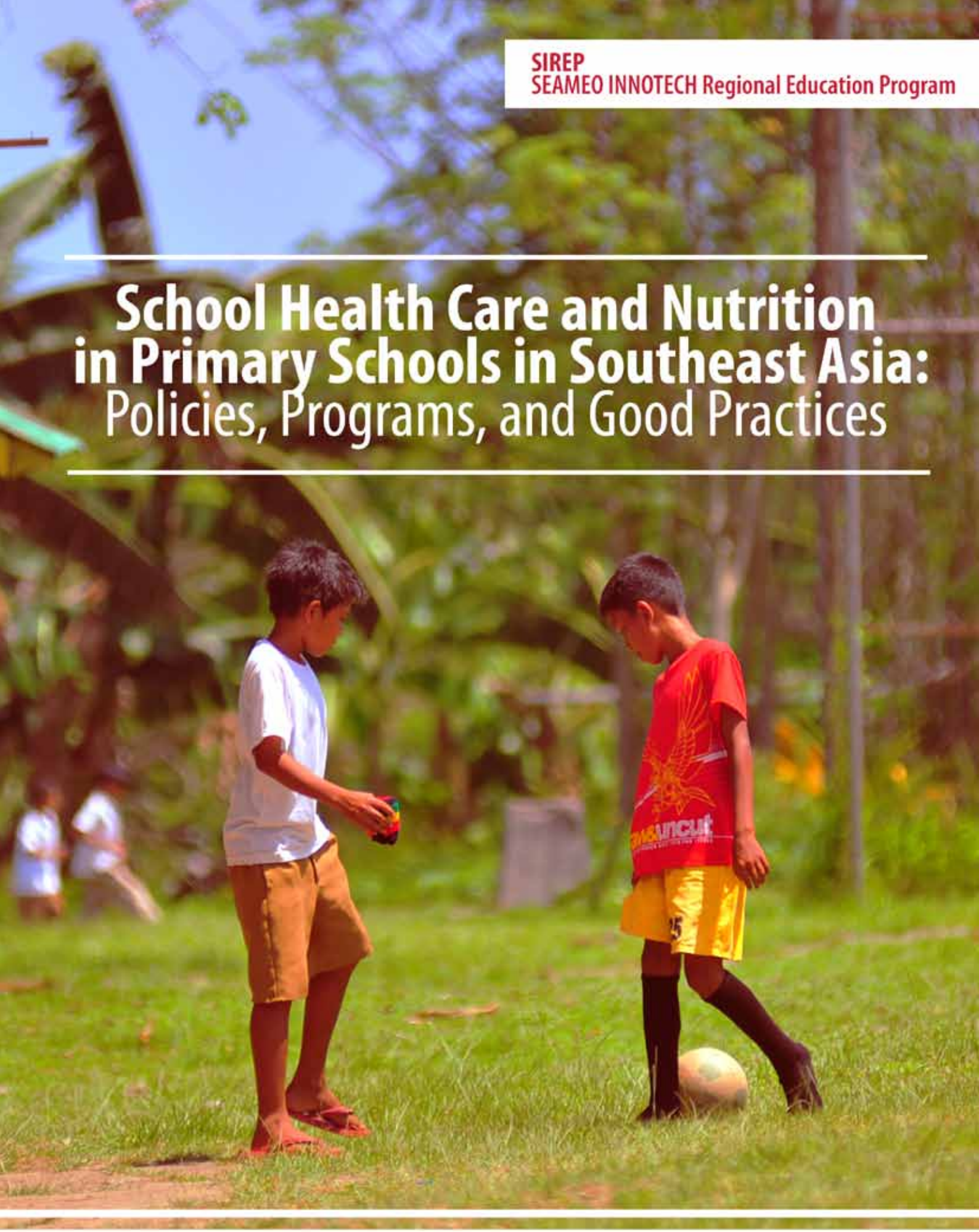
SIREP
SEAMEO INNOTECH Regional Education Program

School Health Care and Nutrition in Primary Schools in Southeast Asia: Policies, Programs, and Good Practices



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School Health Care and Nutrition in Primary Schools in Southeast Asia:
Policies, Programs, and Good Practices

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FOREWORD

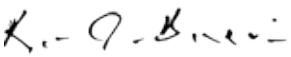
Member countries of the Southeast Asian Ministers of Education Organization (SEAMEO) consider school health care and nutrition (SHCN) as crucial to improving quality and access to education. Ministries of education have been working with nongovernment, government, and international organizations to promote increased health and nutrition services in schools through various programs and initiatives.

SEAMEO INNOTECH recognizes this convergence of education with health and nutrition issues and has declared this as a strategic program priority under its 8th Five-Year Development Plan for 2011-2016. Pursuant to its research agenda, SEAMEO INNOTECH conducted a two-phase study on School Health Care and Nutrition in Primary Schools in Southeast Asia. Phase 1 reviews current national policies, frameworks, and programs implemented in support of SHCN in seven member countries: Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines and Thailand. Meanwhile, Phase 2 presents case studies of selected primary schools with good SHCN programs and practices in six countries: Indonesia, Myanmar, Philippines, Singapore, Timor-Leste, and Vietnam. This publication presents the findings from both phases of the regional study.

Research findings show that SHCN implementation in the seven countries covered in Phase 1 of the study is strengthened by the existence of many national policies and frameworks on health and education, and that particular conditions such as adequate funding, strong leadership, and adequate human resources lead to successful SHCN implementation. However, the study also identified challenges that should be addressed such as lack of parent engagement, insufficient funding, and unsustained behavior change in students.

The case studies of primary schools in the countries featured in Phase 2 of the study reveal that what education ministries consider as successful SHCN implementation varies among countries, as schools visited had varied levels of access to financial and human resources, hygiene promotion facilities, and support from parents and other stakeholders. Nevertheless, majority of the programs in the schools visited reflect how national SHCN initiatives are implemented at the school level and even customized to adjust to the available resources and students' needs. Principals of schools with successful SHCN programs generally take a needs-based approach when choosing which SHCN programs to prioritize. This shows that school-based management can be a good vehicle for implementing responsive and quality SHCN programs and must therefore be strengthened further.

SEAMEO INNOTECH hopes that through this report, more education professionals will recognize the importance of promoting and protecting the overall health and well-being of students in Southeast Asia. More importantly, it is hoped that the findings from the study will support SEAMEO member countries in their efforts to strengthen their SHCN policies, address current challenges to effective SHCN implementation, and ultimately close the gap between SHCN as envisioned in national education and health plans and how it is actually implemented in districts and schools.



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The team behind this report on SHCN implementation in primary schools in Southeast Asia was led by former Senior Specialist and Educational Research Unit (ERU) Head Dr Ethel Agnes Pascua-Valenzuela, and comprised of Donalyne Rasalan Lampa, Cristina V. Moreno, Elaissa Marina E. Mendoza, Ralf Panse, Cecilia A. Andres, Merjielyn M. Calimag, May Ann V. Garay, and Nicole M. Asedillo. Current ERU head, Dr. Sherlyne A. Acosta, also provided some inputs to the final draft of the report. They all worked under the guidance of SEAMEO INNOTECH Center Director Ramon C. Bacani and Educational Research and Innovation Office (ERIO) Manager Philip J. Purnell.

