposure of all teachers involved in the education system to training about HIV/AIDS. (In contrast, in-service training is seldom able to cover all members of the teaching population).
- Teachers are trained in HIV/AIDS education and the participatory methodology this involves as they begin their teaching career and are open to taking on new pedagogical ideas. In contrast, in-service teachers may find it difficult to move from the "chalk and talk" methodology in which they were trained.
- Pre-service training of teachers enables them to be informed about HIV/AIDS throughout their careers, enabling them from their first day in the classroom to avoid any risky behaviors and also to prevent stigma and discrimination where they see these happening.

HEALTH EDUCATION FOR OUT-OF-SCHOOL YOUTH – CAMBODIA AND LAO PDR

INTRODUCTION

Out-of-school youth, particularly those living on the streets, are amongst the most vulnerable to poor health, nutrition and infection with HIV/AIDS. Addressing the needs of such children is a complex activity; if vulnerable children are to benefit from health education they must be enabled to be in a place where they can receive the education given. In Cambodia and Lao PDR, the organization Friends International runs a holistic program that enables out-of-school youth, particularly street children, to be helped out of situations of vulnerability and to receive child-centered life skills education. The success of the program has depended on the collaboration of a wide range of different stakeholders.

AIMS AND OBJECTIVES

- To respond to the needs of out-of-school, particularly street children, their families and their communities, with the ultimate aim of supporting their social reintegration.
- To support the sustainable reintegration of street and out-of-school children (aged 5 to 24 years) into the public school system through the development of Non-Formal Education (NFE) methodologies.

PROGRAM OVERVIEW

Background

In Cambodia and Lao, many thousands of children are out-of-school. Some of these children live on the streets either with or without the care and support of their families. The program of Friends International was developed to meet the needs of these children, enabling both their social reintegration, their education and their exposure to a wide range of child-centered life skills education.

Program Implementation

The program is implemented by Friends-International (Mith Samlanh) in close collaboration with the Ministry of Education, Youth and Sport (MoEYS), National Institute of Education (NIE), and the Ministry of Social Affairs, Veterans and Rehabilitation (MoSAVY).

Program Duration

The program commenced in 1994 and is ongoing.

Target Groups

The primary beneficiaries are out-of-school children and youth aged 5 to 24 years.

Program Activities

The diagram on page 20 represents Mith Samlanh's social reintegration process. Street children are provided with a number of different opportunities and means of leaving the streets towards integration into safer and more supportive environments. As this occurs, careful monitoring and follow-up of children is undertaken on a weekly basis by project social workers to ensure that the young people receive necessary support at academic, emotional and social levels.

Once children/youth have reached a level whereby they are deemed ready for the public school system, it is essential that the reintegration is undertaken through careful planning with the schools by working closely with the school directors and the teachers into whose classes the children/youth will be entering.

Included within all Friends-International (Mith Samlanh) programs are the life skills curricula: HIV/AIDS (Prevention, Care of HIV-positive, Support of Children Affected by AIDS); Drugs (Prevention, Health, Detoxification, Rehabilitation); Child Rights (Implementation of the United Nations Convention on the Rights of the Child, Monitoring and Evaluation); Reproductive Health; Sexually Transmitted Diseases (STDs); Nutrition; and Hygiene and Culture. The curricula for life skills as well as for basic education (e.g. literacy and numeracy) are under constant evaluation and improvement, both in terms of content as well as in terms of methodology. All curricula are tested on the children and all educators receive on-going training and input into delivery techniques to ensure child-centered learning at all times. A 'toolbox' of activities has been established to guide educators in this process.

The life skills curricula on Information, Education, Communication (IEC) materials are all produced in picturecard form to ensure that those children who are illiterate within the program are fully able to understand the subjects being learned. Setting up child-centered IEC materials creates practical and accessible information for a target group where delivery is difficult. For example, for the topic of hygiene, trying to get children to wash themselves seems like a simple message, yet for street children who are either living or working on the street and who have no access to running water, practical options must be found to provide access to drop-in-centers and cleaning facilities (including the river) in order to ensure sustainable behavior change.

Working with children, however, is not enough. Health promotion needs to be reinforced by the parents. It also needs to be recognized that many of the children/youth have dropped out-of-school or have never been to school due to poverty and the need to work on the streets. For this reason, Friends-International (Mith Samlanh) has established 'Home-Based Production' as well as small business support and business creation for families.

Photo: World Bank

Program Resources and Finance

Not available.

Program Materials

Not available.

Mith Samlanh Social Reintegration Process

PARTNERSHIPS

Friends-International (Mith Samlanh) works in close collaboration with the MoEYS and the NIE, especially for teacher monitoring and curriculum evaluation. To assist in the reintegration and social follow-up of children/youth within a family structure, Friends-International has a Memorandum of Understanding (MOU) with MoSAVY and works through the local departmental structures of the Office of Social Affairs, Veterans and Rehabilitation (OSAVY) for social follow-up essential in ensuring sustainable reintegration of formally marginalized and out-of-school children.

KEY OUTCOMES AND LESSONS LEARNED

The establishment of strong partnerships at all levels has been essential to the success of the program. Not only must partnerships be formed with relevant ministries (see above) but also with other key stakeholders.

An essential partnership within this process is also between the social worker and the child/youth. It is through this relationship that a mutual understanding of the issues with which the 'client' is dealing can be reached and henceforth, the journey towards establishing future plans can be commenced. The reintegration process, however, will not be successful if strong partnerships are not also fostered with the parents, in order to assist them in understanding the importance of education as well as ensuring sustainable income-generating options for the family.

Collaboration between children/youth, educators and the Department of Non-Formal Education and the NIE (formerly the Faculty of Pedagogy) has also been important in ensuring the adoption of holistic and adapted curricula.

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HIV/AIDS PREVENTION EDUCATION FOR COLLEGE STUDENTS – CHINA

INTRODUCTION

This program enables college students to gain knowledge about HIV/AIDS, to change their attitudes towards life, and to cultivate behavioral habits beneficial to their survival and health. As part of the program, student volunteers raise awareness on HIV/AIDS prevention in the community, ultimately benefiting the progress and development of the whole population.

AIMS AND OBJECTIVES

- To safeguard college-age students from HIV/AIDS infection by empowering them with knowledge and life skills education that encourage healthy behaviors.
- To raise awareness on HIV/AIDS prevention in the community by educated college students, ultimately to benefit the progress and development of the whole community.

PROGRAM OVERVIEW

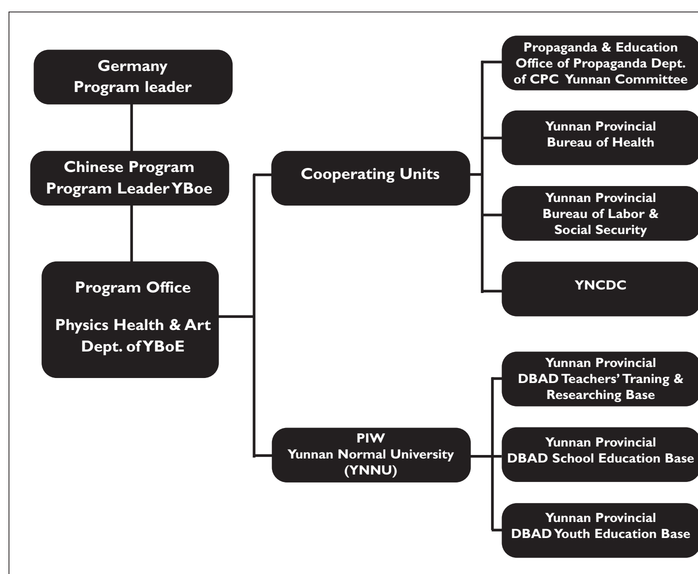
Background

Yunnan province is one of the areas in China that is affected by HIV/AIDS. Because they are of an age of higher sexual activity, college students are at a higher risk of infection by HIV/AIDS than other population groups. There are 59 colleges and universities in Yunnan with 463,500 students. Therefore, offering an HIV/AIDS educational course to college students in Yunnan is a key measure in guarding against HIV/AIDS in the province.

Program Implementation

At first, the program operated in schools in bordering areas where poor, uneducated ethnic groups live. From 2005, led by the Yunnan Provincial Committee of Education and partnered with the 3 educational bases (Yunnan Provincial Drug-Banning and AIDS-Preventing Teacher Training and Researching Base; Yunnan Provincial Drug-Banning and AIDS-Preventing School Education Base; and Yunnan Provincial Drug-Banning and AIDS-Preventing Youth Education Base), the program has been in operation in universities throughout Yunnan province. The program operates with the support of representatives from the Propaganda and Education Office of the Propaganda Department of the Communist Party of China (CPC) Yunnan Committee; Yunnan Provincial Bureau of Health; Yunnan Provincial Bureau of Labor and Social Security; and Yunnan Provincial Center for Disease Control and Prevention.

Coordination of different stakeholders is undertaken by a Program Implementing Workgroup. A leading group has been established at the provincial level with a program office established at the Physics, Health and Art Department of the Yunnan Provincial Bureau of Education. The workgroup serves as the executing and operating unit at the regional level for the Yunnan province. The operational framework for the new 4-year program is illustrated in the diagram below.



Program Duration

The program has been in operation for 6 years. The new program will run for a further 4 years.