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ACRONYMS AND ABBREVIATIONS

3K	*Kebersihan, Kesihatan, Keselamatan* (Malaysia's Health Promoting School Program)
ADB	Asian Development Bank
AED	automated external defibrillator
ASCD	Association for Supervision and Curriculum Development
ASCC	ASEAN Socio-Cultural Community
ASEAN	Association of Southeast Asian Nations
Banuyo ES	Banuyo Elementary School
BESRA	Basic Education Sector Reform Agenda
BMI	Body Mass Index
BNC	Barangay Nutrition Council
CARE	Children Active in Recreation and Exercise
CCT	Conditional Cash Transfer
CDC	Centers for Disease Control and Prevention
CIED	Community Integration for Education Development
DA	Department of Agriculture
DENR	Department of Environment and Natural Resources
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DPWH	Department of Public Works and Highways
DSWD	Department of Social Welfare and Development
ECD	Early Childhood Development
ECCE	Early Childhood Care and Education

EDF-Lao	Education for Development Fund - Lao
EDP	Endeavour Primary School
EENT	Eyes, Ears, Nose, and Throat
EFA	Education for All
EHCP	Essential Health Care Program
E-PAL	Endeavour Program for Active Learning
EQS	Education Quality Standard
ESAO	Education Service Area Office
ESP	Education Strategic Plan
ESV	External Safety Validation
F. Benitez-Main	Francisco Benitez Elementary School - Main
FFS	Fit for School
FGD	Focus Group Discussion
FNRI	Food and Nutrition Research Institute
GDP	gross domestic product
GIZ	Gesellschaft für Internationale Zusammenarbeit
GO	government organization
GPTA	General Parent-Teachers Association
HCS	Healthier Choice Symbol
HDB	Housing and Development Board
HE	Health Education
HEF	health education fund
HFA	Health for All
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HKP	Healthy Kids Programme
HNC	Health and Nutrition Center
HPB	Health Promotion Board

HPS	Health Promoting School
HSS	Healthier Snack Symbol
ID	identification card
IDRC	International Development Research Centre
IGO	Inter-governmental Organization
IGP	income generating project
INGO	international non-governmental organization
ISHN	International School Health Network
ISHP	Integrated School Health Program
J&J	Johnson & Johnson
JICA	Japan International Cooperation Agency
KAHP	Korea Association of Health Promotion
KKM	*Kementerian Kesihatan Malaysia* (Malaysia's Ministry of Health)
KPM	*Kementerian Pendidikan Malaysia* (Malaysia's Ministry of Education)
LGU	Local Government Unit
LSE	Life Skills Education
MAFF	Ministry of Agriculture, Forestry and Fisheries
MAPEH	Music, Arts, Physical Education, and Health
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MEWR	Ministry of the Environment and Water Resources
MHO	Municipal Health Office
MOE	Ministry of Education
MOE	Maintenance and Other Expenses (a type of DepEd fund)
MOEC	Ministry of Education and Culture
MOES	Ministry of Education and Sports
MOET	Ministry of Education and Training

MoEYS	Ministry of Education, Youth and Sport
MOH/MoH	Ministry of Health
MOHA	Ministry of Home Affairs
MOIA	Ministry of Internal Affairs
MORA	Ministry of Religious Affairs
MPH	Ministry of Public Health
MPH	multi-pupose hall
MRD	Ministry of Rural Development
NAPFA	National Physical Fitness Award
NCCTC	National Coordinating Committee for Tobacco Control
NCD	non-communicable disease
NCR	National Capital Region
NDRRMC	National Disaster Risk Reduction and Management Council
NEA	National Environment Agency
NGO	non-governmental organization
NGP	National Greening Program
NIN	National Institute of Nutrition
NMM	Nutrition Month Malaysia
NSHP	National School Health Policy
NSM	Nutritional Society of Malaysia
OIC	officer-in-charge
PAGASA	Philippine Atmospheric, Geophysical and Astronomical Services Administration
PAL	Program for Active Learning
PBES	Padre Jose Burgos Elementary School
PDA	Philippine Dental Association
PE	Physical Education
PESEB	Physical and Sports Education Branch

PLTS	Pupil-Led Total Sanitation
PMT-AS	*Pemberian Makanan Tambahan pada Anak Sekolah*
Project BANUYO	Project *Batang malinis at Ayos ang NUtrisyon Yaman ng Organisayon*
Project FEED	Project Food for Excellent Education and Development
PT	Pei Tong Primary School
PT	Physical Training
PTA	Parent-Teacher Association
PTCA	Parent-Teacher-Community Association
Puskesmas	*Pusat Kesehatan Masyarakat* (Indonesia's Primary Health Care Center)
RAMS	Risk Assessment Management System
RMNCAH	Reproductive Maternal Neo-Natal Child Adolescent Health
RMT	*Rancangan Makanan Tambahan* (Malaysia's School Feeding Program)
SARS	Severe Acute Respiratory Syndrome
SBF	School-Based Feeding
SBFP	School-Based Feeding Program
SBM	School-Based Management
SCI	Save the Children International
SCPC	Special Committee for the Protection of the Child
SDG	Sustainable Development Goal
SEAMEO INNOTECH	Southeast Asian Ministers of Education Organization Regional Center for Educational Innovation and Technology
SEAMEO RECFON	Southeast Asian Ministers of Education Organization Regional Centre for Food and Nutrition
SHCN	School Health Care and Nutrition
SHD-BLSS	School Health Division-Bureau of Learner Support Services
SHP	School Health Promotion
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SMHF	Sasakawa Memorial Health Foundation
SMK	*Sekolah Mempromosikan Kesihatan* (Brunei's Health Promoting School Unit)
SOP	standard operating procedure
SPED	Special Education
SSU	School Safety Unit
STH	Soil-Transmitted Helminth
Swiss TPH	Swiss Tropical and Public Health Institute
TB	Tuberculosis
TTC	Teacher Training College
UKS	*Usaha Kesehatan Sekolah* (Indonesia's School Health Program)
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
YCDC	Yangon City Development Council

GLOSSARY OF TERMS

Regional Profile is a brief profile of Southeast Asia in terms of SHCN implementation. This includes the number of primary schools and students enrolled in the region, the percentage of primary students suffering from various health conditions, the availability of facilities and staff dedicated to student health and nutrition, and the kinds of health care and nutrition programs currently rolled out in primary schools.

Policy is the general term for government-issued resolutions, plans, and guidelines adopted to achieve a society's overall health care[1] and nourishment[2] objectives. This includes specific decrees, regulations, and programs implemented as a result of the policy.[3]

School Health Care and Nutrition refers to services or interventions implemented in schools or other education systems as well as factors in the school environment which are designed to improve and maintain student health and well-being, and is made up of the following components[4]:

> **Counseling, Psychological, and Social Services** are services designed to prevent problems early on and enhance healthy development, such as individual and group assessments, interventions, and referrals.
>
> **Family and Community Involvement** is an integrated school, parent, and community approach for enhancing the health and well-being of students.
>
> **Health Education** refers to classroom instruction that addresses the physical, emotional, mental and social aspects of a student's health.
>
> **Health Promotion for Staff** is composed of opportunities that encourage school staff to pursue a lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program.
>
> **Health Services** includes all preventive services, education, emergency care, referrals, and management of acute and chronic health problems which are designed to ensure care for students.
>
> **Healthy and Safe School Environment** refers to the physical and aesthetic surroundings and the psychosocial climate and culture of the school.

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1 WHO, "Health Policy," http://www.who.int/topics/health_policy/en

2 Olivier Ecker and Mackie Nene, *Nutrition Policies in Developing Countries: Challenges and Highlights, International Food Policy and Research Institute*, (Washington, D.C.: International Food Policy Research Institute, 2012), p. 1, http://www.ifpri.org/sites/default/files/publications/nutritionpolicies_pn.pdf

3 Ibid.

4 Components adapted from CDC, *School Health Index*.

Nutrition Services is the integration of nutritious, affordable, and appealing meals; nutrition education; and an environment that promotes healthy eating.

Physical Education refers to the planned sequential K-12 curriculum that promotes lifelong physical activity and develops basic movement skills and sports skills.

Successes are factors that contribute to the smooth implementation of SHCN programs in primary schools.

Challenges refer to the factors that make the implementation of SHCN programs difficult or impossible.

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EXECUTIVE SUMMARY

Overview

The focus of School Health Care and Nutrition (SHCN) in recent decades has shifted away from preventing diseases and towards promoting and protecting the health and well-being of all pupils, particularly those who are poor and vulnerable. As a result, SHCN programs have successfully led not only to improved student health and performance but also to increased chances for disadvantaged children to attend and finish school.

Given this well-established link between student performance and their health and nutrition, countries in Southeast Asia have been working with non-government, government, and international organizations to develop, fund, implement, and monitor school-based health and nutrition programs. Many of these school health initiatives target grade school students, as the primary school system has been the main channel for delivering basic health and nutrition services to children.

Photo credit: SEAMEO INNOTECH

Taking the perspective that effective SHCN is crucial to improving quality of and access to education in the region, this report looks at the extent to which the following components of SHCN are addressed in primary schools in Southeast Asia:

- *Healthy and Safe School Environment* which covers the school's physical environment, access to WASH (water, sanitation and hygiene) facilities, psychological climate, and overall culture;
- *Health Education* which refers to classroom instruction addressing the physical, emotional, mental and social aspects of student health and well-being;
- *Physical Education* which refers to the planned sequential curriculum aimed at promoting physical activity and fitness as well as developing sports skills among students;
- *Nutrition Services* which pertain to all efforts to promote healthy eating among students both inside and outside the school;
- *Health Services* which include programs, emergency protocols, and nursing and dental services designed to prevent health problems and injuries and ensure care for students;
- *Counseling, Psychological, and Social Services* which aim to prevent mental and emotional problems early on and enhance healthy development;
- *Health Promotion for Staff* which covers school programs that encourage school staff to lead healthy lives and support the school's overall coordinated health program; and
- *Family and Community Involvement* which refers to all efforts by the school to elicit SHCN support from the students' families and the surrounding community.

Key Findings

1. **SHCN-Related Data.** Southeast Asian countries represented in Phase 1 of the study tap both Ministries of Education and Health (MOE/MOH) to routinely gather pupil health data and other information relevant to SHCN implementation, with the exception of Brunei Darussalam which collects pertinent statistics only through its MOH. The kind of data gathered varies among countries, but governments mainly collect percentage data on pupils afflicted with certain illnesses or conditions, schools with health- and nutrition-related resources, and schools where particular SHCN programs are being implemented.

2. **Common SHCN Problems.** Health and nutrition concerns among grade school students differ from country to country. The most common SHCN problems in the countries represented in Phase 1 of the study are underweight and dental problems, followed by overweight, and then EENT (eyes, ears, nose, and throat) problems and water- and sanitation-related illnesses. The findings particularly on underweight and dental problems tie in with data from the Southeast Asian Ministers of Education Organization Regional Centre for Food and Nutrition (SEAMEO-RECFON) which reflect that many children in Southeast Asia who experience nutritional problems suffer from undernourishment and worm infestation.

3. **Supporting SHCN at the National Level.** SHCN initiatives in Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines and Thailand are mandated by specific provisions in the country's Constitution, administrative orders and memoranda released by particular ministries, and national and local health and

education policies. Government-issued resolutions are anchored on national education or strategic development plans or drafted in response to calls from the international community to support Education For All (EFA) goals or Millennium Development Goals (MDGs). There are legal policies addressing the components of *Healthy and Safe School Environment, Health Services, Physical Education, and Health Education* in all seven countries surveyed for Phase 1 of the study. Most have explicit laws and regulations addressing *Counseling, Psychological, and Social Services*, while *Health Promotion for Staff and Family and Community Involvement* are the components receiving the least attention in the current health and education policies in Southeast Asia.

4. SHCN Policies and Programs, and Main Implementing Agencies

Brunei Darussalam. It is part of Brunei Darussalam's Strategic Plan for 2012-2017 to nurture the minds and bodies of Bruneian children through quality and holistic education. In pursuit of this goal, various SHCN programs have been rolled out in primary schools. Primary students undergo periodical health check-ups, weight and height monitoring, and annual screenings for various health disorders. Physical Education (PE) is mandated in all schools, and there are also feeding schemes and oral health care programs. Several agencies of Brunei Darussalam's Ministries of Education and Health (MOE/MOH) work together to administer SHCN programs, but the MOE's School Health Promotion Unit has an overarching role in SHCN implementation nationwide. This agency coordinates with other government agencies and ministries in rolling out and monitoring health promotion and school safety programs.

Cambodia. Two of Cambodia's SHCN-related laws are the 2006 Policy on Child Friendly Schools and the 2009 Policy on School Health. The former lays down a framework for upholding the basic rights of Cambodian children and ensuring student health, safety, and protection. In addition, the Policy on School Health has been enacted to improve the health status of schoolchildren, teacher trainees, and other school staff in all


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public and private educational institutions. It is expected that this, in turn, will lead to improved education outcomes in Cambodia. PE in Cambodian primary schools, for example, is integrated in the students' regular schedule. A national deworming program has also been rolled out, and the national government has looked into monitoring the food sold in school canteens, delivering basic child health care, and improving access to clean food and drinking water in schools. The Ministry of Education, Youth and Sport's School Health Department is the primary implementing unit for Cambodia's SHCN programs. It works closely with an inter-ministerial school health working group composed of representatives from various government ministries, local agencies, and nongovernment organizations (NGOs).

Indonesia. The main objective of Indonesia's Usaha Kasehatan Sekolah (UKS) or School Health Program is to improve the quality of education in the country by protecting the health of pupils and providing them with an environment wherein they can easily focus on learning. Programs implemented in primary schools under this overarching framework include garbage disposal schemes, school feeding, handwashing and oral hygiene campaigns, information drives against smoking and drugs, and periodic dental health assessment. The program is jointly implemented by the Ministry of Education and Culture, the Ministry of Health, The Ministry of Religious Affairs, and the Ministry of Internal Affairs. The first three are tasked with administering and evaluating SHCN programs in both non-sectarian and Muslim primary schools, while the last ministry in the list is in charge of the human resources, budget, and infrastructure needed for proper SHCN implementation.

Lao PDR. Representatives from international organizations and the country's ministries of education and health drafted the first version of Lao PDR's National School Health policy in 2005, whose main objective is to improve the health status, increase enrolment, and reduce absenteeism and dropout rates for pre-primary and primary students. The policy was revised in 2010 and the current version's concept of school health is composed of seven components: personal hygiene and life skills, physical school environment, psycho-social school environment, disease control and prevention, health care services, nutrition promotion, and cooperation between school and community. This policy has led to school health initiatives such as the Fit for School (FFS) and Water and Sanitation (WASH) programs, the development of a health resource kit for primary teachers in Lao PDR, and campaigns to promote respect and nondiscrimination in schools and the larger community. The Ministry of Education and Sports and the National School Health Taskforce are the main implementing agencies of SHCN programs in Lao PDR. They often work together with the provincial and district governments, school communities, international agencies, and NGOs.