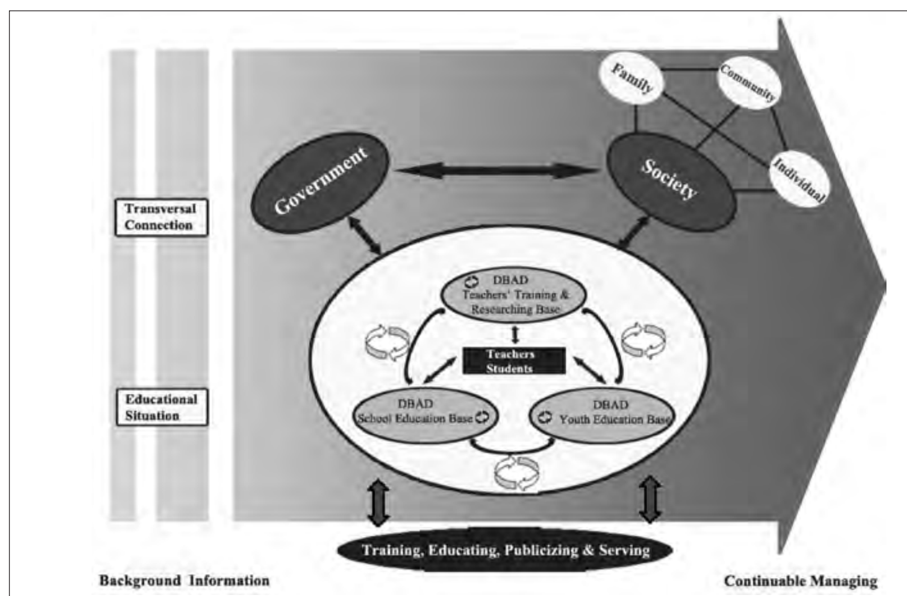
Target Groups

University students in Yunnan Province.

Program Activities

The diagram on page 23 illustrates the operational framework for the program that has been in existence for 6 years.

Photo: World Bank



The program has undertaken the following activities:

- Yunnan Provincial University AIDS-Preventing Education Base was built by Yunnan Committee of Education.
- Trainers were trained by key teachers in Kunming.
- Key teachers were trained by trainers, including college teachers in Yunnan.
- Student volunteers were trained by key teachers.
- Student education was delivered by key teachers and student volunteers.
- Educated students became involved in advocacy within the community.

Program Resources and Finance

Not available.

Program Materials

Not available.

PARTNERSHIPS

The program was developed in partnership with relevant agencies and organizations including Save the Children; United Nations Educational, Scientific and Cultural Organization (UNESCO) and Southeast Asian Ministers of Education Organization (SEAMEO) for 3 subjects in 1999 and 2001 respectively.

KEY OUTCOMES AND LESSONS LEARNED

The task of eradicating HIV/AIDS is substantial, but education on HIV/AIDS prevention has been hindered in Yunnan province by the lack of up-to-date information, equipment and training. The program has therefore met both opportunities and challenges.

The program aims at taking full advantage of college students' enthusiasm for HIV/AIDS prevention, so as to:

- Create partnerships among the government, schools and society.
- Explore ways to maximize outcomes with current investments.
- Promote the sustainable development on HIV/AIDS prevention education in the Yunnan province.

In view of the background, this program has sought to:

- Receive support by all relevant departments.
- Establish a center for HIV/AIDS prevention education for colleges.
- Train key teachers and student volunteers to educate college students.
- Circulate HIV/AIDS prevention messages throughout the community via the mass media.

Over the past 2 years the program has achieved the following:

- A total of 330 key teachers have been trained.
- Approximately, 98% of colleges have established a curriculum for HIV/AIDS.
- Around 3,300 student volunteers have been trained to educate other college students and to spread basic knowledge about HIV/AIDS throughout the whole society.
- The awareness rate of college students for HIV/AIDS has reached 85%.

A further challenge is that whilst awareness of HIV/AIDS prevention has developed rapidly, the knowledge fails to match the skills and, as a result, life skills-based HIV/AIDS education needs to be developed.

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LIFE SKILLS EDUCATION AND HEALTH PROMOTION MATERIALS: BLUE BOX – LAO PDR

INTRODUCTION

The Blue Box is a toolkit of materials that enables teaching and learning both in and out of the classroom about health behavioral skills such as hand washing, personal hygiene, environmental sanitation, prevention skills against common communicable diseases, and water and latrine usage through games and stories.

AIMS AND OBJECTIVES

- To provide a comprehensive package for teaching and learning in both primary schools and Teacher Training Colleges (TTCs).
- To train teachers on the use of the Blue Box materials as well as life skills education and child-centered methods of teaching.
- To help teachers guide students to use materials through a child-to-child/peer education approach.

Photo: UNICEF

PROGRAM OVERVIEW

Background

The Blue Box originated with the United Nations Children's Fund (UNICEF) and was developed to support children's hygiene and sanitation. The materials in the Blue Box (see Figure 3: Samples of Materials in the Blue Box) compose a comprehensive toolkit to support health education teaching and learning activities and are part of the indicators to measure the implementation of the National School Health Policy (NSHP). The Blue Box is disseminated and used by schoolteachers in targeted schools. The contents of the Blue Box have been revised appropriately to match all existing health topics in the curriculum by the local government, the World Health Organization (WHO) and other development partners.

Program Implementation

- ***Ministry of Education:*** National Research Institute for Educational Science, Department of General Education, Department of Teacher Training, Faculty of Medical Sciences, Representatives from provincial education services and teachers from a number of primary schools and TTCs.
- ***Ministry of Health:*** Department of Hygiene and Prevention, Department of Curative, Department of Personnel, Center for Health Education Information, Center for Malaria, Center for Water and Sanitation.

Program Duration

The program has been in operation for 1 year.

Target Groups

The program targets primary schools in all 17 provinces and in 8 TTCs in Lao PDR.

Program Activities

The resources contained in the Blue Box enable the use of child-to-child and child-to-adult teaching about health and nutrition. In turn, educational messages are spread by the children to their homes, villages and districts through word-of-mouth and through the media.

Blue Box materials have been distributed and pre-service teachers have been trained in all 8 TTCs, so that teachers are well trained in using the materials for teaching health education before they are assigned to schools.

Program Resources and Finance

Not available.

Figure 3: Samples of Materials in the Blue Box

Program Materials

The Blue Box contains the following 20 items related to health education:

- Two teacher guideline books.
- Five posters on: the transmission of hookworms; the transmission of roundworms; food groups; key hygiene practices that prevent diseases; and instructions on hand washing.
- Three games: Snakes and Ladders; Prevention of Parasites; and word card games.
- Four comics/stories on: parasites; HIV/AIDS; hygiene and sanitation; and malaria prevention.
- Five Kamishibai, or story telling cards on: the encouragement of latrine usage; a safe environment; dental health; safe waste disposal; and clean and safe drinking water.
- A complete set of songs about hygiene and sanitation.

To certify quality and appropriateness, the materials had been pre-tested in schools for 2 months by schoolteachers who used them as a tool for teaching 'The World Around Us' curriculum.

PARTNERSHIPS

The international partners who supported the program were Japan International Cooperation Agency (JICA/KIDSMILE), Lao Red Cross, UNICEF and WHO.

KEY OUTCOMES AND LESSONS LEARNED

Schoolteachers, members of United Nations (UN) organizations and non-government organizations (NGOs) were strongly involved in the development of the Blue Box materials through the use of workshops and discussions. All stakeholders shared ideas as well as resources to develop the package of materials for use in schools.

Prior to publication, the materials were piloted in a number of schools. As the Blue Box was disseminated to pilot schools, the need for trained schoolteachers in using the materials became apparent.

Feedback from the users revealed the benefits and effects to schoolchildren and people in the community. The use of the Blue Box in schools and communities was found to stimulate learning, not only for the learners but also for teachers and literacy trainers. Observations further revealed improvements in the health and safety of the environment.

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TAKING LIFE SKILLS-BASED EDUCATION TO NATIONAL SCALE – MYANMAR

INTRODUCTION

Many countries around the world have seen smaller scale HIV/AIDS activities occurring in schools through the work of nongovernmental organizations or through the piloting of approaches by governments and other agencies. Taking such small-scale approaches to national scale is a major challenge – what has been effective in just a few schools may not be so readily implemented amongst many. In Myanmar such a transition was achieved as a pilot project, the School-Based Healthy Living and HIV/AIDS Prevention Education (SHAPE) program, became the basis for a nationally delivered life skills curriculum.

AIMS AND OBJECTIVES

- To promote and build the knowledge, competencies and psychosocial skills that primary schoolchildren need for healthy living.
- To empower primary schoolchildren to adopt positive behaviors and make informed decisions that will enable them to deal effectively with the challenges of everyday life.
- To empower primary schoolchildren to protect themselves against HIV/AIDS.

PROGRAM OVERVIEW

Background

With the increase in HIV/AIDS infections, the need for intensified prevention efforts for children and young people became evident in Myanmar in the early 1990s. Myanmar Health and Education Ministries recognized the importance and need for a life skills-based education program to be introduced in schools to combat HIV/AIDS. With technical and financial support from the United Nations Children's Fund (UNICEF), the Ministry of Education (MoE) developed a primary and secondary curriculum and implemented a pilot project entitled SHAPE in one-third of schools in the country between 1997 and 2003. In 1998 the Ministry introduced the life skills education as a separate core subject (with exams) at the primary level using the main contents from the SHAPE curriculum. In 2004, based on lessons learned from the SHAPE project and based on the changing trends in HIV/AIDS and emerging issues, it was decided to revise the life skills-based education curriculum to address the new and emerging issues facing the Myanmar children. The revision of the national primary life skills curriculum began in early July 2004 and included revision of the teacher guides and student books for all primary grades.

Program Implementation

With technical and financial support from UNICEF, the MoE started in July 2004 the revision process of the National Primary Life Skills Curriculum (mainly a teacher guide for all primary grades). The need to revise the 1998 curriculum was due to changing trends in HIV/AIDS, emerging issues, and the need for using a life skills-based approach that would encourage children's participation and critical thinking. A taskforce was formed consisting of the curriculum developers, who also served as trainers for primary teachers and educators from education colleges. Personnel from the National AIDS Program and personnel from the Department of Health, including School Health, were also involved from the onset.

Program Duration

The program is on-going and is expected to have primary teachers in all schools trained in the new curriculum by 2009.

Target Groups

The beneficiaries to the program are:

Primary Target Group(s): primary schoolchildren in Myanmar.