Malaysia. SHCN implementation in Malaysia is supported by the National Education Blueprint 2013-2025, earlier policy documents on Health Promoting Schools, Malaysia's current national health promotion program, and the 1996 and 2010 versions of the Education Act. Health and nutrition programs such as Safe Schools, Healthy Kids, and One Child

One Sport are currently implemented in Malaysian primary schools. Malaysia also has a national school feeding program and a network of mobile health and medical teams which monitor student health, give dental and medical treatment, and administer deworming and vaccination programs, among others. SHCN programs are administered primarily by Malaysia's MOE and MOH, but depending on the health initiative being implemented, they often engage the help of other government agencies, local councils, parent-teacher associations (PTAs), NGOs, and partners from the private sector.

Philippines. The enabling policy environment for SHCN implementation in primary schools in the Philippines is particularly strong, as the Department of Education (DepEd) has issued and implemented numerous orders and memoranda governing the implementation of school-based health initiatives. The promotion and protection of the physical, intellectual, psychological, and social well-being of Filipinos are also enshrined in the 1987 Philippine Constitution, while Executive Order 117 s. 1987 established what used to be the Health and Nutrition Center (HNC) and is now the School Health Division - Bureau of Learner Support Services (SHD-BLSS), the Department of Education (DepEd) agency primarily responsible for delivering health and nutrition education and services to students. SHD-BLSS works with other ministries, government offices, local councils, international aid agencies, and private donors in rolling out SHCN programs in primary schools. Some SHCN initiatives in the Philippines include the Essential Health Care Package program, the WASH program, antidrug and dengue prevention campaigns, and in-school feeding programs.

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Thailand. Following recommendations from the World Health Organization, Thailand has been placing greater emphasis on health education and environmental sanitation in schools. It has been implementing various programs to turn its primary schools into Health-Promoting Schools. For example, undernourished students are fed through the School Lunch Program and the School Milk Project. There are also programs promoting lavatory sanitation, food safety, and dental hygiene. Campaigns to reduce sugar intake and increase consumption of vegetables among students have also been implemented. These school-based health efforts are spearheaded by the MOE which, in turn, enlists the help of other government agencies, national and international groups, and nonprofit organizations.

5. **Good Practices.** Findings from the school case studies from Indonesia, Myanmar, Philippines, Singapore, Timor-Leste, and Vietnam show that many of the programs implemented at the school level are driven and guided by national SHCN policies and strategies, but that the region's decentralized approach to school management allows principals and school heads to 1) choose which programs to prioritize based on the health and nutrition status of their students, 2) customize implementation to best address the school's and community's pressing needs, and 3) craft and implement original SHCN programs to address health and nutrition concerns not covered in the national education or health agenda. Good practices emerging from Phase 2 of the study touch on almost all of the eight SHCN

components, with most focusing on *Nutrition Services, Health Services, and Health Education*. On the other hand, there was no country good practice targeting the *Health Promotion for Staff* component, and most of the existing programs addressing this SHCN component are initiated by individual faculty or staff members instead of embedded in the school's overall SHCN plan.

6. **Successes.** The factors considered to be most crucial to the successful implementation of SHCN programs in primary schools are *effective collaboration between government agencies and strong partnership with different stakeholders*. *Strong policy support and adequate program funding, when available,* also go a long way in ensuring the success of the school's SHCN programs. Also worth noting is the combination of *strong leadership and adequate human resources*, as both are crucial to the success of SHCN particularly at the school level. Some respondents also believe that *solid community support* is key to achieving student health and nutrition targets, while others think that a *holistic and functional monitoring and evaluation (M&E) scheme* is necessary for effective SHCN implementation.

7. **Challenges.** Southeast Asian countries also face conditions which impede successful SHCN implementation in the region. Although already being done, *coordination within and among government agencies can still be improved*. *Limited or insufficient funding* is also a major challenge for some countries, particularly because some of the health and nutrition programs are funded by international aid or private donors. Related to this is the *inadequacy of SHCN facilities* in schools to support effective program implementation, particularly in schools with large student-to-staff ratio. In addition, the *compensation package for school staff is not attractive enough* in a few of the countries to motivate the best licensed professionals to pursue a career in school-based healthcare, while the limited career path is also a disincentive for others. Some also voiced out the *need for more SHCN-targeted professional development opportunities* so that they themselves can be better program implementers. Another common challenge is *lack of full support from the parents of students*, particularly when parents themselves are indifferent to health and nutrition concerns. *Students themselves also lose interest in SHCN* at times, and this often manifests in the *lack of success among schools when it comes to sustaining positive behavior change* in their students.

Recommendations

School principals, head teachers, and ministry officials surveyed for this study offered the following recommendations which could help improve SHCN implementation in primary schools in Southeast Asia:

- **Foster a strong policy environment that encourages inter-sectoral collaboration and helps realize the sustainable development goals (SDG) on ensuring healthy lives, promoting well-being, and providing inclusive and quality education for all.** MOEs should work to establish a policy environment that engenders collaboration among stakeholders and active teacher and student involvement in program implementation. Moreover, the global commitment to take steps to provide adequate healthcare, particularly to the disadvantaged, should also be reinforced.

- **Improve SHCN implementation in the region's primary schools by strengthening operationalization of Focusing Resources on Effective School Health (FRESH), a widely adopted framework for utilizing primary schools as the main channel for delivering basic health and nutrition services to children.** Because funding for child healthcare in many countries in Southeast Asia is insufficient, it makes sense for governments to aim to craft and implement policies that promote and protect the health of everyone at school and ensure that they have access to a clean environment, skills-based health education, and simple yet cost-effective health and nutrition services delivered through the school system.

- **Thoroughly consider implementation concerns during policy formulation.** The facilitation of rapid and large-scale implementation of school-based health and nutrition programs should already be considered early on and throughout the policy formulation process instead of as an afterthought after programs are already being rolled out. Right from the start, MOEs should already be looking for strategies to ensure and maintain quality in the delivery of SHCN programs as they are scaled up.

- **Strengthen capacity-building efforts at the school level.** Representatives from each country's MOH can conduct workshops to adequately train school staff and teachers on their respective countries' national health standards. Training sessions on school-based management can also be held for school heads so they can hone their skills on designing, implementing, and managing SHCN programs and projects within education systems which are increasingly becoming more and more decentralized. Opportunities for knowledge sharing on SHCN among school heads through cluster meetings and other peer-to-peer learning exchanges should also be encouraged and supported.

- **Allot a bigger budget for school-based health and wellness initiatives.** Central governments should make the implementation of effective, timely, and cost-efficient school-based health programs a priority, and government funding allotted to SHCN should reflect that. For countries following a decentralized governance structure, provincial and/or district governments should allocate regular budgets to cover the majority of material costs involved in delivering school health and nutrition interventions.

- **Strengthen efforts to integrate health promotion and wellness into the curriculum whenever possible.** Integrating health and nutrition topics into communication arts, science, or social studies lessons can reinforce what students learn about how to best take care of themselves and thus, help them retain this information. This approach may prove to be more effective in promoting health and wellness than conducting one-off community parades, sports fest, or contests which often require classes to be called off for a few hours or the whole day.