Secondary Target Group(s): primary schoolteachers (including pre-service teachers), school principals, parents and communities in Myanmar.

Program Activities

The following 4 key strategies were used:

1. ***Strategies to Improve Quality of Life Skills Curriculum:*** The lessons learned during the implementation of the (SHAPE) project provided the basis for the revision of the national life skills curriculum increasing its relevance.

The program taskforce looked at several life skills curricula, including the national life skills curriculum, SHAPE and the Japanese International Co-operation Agency's (JICA) pilot life skills program, which provided the base material for the revised version. Each of the 5 revised areas was given to a group within the taskforce to develop appropriate lessons. The 5 revised areas were: Social Skills (self-awareness, safety and protection); Healthy Living; Diseases and Prevention of Drugs; Environment (green issues and cleanliness) and Mental Health. A series of workshops, discussions and meetings was set-up to finalize the lessons. Special support was provided by the UNICEF Regional Office in Bangkok

through the HIV/AIDS project officer. In total, 74 lessons were produced and field tested extensively both in urban and rural schools as well as in ethnic schools. Drafts of the lessons were revised to incorporate the inputs received from children during field testing. The whole process of development, review, revision and finalization of lessons took more than a year. The printed materials were piloted in 315 schools in 3 townships by the end of 2005.

2. ***Strategies to Build the Capacity of Teachers and Education Officials in the Life Skills-Based Learning Approach:***
   The strategies include:
   - Provision of awareness training to Township Education Officers (TEOs) and Assistant State Inspectors (AIS) for supervision of life skills-based preventive education.
   - Provision of sufficient and free life skills teacher guides and student books to all schools.
   - Systematic pre- and in-service training for teachers of life skills to ensure quality delivery of the curriculum.
   - Ensuring that sufficient numbers of life skills trained teachers are placed in all schools.

Advocacy and Orientation of TEOs: With life skills being a fairly new subject, the program focused heavily on the training of teachers at the state and division levels, as well as advocating to township education officials, who received a 3-day orientation workshop focusing on program supervision, coordination and monitoring, especially training and teaching-learning processes in schools.

Cascade Trainings: Various interventions were undertaken to ensure the quality of the program in the delivery of life skills. Around 70% of primary schoolteachers in each township have now been trained. Training involved a cascade model at central, zonal and township levels. At zonal and township levels, a 5-day training workshop was organized, where 80% of the training period for life skills was used for practical sessions/demonstrations of lesson plans from the life skills curriculum. Constructive feedback and evaluation was then carried out to help to improve the effectiveness of the next training levels.

At the workshop a 2-hour 'study time' was planned in the evenings to help teachers prepare for demonstration lessons, where training teams were formed with inputs from the next level of trainers to help strengthen the capacity of the team members. Follow-up monitoring visits were made to townships during and after training to provide necessary support to different levels of education personnel and focus group discussions were conducted with children, teachers and head teachers at randomly selected schools to assess program implementation.

Teacher Learning in Schools: The prescribed teaching periods for life skills subjects in Myanmar are as follows:

- *Lower Primary School:* 3 periods per week, 108 periods per year, or 54 hours for 40 lessons.
- *Upper Primary School:* 2 periods per week, 72 periods per year, or 42 hours for 34 lessons.

Selection of Resource Personnel for Trainings: The recruitment of the trainers from zonal trainings was taken into consideration to prevent a shortage of central trainers from the start of the SHAPE project. The core trainers (Curriculum Developers) carefully identified the potential teachers during zonal training workshops and during their field monitoring visits to schools. They selected and gave refresher training to those potential teachers to help them become central level trainers. The core trainers also received frequent refresher training by the UNICEF regional life skills and HIV/AIDS project officers, who reinforced their knowledge and training skills in delivering life skills-based education.

The next level township trainers were selected by the TEOs and ATEOs from the areas in which they were working and, if assigned, were able to travel to training townships. The criteria for selection were based on the trainers' active involvement, willingness to accept change, flexibility and good communication skills. They were trained by the central level trainers.

3. ***Strategies to Increase Partnership, Sustainability and Accountability:***
   These strategies are:
   - By increasing the involvement of life skills trained teachers in different levels of capacity building

The table below represents the target and attainment of the revised life skills curriculum.

Revised Life Skills Curriculum Target and Attainment

Basic Education	Target		Attained (2005/06/07)			
	Townships	Year	Townships	School	Teacher*	Student
Primary Level	325	2009	238 (73% total)	31,351 (77% total)	83,067 (71% total)	4.05 millions<ns**

*In each township. **national scale

The table below represents the primary life skills material distributed by year to schools.

Primary Life Skills Material Distributed by Year to Schools*

Material Type	2005	2006	2007
Revised teacher guides (5 grades)	1,300 sets	34,715 sets	27,100 sets
Student books	9,500	855,000	764,000

*Distributed to 31,351 schools (77% of total primary schools).

trainings, teachers are able to advocate more for the life skills program and its cross-cutting benefits for children. Inclusion of the program into the Teacher Education Colleges will ensure capacity building, sustainability and partnerships with the schools.

- The Ministry of Health (MoH) provided support for the development of the curriculum.
- The Assistant Township Education Officers (ATEOs) will continue to monitor and provide guidance at the school level.

4. ***Strategies to Increase Community Participation:*** To motivate and organize parents and community participation for schoolchildren to create an enabling environment for the development of safe behaviors and healthy practices.

Program Resources and Finance

Not available.

Program Materials

Teacher guides and student books for each grade were produced for all primary schools. The age-appropriate life skills curriculum covers: areas of personal health and hygiene; nutrition; physical growth and development; mental health; preventable diseases such as diarrhoea, malaria, iodine deficiency; HIV/AIDS; alcohol and substance use/abuse; and environmental health and sanitation.

Social skills such as decision-making, communication skills, interpersonal relationships, empathy, critical and creative thinking, coping with emotions and stress, and fostering self-esteem and self-expression have been incorporated into lessons. Content, teaching-learning methods and hours have been carefully specified for lower primary and upper primary schools. Assessment of all lessons has been based on competency skills.

PARTNERSHIPS

Support was given by UNICEF and various NGOs.

KEY OUTCOMES AND LESSONS LEARNED

Many valuable lessons were learned during the lengthy development process, including:

- Life skills and preventive education objectives in schools have been realized under the revised curriculum. The new curriculum was developed with consideration to the rural poor and schools with few teachers, using few teaching aids and/or the least costly teaching aids.
- Constructive feedback by trainees during training workshops proved to be an essential component for improving content and training.
- Commitment of trainers and supervisors was a key factor in maintaining quality training.
- Teacher commitment to the curriculum needed strong support from school head teachers.
- To deliver a skills-based approach of teaching to teachers, careful selection of township trainers is vital for the effectiveness of larger teacher training at the township level, where several hundred primary teachers participate.
- Adequate venue selection and detailed logistic preparation for training play a major role in assuring the quality of training.

The development of the national life skills curriculum provided a mix of challenges and opportunities.

The challenges presented were:

- In order for skills-based education implementation to be effective, commitment and ownership of all concerned education departments is essential.
- Helping the stakeholders to fully understand and internalize the nature and concept of life skills proved time-consuming and difficult at times.
- Regular monitoring and evaluation trips were difficult in remote, border and mountainous areas, particularly during the rainy season.
- Maintaining active participation of all trainees was a difficult task.

The solutions to the challenges were:

- Quarterly coordination meetings at State, division and township levels will help to keep the key partners up-to-date and maintain their enthusiasm for the program.
- Constructive feedback sessions during annual review meetings with township educators, as well as review meetings with teachers/students, can help reduce bottlenecks.
- Evidence-based studies that show how learners benefit from the curriculum and school can become strong advocacy tools.
- Assessment of the criteria is needed for continuous improvement, accountability and understanding.
- Improved coordination among all departments under the MoE and other Ministries in promoting life skills, using a holistic approach, is desirable.
- Strengthening capacity building through expanded training, workshops and meetings on the monitoring, implementation and assessment of life skills at both national and sub-national levels, and for all aspects including planning, implementation, monitoring and evaluation and data collection is needed.
- Expanded advocacy and research on the importance of life skills at all levels is needed.
- Strengthening of data management and information systems is necessary.

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EDUCATION SERVICES FOR OUT-OF-SCHOOL YOUTH – MYANMAR

INTRODUCTION

Out-of-school children often lack the basic skills to help them survive in the outside world and their chances to become active and productive members of their communities are drastically reduced. Access to non-formal and extended learning opportunities for out-of-school children and young people is extremely limited or non-existent in Myanmar. The lack of alternative and extended learning opportunities makes girls more vulnerable, especially in terms of self-protection.

Life skills education programs are needed to help meet the learning needs of out-of-school young people. It is important to equip young people with life skills to enable them to put what they know into practice. Life skills-based education supports the development of knowledge, attitudes and skills to promote positive behavior and avoid risks. Young people need life skills such as negotiation, conflict resolution, critical thinking, decision-making and communication to make safe choices. Such skills can build self-esteem and help young people resist peer and adult pressure to take risks.

AIMS AND OBJECTIVES

- To increase the access of out-of-school children to non-formal life skills-based education that will allow them to protect themselves and make informed decisions.
- To build the capacity of local non-government organizations (NGOs) and community-based organizations (CBOs) to plan, manage, and implement a life skills education program in selected townships.

PROGRAM OVERVIEW

Background

In Myanmar, the successful national implementation in 1998 of the formal 'School-Based Healthy Living and HIV/AIDS Prevention Education' (SHAPE) project for primary and secondary schoolchildren, led in 2003, to the adaptation of the approach for application in non-formal settings in order to reach out-of-school children. This allowed the knowledge and skills on protection from HIV/AIDS, and the adoption of safe behaviors among out-of-school children aged 10 to 17 years to be improved through the Extended and Continuous Education and Learning (EXCEL) project.

EXCEL is a community-based project designed to build the institutional and programmatic capacity of selected NGOs in Non-Formal Education (NFE) and to increase access to life skills-based education for the most vulnerable out-of-school and working children aged 10 to 17 years. With support from the United Nations Children's Fund (UNICEF) jointly with the MoE, the project emerged as a result of the dire need for access to NFE services for out-of-school children who are at risk of and most vulnerable to HIV/AIDS infection, substance abuse and exploitation. This is largely done through networking of NGOs, capacity building and reaching young people through training on psychosocial competencies, critical thinking, problem solving skills and informed decision-making.

The project also motivates and organizes parents and community participation for out-of-school children to create an enabling environment wherein children can practice new life skills for the development of safe behaviors and healthy practices. Through these behavior and practices, children can cope with daily life pressures and protect themselves against HIV/AIDS. The approach further seeks to strengthen linkages and networks between communities and any available HIV/AIDS-related social services (e.g. psychosocial counseling; community mobilization; information/health services; HIV/AIDS testing; care and support).

Program Implementation

The program was initiated by the Ministry of Education (MoE).

Program Duration

The program commenced from 2003 and will run until 2010.

Target Groups

The program will target 50,000 out-of-school children and youth aged 10 to 17 years, in 46 townships by 2010.

Program Activities

After being briefed on activities over the past 9 months from experienced NGOs and UNICEF, new partner NGOs carried out several discussions with the management level of stakeholders at the central level and set criteria for the selection of townships, villages, village-based young facilitators and monitors, and planned for the establishment of community-based EXCEL committees.

Exploration of data on out-of-school children was initiated by the last week of June after the school year started. Initially, informal data was collected. Sites were selected with consideration to feasibility and accessibility by a concerned NGO.

Training Workshops: The program implemented 3 types of workshops.

1. ***Central Orientation Workshop:*** All partner NGO management staff participated in the orientation and capacity building workshop held in advance of actual implementation. The workshop aimed to enhance the clear common vision of: outcomes; roles and partnerships; and better understanding of the role and terms of references (TORs) for monitors, facilitators and EXCEL committee members from the selected communities. This workshop increased the understanding of the criteria and procedures to recruit monitors and facilitators, and the process of how to set up EXCEL circles. At this workshop, organizational and administrative procedures, a training curriculum and a training structure were discussed.
2. ***Pre-Service and Review Training Workshop:*** The Department of Educational Planning and Training Life Skills Team, which was also involved in the development of the EXCEL curriculum, distributed EXCEL curriculum skills-based participatory methods training structure and monitoring procedures to all selected monitors, facilitators and some EXCEL circle members. EXCEL circle members participated in 6 full days of discussion in 2 phases, while monitors and facilitators participated in 27 full days of discussion in 3 phases. Review workshops had been conducted in advance on the capacity building workshops for facilitators and monitors. The main purposes of the review workshops were to: review and share their work experience; enhance their skills on data handling; receive instructions on remedial teaching; receive updated information; improve their approaches; and enhance effective methods of training. Monitoring tools were also developed together with facilitators and monitors, to be used by partner NGOs at all levels to maintain the quality of teaching, learning and management, and for systematic documentation and review.
3. ***In-Service Training Workshop (Village Level Training for Out-of-School Children):*** These were the follow-up workshops to the pre-service training workshop and were held in 3 phases (1 phase following every 3 months of actual training).

Mode and Duration of Training: The training program consisted of 3 phases. Each phase was divided into 2 terms – A and B. Each term lasted 2 weeks; children attended 2 hours per day, 3 days per week, over 2 weeks (2 hours/day x 3 days x 2 weeks), for the total of 12 hours per term. There was a gap for children between each term while different groups were attending the training. After the completion of the 3-month first phase, the children would have received 24 hours of HIV/AIDS prevention and life skills training. The project period covered 3 phases. Hence, upon completion, every child would have received 72 hours of training in 1 project period (i.e. 9 months).

Photo: UNICEF

The mode of training was non-formal. The time and place of training was flexible and was decided in co-operation with the children and adjusted to suit their availability (i.e. evenings, early mornings or weekends). Every village had 1 EXCEL circle. In each circle, the children were divided into 3 groups. Each group was composed of 20 to 30 children based on age level, vicinity, available time and common interests. Each group was trained by 3 facilitators: 1 lead facilitator and 2 other facilitators. The responsibility of the lead facilitator was to rotate among the 3 facilitators during the different groups and terms throughout the phases of the training program (i.e. 3 facilitators always worked as a team). Each group was broken into thirds, with each facilitator leading a smaller subgroup throughout the training program (i.e. 72 hours). Each facilitator was responsible for supporting and recording the details of the children's progress while the other 2 facilitators assisted. In subsequent sessions, a different facilitator took the lead facilitating role.

Organization and Management: The EXCEL project has been community-based. The basic framework of organization and management was based on the concept that 'at the community level the project processes, messages and results are to be locally planned, organized, managed and owned as much as possible.' Monitoring tools have also been developed to be used by partner NGOs at all levels to maintain the quality of teaching, learning and management and for systematic documentation and review.

EXCEL Committee: Each village had 1 EXCEL circle (known as a committee) comprised of a maximum of 10 members including religious leaders, well-wishers and senior citizens. Nearly half the members were women. This circle was in fact the most important organization and management body of the project implementation in each village. The main purpose of the circle was to organize and sensitize the villagers for community participation and to increase awareness of the importance of the project and to run the training effectively.

Disaggregated indicators were introduced to assess the magnitude of the issues of out-of-school children as part of the monitoring system for the EXCEL program. To effectively conduct training for children, EXCEL committee members met monthly to discuss the progress made and to take corrective actions when necessary. Before the in-service training, the entire village had been informed of the project through Information, Education, Communication (IEC) activities. Information pamphlets were initially distributed followed by building public acceptance and sharing information through discussions. Debriefings were later led by community circle members who attended the orientation training on the process of project implementation and roles of members. About 48% of the village level training for children took place in primary schools while the rest was conducted in monasteries, churches, community halls and in homes of well-wishers. As the majority of trainees were working children, the training was conducted during the evenings and lamps were therefore provided.

Monitoring and Evaluation: Regular monitoring of the activities was carried out by all key agencies involved in the implementation of EXCEL (i.e. by UNICEF and the various NGOs concerned). At the village level, the EXCEL community circle members met monthly to discuss the progress, shortcomings and level of participation of the children in the program. The strengths and weaknesses of trainers/facilitators during the training sessions were assessed. At the township level, the EXCEL monitor received feedback from the community circles and from the EXCEL circle trainers/facilitators. Corrective actions and operational issues beyond their area of responsibility were submitted to UNICEF and the NGO concerned and discussed in the NGO central management meetings.

The monitors met monthly with their respective NGOs, and sometimes with UNICEF, to assess and report on the progress in their respective townships and on the intervention as a whole. Both monitors and facilitators were provided with bicycles which improved the mobility of facilitators, enabling them to conduct more home visits. It also expedited activities such as transportation of teaching-learning materials, refilling batteries and increased frequency of communication with monitors. All stakeholders ensured that those children who completed different phases of training received incentives, such as caps, T-shirts and backpacks, to encourage future participation.

The whole monitoring mechanism, through reviewing and renewing monitoring tools, has been improved. As a result, facilitators, monitors and NGO project staff have been trained on the utilization of these new tools and a standardized reporting system has been established and is at the initial stage of usage.

PARTNERSHIPS

Support has been given by UNICEF and various NGOs.

KEY OUTCOMES AND LESSONS LEARNED

Reaching the Vulnerable: Beginning in mid-2003, the project initially targeted 5 pilot townships (15 EXCEL circles) with 1 NGO and has now been expanded to 14 townships (202 EXCEL circles) with 3 national NGOs. Thus far, 16,620 children have been enrolled and 95% have completed the 3-phase, 9-month course; 5% failed to complete the course mainly due to migration. Of the 16,620 children, more than 50% have been girls, and the majority has been working children. In addition, 420 young facilitators and monitors have completed the training and support implementation of the program in the targeted villages and 700 community members have been trained to support village level training. The 9-month training course for each project cycle starts and ends in June, including the preparatory phase. The table below represents the number of selected townships, communities and children in the EXCEL program.

Regarding quality and equity outcomes of life skills and HIV/AIDS prevention in out-of-school programs, facilitators' observations as well as internal assessments in 2005 noted the following positive behavioral changes:

- Improved family relationships and communication skills.
- Increased awareness of personal safety and protection.
- Significant improvement in personal hygiene practices.
- Improved awareness of HIV/AIDS and drug use, and increased avoidance of alcohol, tobacco, betel nut and narcotics.
- Improved time management.
- Greater awareness of nutrition and healthy eating.
- Improved literacy.
- Greater self-confidence and ability to bargain wages with farm owners and employers.
- Increased knowledge on HIV/AIDS and preventive measures, as well as improved attitudes on living with people with HIV/AIDS in the community.

Children's Participation: The program also aimed to increase children's participation in their own communities. Recently, a literacy component had been added through the 'Let's Read' initiative, where selected EXCEL children who had not completed the primary level of schooling participated in a series of book writing workshops and produced 15 books using their own life experiences as a basis for their stories. These books exposed the children to appropriate reading materials and served as a catalyst to increase their interest in reading and writing.

Recruitment of Trainers: To strengthen the capacity of NGOs and to scale-up the program, 20 trained and experienced young facilitators, who demonstrated high performance levels in their facilitation skills, were selected to become trainers. All of them received refresher training before the implementation of each phase. After completion of in-service training, the new selected trainers joined the central level training, together with central trainers. The young facilitators proved capable in conducting quality training.