- **Expand on simple, scalable, and sustainable school-based health initiatives.** Many of the common health problems of grade-school children can be avoided if they consistently observe good hygiene, so there is a need to expand on SHCN efforts, such as or similar to the Fit for School (FFS) program, that promote hand washing, toothbrushing, deworming, and sanitary practices.

- **Engage pupils as active partners in implementing SHCN programs.** A good number of established and successful SHCN initiatives in the region provide students with opportunities to become health ambassadors and student leaders. Apart from the WASH in Schools program in which students are asked to help teachers supervise group activities such as handwashing and teach proper hygiene to their younger counterparts in school, programs such as Indonesia's "Little Doctors" and the Philippines' "Pupil-Led Total Sanitation" (PLTS) show that when students are given the chance, they can be effective change agents in their respective schools and communities instead of just being mere beneficiaries of the SHCN initiatives.

- **Encourage parents and other members of the school community to become more involved.** Efforts to enlist the support and increase the participation of all stakeholders should continue. Schools can work more with the PTA, local government officials, and other NGOs to increase parent and community engagement.

- **Strengthen school-based management (SBM) and inter-sectoral collaboration.** SBM can be an effective vehicle to implement responsive, quality SHCN programs, particularly if these are anchored on strong school-community partnerships as advocated by the FRESH framework. Involving stakeholders beyond those in the school and further intensifying collaboration with them can help make SHCN initiatives more effective and sustainable. Apart from education and health ministries, local government units (LGUs), nongovernment organizations (NGOs) and even sanitation and social protection agencies should also be engaged as partners as this could also help ensure successful SHCN implementation. The multi-stakeholder approach towards implementing SHCN would also give schools a wider support base from which to seek assistance and with which to share accountability. Representatives from the different agencies can hold quarterly coordination meetings, and a central online portal where everything can be updated, coordinated, and monitored may also help align efforts within and among government offices.

- **Strengthen monitoring and evaluation (M&E) systems and use data for benchmarking purposes as well as to plan and design SHCN program assessment.** To encourage accountability and further engage school administrators and project managers, countries should develop or enhance assessment systems to monitor and evaluate the impact and success rate of school-based health programs. A comparison of results among different schools can also be done in order to identify best practices and common pitfalls.

- **Conduct further studies to help stakeholders better overcome the challenges to successful SHCN implementation.** School heads and education ministry officials in Southeast Asia have reported finding it difficult to enlist genuine engagement from the community, generate enough funds, and sustain behavior change in their students. As such, future research endeavors can look into cases of particular schools and countries that have successfully overcome such hurdles in their implementation of health and nutrition initiatives from school-aged children. Education ministries can look into effective approaches to best support primary students in the region to translate their awareness of and learnings on health and wellness to good habits that they will continue to practice inside and outside of school.

Photo credit: SEAMEO INNOTECH

PART 1
INTRODUCTION

OVERVIEW

Background and Rationale

When world leaders gathered in Jomtien, Thailand in March 1990 for the World Conference on Education for All (EFA): Meeting Basic Learning Needs, health and nutrition were identified to be important contributors to the success of learners and the learning process. Many studies have shown that the state of health and nutrition of learners affect their school performance.[5] For instance, "nutritional deficiencies, helminth infections and malaria affect school participation and learning"[6] of children. "Iron deficiency can shorten a child's attention span, alertness and ability to concentrate."[7] "Hunger can also interfere with a learner's concentration at school."[8] This may explain why school breakfast programs have been found to improve the academic performance and cognitive functioning of severely undernourished students.[9] On the other hand, most recent studies have shown obesity to have a negative impact on the academic performance of school-aged children. "Students who are overweight are more likely than healthy students to report

5 UNESCO, *Thematic Studies: School Health and Nutrition* (Paris, France: Author, 2001), http://portal.unesco.org/education/en/files/37521/11032054493Thematic_Study_on_School_Health_and_Nutrition.pdf/Thematic%2BStudy%2Bon%2BSchool%2BHealth%2Band%2BNutrition.pdf.

6 Ibid, p. 4

7 Christine Reifeiss, "Nutrition and School Performance," last modified January 28, 2015, http://www.livestrong.com/article/353954-nutrition-and-school-performance/.

8 Ibid.

9 Howard Taras, "Nutrition and Student Performance at School," *Journal of School Health* 75, no. 6 (August 2015): pp. 199-213, doi: 10.1111/j.1746-1561.2005.00025.x

impaired school functioning. For younger children, math and reading scores were found to be lower in overweight students."[10] Thus, based on these findings, education authorities are led to conclude that healthy children stay in school longer, attend classes regularly, and learn better.

The Southeast Asian Ministers of Education Organization Regional Center for Educational Innovation and Technology (SEAMEO INNOTECH) recognizes the significance of the convergence of education with health and nutrition issues. This area has become one of its programmatic strategic priorities under its 8th Five-Year Development Plan (FYDP) 2011 to 2016, which was approved during the Center's 52nd Governing Board meeting in September 2009 held in Brunei Darussalam. The Center foresees that "pandemics such as HIV/AIDS and AH1N1 and critical health-related issues such as nutrition, sanitation, water values, reproductive health, ageing, etc. will increasingly impact on and require responses from education systems, particularly schools,"[11] since empirical findings have already shown a significant relationship between health/nutrition issues and education dimensions such as students' access to basic education services and quality of their learning experience, among others.

Furthermore, in its "Competency Framework for Southeast Asian School Heads," the Center also identified "promotion of primary health care" as one of the competencies that school heads must possess in order to lead 21st century schools. This role is more emphasized given that some studies also found that "school-based nutrition and health interventions can improve academic performance."[12]

The Ministries of Education (MOEs) of the member countries of the Southeast Asian Ministers of Education Organization (SEAMEO) also consider school health care and nutrition as important dimensions to improve quality and access to education. Some MOEs partner with nongovernment, government, and international organizations to promote increased health and nutrition services in schools. Some interventions include programs such as deworming, micro-nutrient supplementation, control of malaria, and vision/hearing screening. Other MOEs attend to programs that increase access to safe water, sanitation, and hygiene in schools. Some initiatives promote healthy lifestyle and behavior through skills-based education. However, many of these school health care and nutrition policies and programs have not been extensively studied and thus, SEAMEO member countries have historically not benefitted from a systematic comparative research.

To address this gap, the Educational Research Unit of SEAMEO INNOTECH conducted a study of national policies, frameworks, and programs related to school health care and nutrition (SHCN) and visited selected primary schools identified by education ministries as having successfully implemented SHCN practices. The study only focused on primary schools because this is the most crucial stage since success in the primary level can determine success in succeeding levels of education. This research is expected to provide a regional perspective towards the development of a SHCN agenda for primary schools in Southeast Asia.

10 Jenny Hildenbrandt, "Link Between Nutrition and Academic Performance," accessed August 26, 2010, http://suite101.com/article/link-between-nutrition-and-academic-performance-a278743.

11 SEAMEO INNOTECH, "8th Five Year Development Plan (2011 to 2016)," 30.

12 UNESCO, *Thematic Studies: School Health and Nutrition*

Objectives of the Study

The main purpose of this research is to examine the state of SHCN implementation in primary schools in Southeast Asia by answering the following research questions:

1. What policies currently exist to support SHCN in primary schools in Southeast Asia, and what are some of the related SHCN programs that have been implemented?