- A wide age gap of 8 years (aged 10 to 17 years and above) among adolescents creates difficulties for young facilitators in conducting training and lesson preparation; thus, group work needs to be strengthened.
- It is difficult to maintain the service of young volunteer peer educators once they reach age 24.
- Questions raised by peers are sometimes difficult for peer educators to answer; therefore frequent refresher training for peer educators is required.
- Seasonal drop-outs due to labor migration necessitate the consideration of flexible and effective alternative programs.
- Data collection and regular reporting systems on project implementation need to be established.

Challenges and Solutions

The challenges presented were:

- Migration of children due to new job opportunities for themselves and also for their parents.

EXCEL: Number of Selected Townships, Communities and Children

Year/ Month	Selected Township	Selected Community	Children attended (Total)	Children completed (%)
2003/04	5	15	1239	62.8
2004/05	7	36	2773	56.6
2005/06	10	61	4693	58.5
2006/07	13	90	7915	55.7
2007/08	22*	141	11560	–

*Planned.

As the project expanded and more trainers were required, young facilitators and monitors were carefully identified during pre- and in-service training by central trainers as well as from central level NGO staff. The selected personnel jointly facilitated the pre-service training with central trainers. After 4 years of implementation, 25 young facilitators and monitors became skillful trainers.

The lessons learned from the program were:

- In the out-of-school context, social mobilization of communities was important for understanding that life skills education is vital.
- Joint accountability among all stakeholders in identifying the needs of EXCEL activities at village level is crucial for ownership and sustainability.

- The approval of parents and employers for the regular attendance of working children, especially those who were considered to be 'bread winners' and seasonal workers, remains a major challenge.
- The quality of data collection and maintenance of the regular reporting system on project implementation needs strengthening.
- Regular field monitoring trips are difficult due to the inaccessibility of some remote areas, especially during the rainy season, and high costs in areas with no public transport.
- A better understanding of the non-formal life skills training program among some stakeholders is needed.
- There are very few HIV/AIDS-related services for young people aged between 10 to 17 years (e.g. counseling).

The solutions to the challenges were to:

- Establish community and qualitative baseline data collection on behavioral change and lifestyles of children aged 10 to 17 years and above.
- Establish the usage of revised monitoring forms and indicators for the program.
- Review and revise the program communications strategy for more effective advocacy and community mobilization.
- Build networks with NFE providers and raise awareness among communities.

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STUDENT INVOLVEMENT IN THE DEVELOPMENT OF IEC/BCC MATERIALS – VIETNAM

INTRODUCTION

Traditionally, development of textbooks and IEC materials is undertaken by professional experts. Children, who will be the primary users of materials are often not involved in such processes and there can be a hesitancy on the part of ministries of education and material designers to encourage their involvement. Even where there is acceptance of children having a role, it may not be clear how to solicit and include their participation. In Vietnam, these issues were addressed when young people were invited to join in the development of IEC/BCC materials for the country's 'Adolescent Development and Participation' project.

AIMS AND OBJECTIVES

- To ensure materials are relevant to the needs of student (e.g. messages, approaches and design).
- To empower students and strengthen their roles.

PROGRAM OVERVIEW

Background

The 'Adolescent Development and Participation' project is being implemented by the Ministry of Education and Training (MoET), Vietnam Youth Association and Vietnam Women's Union, with support of the United Nations Children's Fund (UNICEF). This project addresses life skills education and HIV/AIDS prevention within an adolescent-friendly school environment.

The project is currently being implemented in 12 provinces in Vietnam with the coverage of 120 lower secondary schools. Participation of children has been vigorously promoted throughout the project. As part of this process, the MoET is taking critical steps to involve children in the development of IEC/BCC materials related to life skills and HIV/AIDS prevention.

Program Implementation

The program was initiated by the MoET and the Ministry of Health (MoH), with the Vietnam Youth Association and the Vietnam Women's Union.

Target Groups

The beneficiaries to the program are:
Primary Target Group(s): students and out-of-school children in Vietnam.
Secondary Target Group(s): parents, teachers and education personnel in Vietnam.

Program Activities

Promoting student participation required a thorough process and relevant methodology. Interactive processes were supported in order to enable active involvement of the students. Focus group discussions and student workshops enabled appropriate peer dynamics for effective contributions from the youth.

Valuable student feedback led to improving the quality of materials. For example, most messages on HIV/AIDS had previously been presented as avoiding involvement in sex work and drug use. The children proposed that HIV/AIDS prevention messages should be expanded to include young people's active participation relating to HIV/AIDS prevention and reducing HIV/AIDS-related stigma and discrimination.

PARTNERSHIPS

Support was given by UNICEF and donor partners such as Committee for Children.

Photo: Tara E. O'Connell

KEY OUTCOMES AND LESSONS LEARNED

Experience demonstrated that students helped to improve the quality of materials to address such issues as gender stereotypes, inclusion of various groups of children (e.g. ethnic minorities and rural children) and relevance of text and pictures. As the children became involved in the process, they were empowered through peer interaction and group dynamics. The children became more confident, introducing ideas and proposals as well as feeling good about their contributions. The children appreciated this new experience of participation as, until recently, materials had been developed by experts and distributed without including the children's input.

The process was a learning experience for the Ministry and all involved (e.g. Vietnam Youth Association and Vietnam Women's Union). The partners learned to appreciate that more widespread involvement is vital to ensure meaningful participation in life skills education. This necessitated investment of time for several rounds of revisions by the artists following feedback from the students. Even after the posters/pictures had been printed, the teachers continued to collect feedback from students in order to continue improving the materials during subsequent reprints.

Sensitizing parents and teachers on the rationale of child participation was essential to ensure student participation. Greater understanding by parents and teachers led to increased student participation in focus group discussions and activities to provide input to the development of materials. More broadly, advocacy via the mass media helped to communicate the experiences learned to a wider audience and raised awareness on the issues of child participation with parents and the larger community.

Above all, in order to initiate student/youth participation in the development of materials, particularly those related to the delivery of life skills education, a significant lesson learned by the MoET was in trusting the youth and their ability to participate in discussions. This trust not only allowed the MoET to encourage students to offer their contributions but also allowed the MoET to take youth contributions seriously.

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BOX 3

Student Involvement in the Development of IEC/BCC Materials in Cambodia

In Cambodia, young people were involved in the design of materials for the country's 'Life Skills for HIV/AIDS Education' (LSHE) program: an activity of the Ministry of Education, Youth and Sport (MoEYS) in partnership with World Education Cambodia.

Student involvement in the material development process was a great opportunity for students to build skills, gain better understanding and recognize the usefulness of Information, Education, Communication (IEC) materials.

Student and youth participation in regular program activities at the field level led to the development of relationships between schoolteachers, district team members and key community members to discuss program issues such as planning, training, and monitoring and evaluation (M&E). These issues are key mechanisms to ensure children and youth carry out their activities continuously.

Peer educator involvement in the planning and M&E process was a valuable approach as the youth were proud of their contributions to the program and wanted to perform well for their district team and their teachers. The youth also adjusted their behavior to take on the leadership role of providing information rather than just receiving it. In addition, students devoted time to reviewing and planning lessons and materials that would be used for upcoming HIV/AIDS education and prevention activities.

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Chapter 4:
School-Based Health and Nutrition Services

DEWORMING FOR SCHOOLCHILDREN – CAMBODIA

INTRODUCTION

Cambodia is committed to promoting sustainable control of soil-transmitted helminths (STH) with a vision to ensuring that children grow up free of intestinal worms so they can develop, play, learn and enrich their communities. This initiative strives to reach children with limited access to safe and effective treatment that are at high-risk of infection and associated morbidity in Cambodia. In order to achieve this, the Ministry of Health (MoH) implements a school-based deworming program and outreach services and combined them with immunization services, the delivery of vitamin A capsules, birth spacing and the administration of mebendazole tablets.

AIMS AND OBJECTIVES

- To cover at least 75% of all school-age children at risk of morbidity, using the educational system as well as other channels to reach non-enrolled school-age children.
- To reduce the prevalence and intensity of STH infection to less than 10% by 2015.
- To increase the knowledge and awareness of the causes of intestinal helminths in schoolchildren.

PROGRAM OVERVIEW

Background

The Cambodia National Soil-Transmitted Helminth Prevention and Control policy and guidelines were developed in April 2004 by the National Taskforce for the Control of Soil-Transmitted Helminths, Schistosomiasis and Elimination of Lymphatic Filariasis. The Cambodian Ministry of Health recognized that STH is a major health problem, particularly affecting selected target groups. As a result, this program was set up with the aims of reducing associated STH infections in the main target groups and providing access to regular chemotherapy (i.e. with mebendazole or albendazole) and health education to all school-age children at risk of morbidity. Furthermore, periodic treatment will be integrated into existing public health activities addressing children between 2 to 5 years of age, and the control of helminth infections will be supported through government policies and infrastructure.

The program is essential as the prevalence of STH in Cambodia is estimated to be greater than 50%, with 70% prevalence in some provinces. There is also insufficient access to appropriate sanitation and safe water, with lack of latrines. Against this backdrop, in April 2003, the deworming program for primary school-age children was started, targeting 11 provinces. The program trained school directors and provided Information, Education, Communication (IEC) materials (e.g. wall posters). In February 2004, coverage was extended to all provinces in Cambodia. Since then, the program has continued administering mebendazole tablets biannually and in January 2006, the biannual administration of mebendazole tablets was extended to pre-school children (aged 1 to 5 years).

Program Implementation

The program was developed by the Ministry of Education (MoE), the Ministry of Health and the Ministry of Education, Youth and Sport (MoEYS).

Program Duration

Phase 1 commenced from 2002 to 2004.
Phase 2 commenced from 2004 and will continue through 2015.

Target Groups

The beneficiaries to the program are:

Primary Target Group(s): primary school-age children in all provinces in Cambodia.
Secondary Target Group(s): all children aged 1 to 5 years, in all provinces in Cambodia.

Program Activities

There are 6 principal strategies of STH prevention and control. These are:

- In order to decrease morbidity associated with STH infections, a regular distribution of a single dose of mebendazole (500mg) is offered to school-age children in accordance with the World Health Organization (WHO) recommendations. The target is to cover at least 75% of all school-age children at risk of morbidity using the educational system as well a

other channels to reach non-enrolled school-age children.

- Health education, using appropriate IEC materials combined with drug treatment campaigns, will be provided to schools and communities.
- The approach will be school-based, with the education and health sectors equally involved in all phases of development and implementation of both the plan of action and activities.
- Guidelines will define the role of the school-based deworming program in the new health strategic plan to standardize the different current practices. Specific financial effort from the MoH to fund these activities emphasize their importance and should aid their implementation in collaboration with the MoE, United Nations Children's Fund (UNICEF), WHO, the World Bank, non-government organizations (NGOs) and other partners.
- Integrate STH within a school health promotion framework, in particular, as part of the health promoting school activities.
- Integrate STH control with existing health programs including the administration of mebendazole and the delivery of immunization services, vitamin A capsules and birth spacing.

In order to reduce morbidity due to STH, the program would need to:
- Monitor the prevalence of intestinal parasitic infection in sentinel sites.
- Conduct mass treatment every 6 months for school-age children in all provinces.
- Train school directors, teachers and health centers on deworming and health education activities at schools and in communities.
- Supervise deworming programs at schools and in outreach activities in 11 provinces.

The program was implemented to train school directors and health center staff on deworming and on IEC materials related to it. Regular biannual mass treatments with single doses of mebendazole (500mg) were administered along with occasional surveys on assessing prevalence of disease.

Staff Selection and Training: One-day training of school directors and health center staff on STH and on how to use IEC materials developed on STH.

Needs Assessment: Training and communication needs assessments were conducted to train teachers and health staff. Posters were developed for imparting health education.

Program Resources and Finance

Human Resources: MoH, MoEYS and WHO.
Material Resources: MoH (supply of mebendazole).
Financial Resources: Government of Japan, Sasakawa Memorial Health Foundation (SMHF), UNICEF and WHO.

Program Materials

Posters for schoolchildren and a teacher training manual.

PARTNERSHIPS

The partners involved were the Government of Japan, SMHF, UNICEF, WHO, the World Bank, various NGOs and health center staff and teachers.

KEY OUTCOMES AND LESSONS LEARNED

In 2004, Cambodia became the first country to reach the target of 75% coverage of schoolchildren with regular deworming. In 2001, Cambodia was committed to the World Health Assembly resolution 54.19 for the control of STH and schistosomiasis, stipulating that 75% to 100% of all school-age children at risk of morbidity will be covered by 2010 with regular administration of chemotherapy. Towards this end, the MoH has adapted the school-based deworming program and outreach services and combined them with immunization services, the delivery of vitamin A capsules, birth spacing and the administration of mebendazole tablets.

The helminthiasis control program continues to make great progress and has been incorporated into other health programs including outreach services such as measles immunizations, nutrition programs and Integrated Management of Childhood Illness (IMCI).

The MoE has given high priority to education on helminthiasis control in the school health curriculum and strengthened the support for schoolteachers to carry out educational activities around helminthiasis. The MoE has encouraged local NGOs to participate in the program and NGOs are now fully involved in the implementation of controlling activities in their target areas. UNICEF and WHO also continue their technical and financial support to the deworming activities for school-age children.

Regularly deworming schoolchildren can protect them from worms and can also maintain a low prevalence rate. Monitoring the school-based deworming program is very important to ensure that the program runs properly and successfully by health staff and schoolteachers. It also helps encourage staff to collaborate between both systems (MoH and the MoE).

Monitoring also ensures that data collection of mebendazole distribution is carried out properly from the processes, bottom-up (e.g. schools and health centers) to top-down (e.g. MoH and MoEYS) in both systems. Some of the characteristics that led to successful program implementation were:

- Political commitment.
- Good collaboration between MoH and MoEYS.
- Establishment of a national taskforce.
- Simple interventions and integration with other activities.
- Technical and financial support from UNICEF and WHO.
- Local procurement of drugs.

The next steps for the program were:

- *Elimination of STH in Cambodia by 2015:* Acquired through continuous program assessment, implementing regular drug administration and conducting occasional surveys on disease prevalence.
- *Continued Financial Support to Eliminate STH by 2015:* Acquired through requests made by the MoE to relevant organizations to continue their financial support.

Program Evaluation

Occasional surveys are conducted to assess disease prevalence and to follow-up on the program.

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EDUCATIONAL CARE SERVICES FOR HIV/AIDS AFFECTED CHILDREN – CHINA

INTRODUCTION

Children affected by HIV/AIDS are amongst the most vulnerable children living in any community. In Yunnan Province of China, a program designed to support and care for children affected by HIV/AIDS has been established.

AIMS AND OBJECTIVES

- To support all HIV/AIDS affected children to have a better education.
- To strengthen the social adaptation capacity of children.
- To enhance the recognition of self-healthcare.

PROGRAM OVERVIEW

Background

HIV/AIDS prevention and control has been enhanced in Yunnan Province over the past 17 years. In 2003, the Chinese Government issued the 'Four Frees and One Care Policy' (FFOCP) and the Yunnan Provincial Government issued the 'Two Frees and One Supply Policy' (TFOSP) for children of poor families including AIDS orphans.

Program Implementation

The program was developed with the support and assistance from the Central Party Committee, the State Council and its Ministries, Yunnan Provincial Bureau of Education (YBoE) and the Yunnan Provincial Bureau of Health (YBoH), led by the Yunnan Provincial Party Committee and the Yunnan Provincial Government.

Program Duration

The program has been operating for 4 years and is ongoing.

Target Groups

The program operates at all education levels and cares for children affected by HIV/AIDS.

Program Resources and Finance

The program operates at all education levels and cares for children affected by HIV/AIDS.

Program Materials

Not available.

PARTNERSHIPS

The program runs in co-operation with YBoH; Yunnan Provincial Center for Disease Control and Prevention; Yunnan Provincial Drug-Banning and AIDS-Preventing Teacher Training and Researching Base; Yunnan Provincial Drug-Banning and AIDS-Preventing School Education Base; Yunnan Provincial Drug-Banning and AIDS-Preventing Youth Education Base; and Yunnan Provincial University AIDS-Preventing Education Base.

Program Activities

The program focuses on the provision of educational services for children affected with HIV/AIDS, including HIV-positive children, the children of HIV-positive parents, and AIDS orphans (see diagram below).

The program conducts 4 services:

- Free education.
- Psychological counseling.
- Exchange activities.
- Health check-ups.

Framework on "Educational Care Services for HIV/AIDS Affected Children" Program.

KEY OUTCOMES AND LESSONS LEARNED

When the program began in 2003, its main concern was to provide free education to primary school children. It was quickly realized that children affected by AIDS needed additional support as well, and three further areas were then provided:

- Psychological counseling.
- Exchange activity.
- Health check-ups.

In time, secondary schools were also included in the program.

The need for effective training of teachers in the care of children affected by AIDS was also identified. In 2005, the Yunnan Provincial Drug-Banning and AIDS-Preventing Teacher Training and Researching Base, the Yunnan Provincial Drug-Banning and AIDS-Preventing Youth Education Base, the Yunnan Provincial Drug-Banning and AIDS-Preventing School Education Base and Yunnan Provincial University AIDS-Preventing Education Base were established. These educational bases made great achievements to the training of trainers.

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DEWORMING FOR PRIMARY SCHOOL-AGE CHILDREN – LAO PDR

INTRODUCTION

Soil-transmitted helminths (STH), roundworms, hookworms, and whipworms, are among the most common chronic infections in school-age children. Parasitological surveys among primary schoolchildren were carried out on a national scale in all 17 provinces in Lao PDR and showed a high prevalence of infections (1% to 96%). This was recognized as an important national public health problem that needed to be addressed urgently. As a result, a 'Helminth Control' policy was formulated and signed as well as a Memorandum of Understanding (MOU) between the MoE and MoH. Furthermore, a Joint School Health Committee (JSHC) consisting of education and health sectors at central and lower levels was set up to provide a strong platform for implementing school-based deworming activities. These efforts led to the launching of Lao PDR's Mass Drug Administration (MDA) campaign; a joint program developed by the Ministries of Health (MoH) and Education (MoE) to target primary schoolchildren with the delivery and support services needed to ensure anthelmintic treatment to 75% of primary school-age children on a 6-monthly or yearly basis in Lao PDR.

AIMS AND OBJECTIVES

- To improve the health and school performance of Lao PDR school-age children.
- To provide at least 75% of primary school-age children with anthelmintic treatment on a 6-monthly or yearly basis, depending on the prevailing epidemiological situation.

PROGRAM OVERVIEW

Background

In 2001, the MoE and MoH joined to implement a school deworming pilot program in 5 districts of the Vientiane province. Its aim was to make use of the primary school system as an entry point to reach children with parasite control campaigns. After 6 rounds of treatment, the pilot program was successful in reducing STH infection by 43%, with over 90% of children having only "low" infections (as defined by WHO standards). As a result, the effects of the parasites on children's health and school performance either greatly decreased or were negligible.

The results from the pilot program demonstrated the feasibility of deworming using schools as entry points, and served as a platform towards coordination and collaboration among schoolteachers, health personnel and different donor agencies, creating further awareness among all. As a result, a national school deworming program was implemented, where schoolteachers were assigned as key implementers and health staff worked as strong technical support to the deworming campaign in schools. The national program now aims to ensure that Lao PDR meets the World Health Organization (WHO) target of providing at least 75% of primary school-age children with anthelmintic treatment on a 6-monthly or yearly basis.

Program Implementation

The program is carried out under the leadership of JSHC (Ministries of Health and Education) with participation from local authorities.

Program Duration

The program has been in operation for 3 years (2005 through 2007) and will continue until 2009.

Target Groups

The program is carried out at the primary school level, where enrolled and non-enrolled children and teachers are the main beneficiaries of the program.