2. Which of the following SHCN components are addressed in primary schools in Southeast Asia, and to what extent?

    a. Healthy and safe school environment

    b. Health education

    c. Physical education

    d. Nutrition services

    e. Health services

    f. Counseling, psychological, and social services

    g. Health promotion for staff

    h. Family and community involvement

3. What are some of the good and successful SHCN initiatives in schools which other schools in the region can replicate, adapt, and/or learn from?

4. What are the successes and challenges experienced by Southeast Asian countries in implementing SHCN programs in primary schools?

School Health Care and Nutrition

The world has been working together to achieve school health goals for more than 120 years now, but in the last three decades, there has been a substantial shift in the global approach towards SHCN.[13] In the 1990s, school health was largely uncoordinated, took on a more medical approach, focused on disease prevention, and concentrated on centrally-located schools in urban areas. In addition, the focus of health education used to be on imparting scientific knowledge to students.[14] However, major changes began taking place when research studies in the 1980s found SHCN programs to be helpful not only in improving student health and well-being, but also in giving children coming from poor families better chances to attend and finish school.[15] As such, experts began to make the case for an approach towards SHCN that seeks to improve the health and well-being of all children, especially those who are poor and vulnerable.

Once the link between health and education outcomes had been established, health agencies and international organizations began to see that as an education intervention, SHCN programs have the potential to have the most impact on the poorest children and their families because it is usually the poor children who are stricken with diseases which impede learning and

13 Ibid.

14 Ibid.

15 Donald Bundy et al., "School-Based Health and Nutrition Programs," in *Disease Control Priorities in Developing Countries* 2nd Ed., ed. Dean T. Jamison et al. (Washington, D.C.: The International Bank for Reconstruction and Development/ The World Bank, 2006).

growth.[16] Prioritizing their health and nutrition also improves their capacity to benefit from formal schooling[17] while as healthy adults later on in life, they can also reap the economic benefits of joining the workforce and becoming productive members of society.[18] From a practical standpoint, administering basic health and nutrition programs through the established channels of an education system has proven to be cheaper and more cost-effective than to do the same via the health system.[19] For instance, a study on a school-based deworming program implemented in Kenya found teacher-delivered approaches to be just as effective and yet ten times cheaper than those delivered via mobile health teams.[20]

A significant step towards uniting global efforts to improve SHCN implementation was the development of a common framework called FRESH, which stands for Focusing Resources on Effective School Health.[21] Launched during the 2000 Education for All conference in Dakar, the FRESH framework is the result of the collective efforts of the World Health Organization (WHO); the United Nations Children's Fund (UNICEF); the United Nations Educational, Scientific and Cultural Organization (UNESCO); and the World Bank (WB). It was also designated as a primary strategy to help achieve EFA objectives.[22] The FRESH framework designates the primary school system as the main channel through which basic health and nutrition services for children will be delivered. Figure 1 outlines the core components of the FRESH framework which should be simultaneously present in all schools and the strategic partnerships necessary for effective implementation.

16 UNESCO, *Thematic Studies: School Health and Nutrition.*

17 Matthew H.C. Jukes et al., *School Health, Nutrition and Education for All: Levelling the Playing Field* (Oxfordshire, UK: CAB International, 2008).

18 UNESCO, *Thematic Studies: School Health and Nutrition.*

19 Ibid.

20 Helen Guyatt, "The Cost of Delivering and Sustaining a Control Program for Schistosomiasis and Soil-transmitted Helminthiasis," Acta Tropica 89, no. 2-3 (May 2003): 267-74, doi: 10.1016/S0001-706X(03)00047-0.

21 Bundy et al., "School-Based Health and Nutrition Programs."

22 UNESCO, *Thematic Studies: School Health and Nutrition.*

Figure 1. The FRESH (Focusing Resources on Effective School Health) Framework

Figure based on information on the FRESH Framework from UNICEF, *Focusing Resources on Effective School Health,* final report on the World Education Forum 2000, http://www.unicef.org/lifeskills/files/FreshDocument.pdf.

More specifically, these core components refer to a) policies that promote and protect overall health and well-being among students, teachers, and staff; b) access to clean water and adequate sanitation facilities for all; c) skills-based health education; and d) simple and cost-effective school-based health and nutrition services.[23]

The FRESH framework has brought about more coordination not only among international organizations but also between the health and education sectors as well as the individual schools and the communities they serve. FRESH has also played a major role in making health and nutrition initiatives more accessible and most beneficial to the poorest and most vulnerable children.[24] Table 1 summarizes some studies on SHCN in primary schools and their impact on students.

23 Bundy et al., "School-Based Health and Nutrition Programs."

24 UNESCO, *Thematic Studies: School Health and Nutrition.*

Table 1. Some Primary Studies on SHCN Programs

Author/s and Year	Country	SHCN Program	Participants	Primary Findings
Monse, Benzian, Naliponguit, Belizario Jr, Schratz, and Helderman, 2013	Philippines	Fit for School Project (Handwashing, Toothbrushing, Deworming, twice-a-year access to Urgent Oral Treatment)	Grade 1 students aged 6-7	The program's first year of implementation resulted in a rise in body mass index (BMI), a decrease in worm infections, and a reduction in dental caries among participants.
Courtney, 2007	Cambodia	Kampot School Health Project (School Health Day, Professional Development for School Directors and Teachers)	Students attending 51 schools in the Kampot region	Teachers noted that students started wearing footwear to school and washing their hands more regularly. Directors also reported having implemented procedures to ensure a safer school environment for everyone (providing trash bins and water for handwashing, setting up a system for cleaning latrines).
Miguel and Kremer, 2004	Kenya	Primary School Deworming Project	Primary school students aged 6-18	School-based deworming programs generally reduced absenteeism by 25 percent, with those belonging to the youngest and the most ill cohort recording the biggest improvement.
Simeon, 1998	Jamaica	Feeding	Primary school students aged 9-10 and 12-13	Participating classes attended school more regularly and raised their arithmetic scores compared to the control classes after one semester.

As outlined in the table, the 2004 study by Miguel and Kremer found that although school-based deworming programs reduced absenteeism among Kenyan primary school students in general by 25 percent, those belonging to the youngest and the most ill cohort before the treatments began recorded the biggest improvement in school participation.[25] Results of a school-based feeding program in Jamaica also showed that participating classes attended school more regularly and raised their arithmetic scores compared to the control classes after just one semester.[26] Moreover, schools which purposefully promote and protect the overall health and well-being of their students and staff enjoy higher academic performance.[27] In general, studies assessing SHCN programs have found that such interventions can increase student IQ levels by four to six points and school participation by 10 percent, as well as add one to two years of schooling among those in danger of dropping out.[28]

School-based programs aimed at reducing malnutrition and worm infections or encouraging students to practice better personal hygiene have also been effective in combating health issues,[29] and SHCN programs implemented in SEAMEO countries are no exception. In the Philippines, for example, a year-long implementation of the Fit for School (FFS) health program resulted in a rise in body mass index (BMI), a decrease in worm infections, and a reduction in dental caries among participating grade 1 students.[30] Meanwhile, in Cambodia, majority of survey respondents asked to evaluate the effectiveness of the Kampot School Health Project reported that after health day, students practice better hygiene and that directors have implemented procedures to ensure a safer school environment for everyone.[31]

Despite these positive developments, there are still difficulties to hurdle as governments, agencies, school systems, and civil society groups work together to implement and sustain school-based health and nutrition programs.[32] Local contexts need to be considered in the planning and design of initiatives, and this may mean differences in the way SHCN programs are delivered. For many countries in Southeast Asia, this may mean adopting interventions that rely mostly on the facilities and resources of the school instead of the health system, engaging the local community and civil society, and getting more educators to converse about student health and nutrition.[33]

25 Edward Miguel and Michael Kremer, "Worms: Identifying Impacts on Education and Health in the Presence of Treatment Externalities," *Econometrica* 72, no. 1 (January 2004): 159-217.