Photo: UNICEF

Program Activities

Since September 2005, the intervention has had 4 key activities. These activities are:

- Capacity building for schoolteachers.
- A health education campaign.
- A mass drug treatment.
- Monitoring and evaluation (M&E).

PARTNERSHIPS

Technical and financial support was provided by the Government of Luxembourg via WHO. Key current international partners who have integrated deworming into their own activities are the World Food Programme (WFP), the United Nations Children's Fund (UNICEF) and several non-government organizations (NGOs). Other partners involved were the Asian Center of International Parasite Control (ACIPAC), Japan International Cooperation Agency (JICA) and community members in Lao PDR.

KEY OUTCOMES AND LESSONS LEARNED

The program is in its fourth run of the deworming campaign, geographically covering 100% of primary schools throughout Lao PDR with 88% treatment coverage for primary school-age children. The treatment will continue until 2009 with grants from the Government of Luxembourg via WHO.

The key outcomes and lessons learned to date are:

- Implementing a pilot project was needed to assure the feasibility of using schools as entry points to reach both enrolled and non-enrolled children nationwide.
- Schoolteachers were assigned as key implementers to run the deworming campaign and to report results directly to senior supervisors. Capacity building was needed to support teachers to organize the campaign effectively.
- Developing relevant educational materials was required as tools to aid teachers to deliver health information to children.
- Ownership by education and health partners was strengthened through a high commitment in delivering anthelmintic drugs from the central level to schools, with no delivery costs. Mebendazole tablets were given to districts by the provincial taskforce, to school cluster directors by the district taskforce and to schoolteachers by cluster school directors, via regular meetings held once a month or every 2 months in some areas. Schoolteachers, who ran the school campaigns, received budget support and deworming tablets as an incentive.
- The mass drug treatment was implemented in association with intensive health education for children on campaign days and through routine teaching-learning health education in schools. Integrating health education into the national curriculum under the subject of 'The World Around Us' ensured long-term life skills on disease prevention among children.
- A regular monitoring scheme was created, where some priority areas were identified as sentinel areas for close monitoring

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BOX 4

School Lunch Program in Thailand

AIMS AND OBJECTIVES

- To ensure all schoolchildren have enough nutritious food to ensure proper physical and intellectual growth and development.
- To provide dietary supplements to micronutrient deficient students.

SUMMARY

Thailand's school lunch program was implemented with a view to ensuring all kindergarten, primary and secondary school-age children receive at least one nutritious meal daily to help support their physical and intellectual development. To offset some of the costs involved in implementation and to encourage sustainability of the program, voluntary assistance for food preparation has been secured in rural communities and school farming programs have been encouraged.

PROGRAM OVERVIEW

Original Program Developers

The program was initiated by the Ministries of Education (MoE) and Public Health (MoPH).

Program Duration

The program commenced in 1981 and is ongoing.

Program Operating Levels

The program operates in all kindergartens, primary and secondary schools in Thailand.

PARTNERSHIPS

The partners involved are the local authorities, local non-government organizations (NGOs) and the local communities.

KEY OUTCOMES AND LESSONS LEARNED

The program has been adjusted regularly according to the current situation of each school in order to:

- Supplement the limited budget allocation for each school.
- Encourage school farming programs (e.g vegetable gardens, chicken or duck farming, fish ponds, dairy cows and rice farms) around school grounds.
- Allow school lunches to be cooked by volunteers (e.g. parents and students) in rural areas.
- Receive raw food materials donated from communities.

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Additional information can be obtained on the website: **www.moe.go.th.**

DEWORMING FOR SCHOOLCHILDREN AND OTHER HIGH RISK GROUPS – VIETNAM

INTRODUCTION

Vietnam's school deworming program works through the schools to distribute deworming tablets to school-age children. It is expected to cover 42 provinces by the end of 2007 with the ultimate goal of reaching 100% of school-age children in prevalence areas of moderate and high infection with deworming tablets once or twice yearly.

AIMS AND OBJECTIVES

- To reduce morbidity due to intestinal worm infections.
- To improve the nutritional and health status of children.
- To ensure 100% of schoolchildren in prevalence areas of moderate and high infection receive deworming tablets once or twice yearly.
- To ensure increasing coverage of deworming in other groups (e.g. pre-school children, secondary schoolchildren, women of childbearing age, etc).
- To affect behavior change around personal hygiene practices.

PROGRAM OVERVIEW

Background

Historically, Vietnam has experienced high prevalence of infection with intestinal parasitic worms which are detrimental to children's health, their cognitive development and their education. Chronic illness caused by worm infections has been found to reduce literacy and thus adult productivity thereby impacting on the economic development of the country. Worm infections can readily be treated using safe, low cost and highly effective anthelmintic drugs, which, when delivered through schools, are amongst the most cost-effective of public health interventions leading to improved educational achievement, health status, physical growth and cognitive development among school-age children.

Program Implementation

The Ministry of Health (MoH) and the Ministry of Education and Training (MoET) are responsible for the deworming program.

The departments involved from the MoH include the Vietnam Administration of Preventive Medicine. Additionally, at the regional level, departments involved include: the Institute for Malariology, Parasitology and Entomology Ho Chi Minh City (IMPE-HCMC) in southern Vietnam; the Institute for Malariology, Parasitology and Entomology Qui Nhon (IMPE-QN) in central Vietnam; and the National Institute for Malariology, Parasitology and Entomology (NIMPE) in Hanoi. The roles of the MoH, IMPE-HCMC, IMPE-QN and NIMPE are to develop guidelines for deworming, provide technical assistance, monitoring and evaluation (M&E), supervision, availability of drug stock and co-ordination with donors.

The departments involved from the MoET include the Department of Physician Education and Training. Additionally, at the provincial-district-commune level, departments involved include: the Provincial Health Department; Provincial Centre for Preventive Medicine; District Centre for Preventive Medicine; Commune Health Station Provincial Education Department; District Education Division; and primary schools (including sub-schools). At the same level, the two Ministries will develop a common plan for deworming.

Program Duration

The program has been in operation since 2000 with 6 districts in 6 provinces. Twelve provinces were covered in 2003; 27 provinces were covered in 2005 and the program is expected to cover 42 provinces in 2007.

Target Groups

The program operates at all levels: central, provincial, district and community.

Program Activities

Before deworming day: The headmaster in each school attends a short training course organized by the district center for preventive medicine. The training involves how to organize the deworming day at schools and a brief introduction to worm infections and prevention. After training, the headmaster relays this information to the schoolteachers, makes a list of all schoolchildren, informs the parents and collates health information (given by parents) on the schoolchildren. The deworming tablets arrive at the school the day before deworming.

On deworming day: The schools prepare clean water for drinking during drug administration. In each class, a member of the health staff gives out information on infection and on the prevention of intestinal worms, and the schoolteacher calls each student from the list for drug administration. Schoolchildren who are absent or ill receive the deworming tablets on the day they return to school. A report form is completed (by schoolteachers and the headmaster) and sent to higher levels for

consolidation. The schoolteachers receive 4 deworming tablets for their family members as an incentive.

Program Resources and Finance

Not available.

Program Materials

Not available.

PARTNERSHIPS

The partners involved are: Asian Development Bank (ADB); Associazione Italiana Carlo Urbani (AICU); the Government of Luxemburg; Ivo de Carneri Foundation (IdCF); the National Institute of Nutrition (NIN); Nucleo Assistenza, Adozione, Affido (NAAA); the World Health Organization (WHO); and various non-government organizations (NGOs). Also involved are: IMPE-HCMC in southern Vietnam, IMPE-QN in central Vietnam, and NIMPE in Hanoi.

KEY OUTCOMES AND LESSONS LEARNED

The key outcomes and lessons learned from the program are:

- The coverage rate has increased annually.
- The program has extended to include additional target groups (e.g. pre-school children, secondary schoolchildren and women of childbearing age).
- More NGOs have become involved over time.
- There was good co-operation between the Ministries of Health and Education at all levels.
- The deworming tablets were inexpensive and safe to administer with no severe side effects.
- Schoolteachers could easily distribute deworming tablets without difficulty.

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Photo: Tara E. O'Connell

Annex 1: School Health and Nutrition, including HIV/AIDS, in the Greater Mekong Sub-Region: Questionnaire Responses

Part A: Identification	Countries					
Questions	Bhutan	Cambodia	China, Yunnan Province	Lao PDR	Thailand	Vietnam
2. Name of Contributor	*	*	*	*	*	*
3. Title/Affiliation	*	*	*	*	*	*
4. No. of Regions in Country	20	24	129	17	19	64

Part B: Policy Planning and Management	Summary Statistics				Countries					
Questions	Yes	No	NR*	NA**	Bhutan	Cambodia	China Yunnan Province	Lao PDR	Thailand	Vietnam
1. Is there a national SHN policy?	4	2	0	0	0	1	1	1	1	0
If Yes, is it implemented by the MoH?	3	1	2	0	NR	0	1	1	1	NR
If Yes, is it implemented by the MoE?	4	1	1	0	NR	1	1	1	1	0
2. Is there a national workplace policy?	4	2	0	0	0	0	1	1	1	1
If Yes, does it include HIV/AIDS?	4	0	2	0	NR	NR	1	1	1	1
3. Is there a SHN and HIV/AIDS unit in the MoE?	6	0	0	0	1	1	1	1	1	1
If Yes, is there a full-time coordinator of the unit?	5	1	0	0	1	1	1	0	1	1
4. Do you have a national HIV/AIDS strategy paper?	5	1	0	0	1	1	0	1	1	1
5. Do you have an education sector HIV/AIDS strategy?	4	2	0	0	1	1	0	1	1	0
6. Do you have an education sector HIV/AIDS action plan?	4	2	0	0	1	1	0	1	1	0
7. Has the MoE or 'other' undertaken any impact assessment of SHN initiatives on supply & demand with regard to their EFA goals?	2	4	0	0	0	1	0	0	1	0
8. Are any health indicators collected as part of the data for the MoE?	4	2	0	0	0	1	1	1	1	0
Can you provide examples?			3	0	NR	Water, Latrines	NR	Water, Latrines	HPS, Nutrition, Life Skills, HIV/AIDS, Drugs	NR
9. Do you have joint programming for SHN involving a number of donors?	5	1	0	0	1	1	1	1	1	0
10. Is the MoE contracting NGOs to assist in the implementation of its HIV/AIDS educational program?	5	1	0	0	0	1	1	1	1	1
11. What is the MoE budget for this year?			1	1	US$ 56,836,812	NR	US$ 129,265,770	NA	US$ 7,354,355,715	Approx 20% of GDP†
12. What is the budget of the MoE allocated to SHN this year?			2	0	0	NR	US$ 155,058	NR	US$ 337,051,500	US$ 12,000
13. What is the proportion of the above amount to the MoE annual budget?			2	0	NR	18.50%	0.12%	NR	4.16%	0.60%
14. What is the budget of the MoE allocated to HIV/AIDS this year?			2	0	0	NR	US$ 526,108	NR	US$ 260,458	US$ 6,000
15. What is the proportion of the above amount to the MoE annual budget?			4	0	NR	NR	NR	NR	0.003%	0.30%
Total	59	20	19	1						

*NR=No Response; **NA=Not Available; GDP=Gross Domestic Product

Part C: School Environment	Summary Statistics				Countries					
Questions	**Yes**	**No**	**NR***	**NA****	**Bhutan**	**Cambodia**	**China Yunnan Province**	**Lao PDR**	**Thailand**	**Vietnam**
1. Is there a national policy requiring schools to provide safe, potable drinking water?	6	0	0	0	1	1	1	1	1	1
2. Is there a national policy requiring schools to provide hand washing facilities that include soap?	3	3	0	0	0	1	0	1	1	0
3. Is there a national policy requiring schools to provide separate latrines for boys and girls?	5	1	0	0	0	1	1	1	1	1
4. Is there a national policy requiring schools to provide separate latrines for students and teachers?	2	4	0	0	0	1	0	0	1	0
5. Is there an annual sanitation survey conducted in all schools?	2	4	0	0	0	0	1	0	1	0
6. Is there an established school hygiene and cleaning regime that includes scheduled rubbish removal and maintenance of school buildings and facilities in all schools?	5	1	0	0	1	0	1	1	1	1
Total	23	13	0	0						

*NR=No Response; **NA=Not Available

Part D: Health Education and Curriculum	Summary Statistics				Countries					
Questions	**Yes**	**No**	**NR***	**NA****	**Bhutan**	**Cambodia**	**China Yunnan Province**	**Lao PDR**	**Thailand**	**Vietnam**
1. Is there a national health education curriculum?	6	0	0	0	1	1	1	1	1	1
If Yes, can they be adapted to individual districts/regions/provinces?	2	4	0	0	0	1	0	0	1	0
2. Is health education taught as a separate subject?	1	5	0	0	0	0	0	0	1	0
If Yes, what is the name of the subject?			4	0	NR	NR	Physiology Health	NR	Health & Physical Education	NR
If No, what is the carrier subject?			1	0	Social Studies, Integrated Science	Local Life Skills, Social Science	Health Education, Life Skills	'The World Around Us'	NR	Natural Social Science
3. Is nutrition education taught in schools in any form?	6	0	0	0	1	1	1	1	1	1
If Yes, is it taught in primary schools?	6	0	0	0	1	1	1	1	1	1
If Yes, is it taught in secondary schools?	4	2	0	0	1	1	1	0	1	0
If Yes, at what age is it introduced into schools?			0	0	6	6	10	6	4	6
Is nutrition education offered in NFE?	6	0	0	0	1	1	1	1	1	1
4. Is hygiene education taught in schools in any form?	6	0	0	0	1	1	1	1	1	1
If Yes, is it taught in primary schools?	6	0	0	0	1	1	1	1	1	1
If Yes, is it taught in secondary schools?	6	0	0	0	1	1	1	1	1	1
If Yes, at what age is it introduced into schools?			0	0	10	6	10	3	4	6
Is hygiene education offered in NFE?	5	1	0	0	0	1	1	1	1	1
5. Is HIV/AIDS taught in schools in any form?	6	0	0	0	1	1	1	1	1	1
If Yes, is it taught in primary schools?	5	1	0	0	0	1	1	1	1	1
If Yes, is it taught in secondary schools?	6	0	0	0	1	1	1	1	1	1
If Yes, at what age is it introduced into schools?			0	0	13	3	10	10	4	10
If Yes, is it taught in NFE and in out-of-school settings?	6	0	0	0	1	1	1	1	1	1
6. If HIV/AIDS is taught in schools, is it embedded in another subject?	6	0	0	0	1	1	1	1	1	1
If Yes, which subjects?			0	0	Science	Local Life Skills, Social Science	Health Education	The World Around Us,' Biology, Geography, Civic Education	Health Education	Biology, Civil Education

Part D: Health Education and Curriculum *continued…*	Summary Statistics				Countries					
Questions	**Yes**	**No**	**NR***	**NA****	**Bhutan**	**Cambodia**	**China Yunnan Province**	**Lao PDR**	**Thailand**	**Vietnam**
7. If HIV/AIDS is taught in schools, have you adopted a life skills approach at the primary level? Or	5	1	0	0	0	1	1	1	1	1
at the secondary level? Or	5	1	0	0	0	1	1	1	1	1
within NFE?	5	1	0	0	0	1	1	1	1	1
8. If HIV/AIDS is taught in schools, is the HIV/AIDS educational program linked to other related topics such as reproductive health, substance abuse, domestic violence, etc?	6	0	0	0	1	1	1	1	1	1
If Yes, what topics?			0	0	Substance Abuse, Adolescent Reproductive Health	Social Science	Reproductive Health	Biology, Population Education, Reproductive Health & Drugs	Reproductive Health, Substance Abuse, Domestic Violence, Morality Education	Reproductive Health, Children's Rights, Drug Prevention, Tobacco & Alcohol Control
9. Are teachers given health education?	6	0	0	0	1	1	1	1	1	1
If Yes, are they given health education pre-service?	4	2	0	0	1	1	0	1	1	0
If Yes, are they given health education in-service?	6	0	0	0	1	1	1	1	1	1
10. Does the teacher training curriculum include SHN?	5	1	0	0	1	1	1	1	1	0
11. Are teachers trained in the approach of delivering effective life skills education to children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they taught during pre-service?	2	3	1	0	0	1	0	1	0	NR
If Yes, are they taught during in-service?	6	0	0	0	1	1	1	1	1	1
12. Is HIV/AIDS integrated into the teacher training curriculum?	5	1	0	0	0	1	1	1	1	1
13. Are teachers taught to protect themselves from HIV?	5	1	0	0	0	1	1	1	1	1
If Yes, is it taught during pre-service?	2	3	1	0	0	1	0	1	0	NR
If Yes, is it taught during in-service?	5	1	0	0	1	1	1	1	1	1
14. Do teachers have access to counseling concerning HIV/AIDS?	3	3	0	0	0	1	0	0	1	1
Total	**159**	**31**	**7**	**0**						

*NR=No Response; **NA=Not Available

Part E: Health and Nutrition Services	Summary Statistics				Countries					
Questions	**Yes**	**No**	**NR***	**NA****	**Bhutan**	**Cambodia**	**China Yunnan Province**	**Lao PDR**	**Thailand**	**Vietnam**
1. Are vaccinations provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	1	5	0	0	0	0	0	0	1	0
MoH staff?	6	0	0	0	1	1	1	1	1	1
No. of Regions in which they are offered?			0	0	20/20	24/24	129/129	17/17	12/12 MoH, 19/19 MoE	64/64
2. Is school feeding provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	6	0	0	0	1	1	1	1	1	1
MoH staff?	0	6	0	0	0	0	0	0	0	0
No. of Regions in which they are offered?			0	0	20/20	8/24	4/129	3/17	19/19	20/64
3. Are hearing and sight examinations provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	3	2	1	0	0	1	0	1	1	NR
MoH staff?	5	1	0	0	1	1	1	0	1	1
No. of Regions in which they are offered?			0	0	20/20	24/24	40/129	Limited	12/19	64/64
4. Are medical examinations provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	2	4	0	0	0	1	0	0	1	0
MoH staff?	6	0	0	0	1	1	1	1	1	1
No. of Regions in which they are offered?			1	0	20/20	24/24	NR	Limited	12/19	32-40/64
5. Is a deworming program provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	4	0	2	0	1	1	NR	1	1	NR
MoH staff?	5	1	0	0	1	1	1	0	1	1
No. of Regions in which they are offered?			0	0	20/20	24/24	40/129	17/17	12/19	15/64
6. Are reproductive health services provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	5	1	0	0	1	1	1	1	1	0
MoH staff?	4	2	0	0	1	0	1	0	1	1
No. of Regions in which they are offered?			0	0	20/20	24/24	129/129	11/17	12/19	64/64
7. Are malaria control services provided for school-age children?	6	0	0	0	1	1	1	1	1	1
If Yes, are they administered by:										
Teachers?	2	4	0	0	0	1	0	0	1	0
MoH staff?	6	0	0	0	1	1	1	1	1	1
No. of Regions in which they are offered?			0	0	4 or 5/20	24/24	42/42	17/17	6/12 MoE, 10/19 MoH	64/64
8. Is an iron supplementation program provided for school-age children?	4	2	0	0	1	1	0	1	1	0
If Yes, are they administered by:										
Teachers?	2	2	2	0	1	0	NR	0	1	NR
MoH staff?	4	0	2	0	1	1	NR	1	1	NR
No. of Regions in which they are offered?			2	0	20/20	4/24	NR	1/17	12/19	NR
Total	**107**	**30**	**10**	**0**						

*NR=No Response; **NA=Not Available

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