26 D.T. Simeon, "School Feeding in Jamaica: A review of its evaluation," *American Journal of Clinical Nutrition* 67 (1998): 7908-7948.

27 Charles Basch, *Healthier Students are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap*, (New York, USA: Columbia University, March 2010), http://www.equitycampaign.org/i/a/document/12557_EquityMatters-Vol6_Web03082010.pdf

28 Bundy et al., "School-Based Health and Nutrition Programs."

29 Kwok-Cho Tang et al., "Schools for health, education and development: a call for action," *Health Promotion International* 24, no. 1 (November 2008): 68-77, doi: 10.1093/heapro/da

30 Bella Monse et al., "The Fit for School health outcome study - A longitudinal survey to assess health impacts of an integrated school health programme in the Philippines," *BMC Public Health* 13, no. 1 (2013): 256, doi: 10.1186/1471-2458-13-256.

31 Jane Courtney, "Does Partnership and Sustainability Really Happen? A Case Study of an In-service Health Education Programme Implemented in One Province in Cambodia," *International Journal of Educational Development* 27 (2007): 625-636

32 Ibid.

33 Robert Valois, Sean Slade, and Ellie Ashford, *The Healthy School Communities Model: Aligning Health and Education in the School Setting* (USA: Association for Supervision and Curriculum Development, 2011)

It is in this context and amid these developments and challenges in the field of SHCN that this study was conducted. The perspective that school-based health and nutrition programs can promote access and achievement particularly among primary school students who come from poor families has also informed this research. It is hoped that through this report, more education professionals will see the importance of promoting and protecting the overall health and well-being of their students and, as a result, take part in professional discussions about the topic.

The Components of School Health Care and Nutrition

For this project, SEAMEO INNOTECH took note of the components of coordinated school health from the School Health Index for primary schools developed by the Centers for Disease Control and Prevention (CDC) and adapted them to form the components of school health care and nutrition. Table 2 enumerates the components as developed by CDC and as revised for this research study.

Table 2. CDC's Components of Coordinated School Health and SEAMEO INNOTECH's SHCN Components

CDC's Components of Coordinated School Health*	SEAMEO INNOTECH's SHCN Components
• School Health and Safety Policies and Environment • Health Education • Physical Education and Other Physical Activity Programs • Nutrition Services • School Health Services • School Counseling, Psychological, and Social Services • Health Promotion for Staff • Family and Community Involvement	• Healthy and Safe School Environment • Health Education • Physical Education • Nutrition Services • Health Services • Counseling, Psychological, and Social Services • Health Promotion for Staff • Family and Community Involvement

* from Centers for Disease Control and Prevention (CDC), *School Health Index: A Self-Assessment and Planning Guide. Elementary school version*. Atlanta, G.A.: 2014.

CDC drafted modules for each component to help schools identify policies that can best support school-based health programs and establish evidence-based health practices that promote and protect student well-being.[34] The operational definitions and indicators used in this research project were adapted from the component checklists drafted by CDC. Although an operational definition for school health care and nutrition is offered in the Glossary of Terms section, the eight components which make up this broad concept are further described below.

Healthy and Safe School Environment refers to the physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include access to water and sanitation facilities, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

Health Education is the classroom instruction that addresses the physical, emotional, mental and social aspects of health. It is designed to help students improve their health, prevent illness, and reduce risky behaviors.

Physical Education is the planned sequential K-12 curriculum that promotes lifelong physical activity and develops basic movement skills and sports skills. Physical education shall be the environment in which students learn, practice, and are assessed on developmentally appropriate motor skills, social skills, and knowledge.

Nutrition Services cover the integration of nutritious, affordable, and appealing meals; nutrition education; and an environment that promotes healthy eating.

Health Services refer to all preventive services, education, emergency care, referrals, and management of acute and chronic health problems which are designed to prevent health problems and injuries and ensure care for students. It can include school nursing as well as dental services and school-based/linked health centers.

Counseling, Psychological, and Social Services are services designed to prevent problems early on and enhance healthy development, such as individual and group assessments, interventions, and referrals.

Health Promotion for Staff is composed of opportunities that encourage school staff to pursue a lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program.

Lastly, **Family and Community Involvement** is an integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health fall under this component.

The specific indicators used to assess each component can be found in the last section under Results and on the school-level Survey on SHCN Programs in Primary Schools in Southeast Asia (Appendix B).

34 CDC, *School Health Index: A Self-Assessment and Planning Guide: Elementary school version* (Atlanta, Georgia: Author, 2012), http://www.cdc.gov/HealthyYouth/SHI/

Methodology and Research Framework

Figure 2. Research Design Framework

Primary data for this research took the form of (a) survey results, (b) country reports, (c) workshop proceedings, and (d) case studies; while (e) secondary sources included research studies, policy notes, and reference materials related to SHCN published by health and nutrition experts and international organizations such as UNESCO, UNICEF, and WHO. Figure 2 illustrates the research design employed in this study.

Survey data were collected via a questionnaire (Appendix A) on SHCN programs in primary schools in Southeast Asia which was distributed to education officials who oversee SHCN implementation in their respective countries. They provided national data such as statistics on students enrolled in primary schools, the percentage of students who are ill or malnourished, which health care facilities and support staff are available in primary schools, and any SHCN policies as well as programs which have been or are being implemented. Completed questionnaires were collected during the regional workshop on SHCN.

A regional research workshop entitled "School Health and Nutrition in Primary Schools in Southeast Asia: Policies, Innovations, Issues and Challenges" was also held from 29 to 31 July 2013 at SEAMEO

INNOTECH in Quezon City, Philippines. Education officials nominated by their respective countries to participate in the workshop presented their country reports on the state of SHCN implementation in their respective countries. The forum also served as a venue for the participants to interact with regional and international experts on implementing school-based health and nutrition programs. Workshop participants also took part in focus group discussions (FGDs) which enabled them to more deeply talk about their experiences in implementing SHCN programs, success stories, issues or challenges at various levels of implementation, and recommendations to help improve the delivery of SHCN services in the region and bring about a shared regional SHCN agenda.

To obtain data from countries that did not take part in the regional workshop, case studies were also conducted in schools identified by their respective education ministries as schools with good SHCN programs and practices. Case study documentation primarily involved qualitative approaches such as focus group discussions (FGD) and key informant interviews (KII) which delved into strategies and approaches to successfully adopt national SHCN initiatives or craft specific programs that address the health and nutrition needs of students in these particular schools. Observations and school tours were also done to gather additional data, and education ministry officials were also interviewed whenever possible.

Quantitative and qualitative data gathered from both primary and secondary sources were tallied, validated against each other, and analyzed for recurring or divergent themes in order to reveal possible regional trends in SHCN implementation. The results are presented in Part 2 of this report.

Scope and Limitations of the Study

This exploratory study looks into and compares the implementation of SHCN programs in Southeast Asian countries and limits itself to basic education, as success in this crucial stage of formal education can determine success in succeeding education levels. *Although all SEAMEO member countries are represented in this study, it should be noted that the first part of the report is based primarily on data from the seven countries that participated in the regional research workshop, presented their country reports, and participated in the survey:* Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, and Thailand. Moreover, *the section on good practices is based on scheduled visits to schools which were identified by the education ministries themselves and interviews with school heads and teachers who are themselves implementers of the SCHN programs as well as students who have been program beneficiaries.* As such, the information gathered is based on limited and subjective data, and should therefore neither be taken as representative of the schools for each country or reflective of the complete state of SHCN in Southeast Asia.

Photo credit: SEAMEO INNOTECH

PART 2
FINDINGS

REGIONAL PROFILE

Statistics on Primary Schools and Students

The national statistics on primary schools obtained from seven SEAMEO member countries reflect the diversity in the region, particularly in terms of population size and socioeconomic profile. Table 3 presents some relevant figures on primary schools in Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines and Thailand.

Table 3. National Population and Primary Schools and Enrolment in Seven Countries in SEA

Country	2014 Population* (millions)	Public Schools		Private Schools		Total		School-to-Student Ratio
		Number of Schools	Students Enrolled	Number of Schools	Students Enrolled	Primary Schools	Primary Students	
Brunei Darussalam	0.4	125	28, 919	89	16,127	214	45,046	1:211
Cambodia	15.4	6, 910	2,142,464	data not available	data not available	6,910	2,142,464	1: 310
Indonesia**	252.8	132,609	23,138,933	14,904	2,993,208	147,513	26,132,141	1:177
Lao PDR	6.9	8, 927	1,297,514	196	57,098	9,123	1,354,612	1:149
Malaysia***	30.2	7, 743	2,742,169	108	35,647	7,851	2,777,816	1:354
Philippines****	100.1	38, 659	13,273,325	10,157	1,236,365	48,816	14,509,690	1:297
Thailand	67.2	31,821	2,211,172	12,052	2,067,860	43,873	4,279,032	1:98

Data from 2013 Survey on SHCN programs in primary schools in Southeast Asia conducted as part of the study, except when more recent figures are available online.
* UNDP. *Human Development Report 2015*, http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf.
** MOEC. *Indonesia Educational Statistics in Brief 2014/2015*, http://publikasi.data.kemdikbud.go.id/../isi_0BCC909B-1F8E-43E5-BB98-4AE4E0C97BB3_.pdf.
*** MOE Malaysia. *Quick Facts 2013: Malaysia Educational Statistics*, http://data.gov.my/folders/KPM/Quicfacts2013.pdf.
**** PSA. *The Philippines in Figures 2014*, http://www.census.gov.ph/sites/default/files/2014%20PIF_0.pdf.

Brunei Darussalam has the least number of primary schools (214) and also has the smallest number of primary students (45,046), but its school-to-student ratio of 1:211 is only the third lowest among the countries surveyed. Thailand posted the lowest school-to student ratio, with one primary school available for every 98 students.

In contrast, Indonesia has the most number of primary schools (147,513) and also the highest number of elementary students (26,132,141). While this is the case, its student-to-school ratio is one of the lowest (1:177), as it is actually Malaysia which has the most number of students per primary school (1:354). The number of primary students varies greatly among the surveyed countries, although it bears noting that because information on private schools in Cambodia and their enrollees are not available, only figures pertaining to public primary schools in Cambodia were considered in this study.

Although primary education is provided free in all seven countries through the public school system, some parents choose to send their school-aged children to private primary schools. The percentage of children attending private primary schools is highest in Thailand at 48.3 percent, while the lowest figure is for the Malaysia, at a little over 1 percent. Brunei Darussalam and Indonesia have the second and third highest percentage of primary students attending private schools at 35.8 percent and 11.45 percent, respectively. About 8.5 percent of primary school students in the Philippines attend private schools, while the percentage of Cambodians attending private primary schools could not be computed due to lack of information.

SHCN Data on Primary Schools

All seven countries surveyed for this subsection routinely collect pupil health information and other data pertinent to implementing SHCN. Table 4 summarizes the agencies in charge of data collection and the frequency with which they undertake this endeavor.

Table 4. Agencies in Charge of Collecting SHCN Data and Frequency of Data Collection

Country	Frequency of Data Collection	
	Ministry of Education (MOE)	Ministry of Health (MOH)
Brunei Darussalam	not applicable	Annually
Cambodia	Annually	Annually
Indonesia*	Annually	Annually
Lao PDR	Annually	Annually
Malaysia	Quarterly	Monthly
Philippines	Annually	Annually
Thailand	Annually	Annually

Source: Survey on SHCN programs in primary schools in Southeast Asia - National level

* MOE Indonesia (2007). Lampiran perauran menteri pendidikan nasional nomor 24 tahun 2007, http://sayembara-iai.org/gallery/documents/sayembara-tipologi-sekolah-negeri-dki-jakarta/Lampiran%20Permen%2024%202007%20Standar%20Sarana%20Prasarana.pdf.

Photo credit: SEAMEO INNOTECH

With the exception of Brunei Darussalam which taps its MOH to collect information, SHCN-related data gathering in Southeast Asian countries appears to be the shared responsibility of the respective countries' Ministries of Education and Health. Table 4 shows that most countries gather information annually, whereas Malaysia's MOE (*Kementerian Pendidikan Malaysia* or KPM) and MOH (*Kementerian Kesihatan Malaysia* or KKM) gather data quarterly and monthly, respectively.

The kind of data gathered varies from country to country, but the data generally fall into three categories:

- percentage of pupils afflicted with certain illnesses or conditions;
- percentage of schools with health- and nutrition-related facilities and staff; and
- percentage of schools where particular SHCN programs are being implemented.

Under the first category, member countries primarily look into how many of their students are underweight, overweight, or malnourished as well as the percentage of their students who suffer from visual or hearing impairment, tooth decay, or worm infection. Regarding the second category, ministries of health and education routinely gather data on the percentage of primary schools with electricity, separate toilets for boys and girls, school canteens, and guidance counselors. Access to potable water and hand-washing facilities is also checked. For the last category, member countries monitor which schools roll out school-based programs aimed at addressing worm infections and dental hygiene problems among students.

Most Common SHCN Problems

Diversity characterizes the region when it comes to the most common SHCN problems in the surveyed countries. Table 5 lists the SHCN problems which member countries have identified to be the most prevalent.

Table 5: Most Common SHCN Problems by Country

Country	SHCN Problems					
	Underweight	Overweight	EENT Problems	Water- and Sanitation-related Illnesses	Skin Diseases	Dental Problems
Brunei Darussalam		X	X			X
Cambodia	X			X		X
Indonesia*	X	X				X
Lao PDR	X		X	X		
Malaysia	X	X			X	
Philippines	X			X		X
Thailand		X	X			X

Source: Survey on SHCN programs in primary schools in Southeast Asia - National level

* Indonesia MOH (2013). Riset kesehatan dasar (retrieved from http://www.depkes.go.id/resources/download/general/Hasil%20Riskesdas%202013.pdf)

At the top of the list of the most common SHCN problems is that of underweight primary students and students suffering from dental problems, with four out of six member countries considering them as most common. Data from the Southeast Asian Ministers of Education Organization Regional Centre for Food and Nutrition (SEAMEO-REFCON) support this finding, as it has found many school-aged children in Southeast Asia to be suffering from nutrition problems, mostly undernourishment.[35] In contrast, Brunei Darussalam, Malaysia and Thailand are battling the problem of overweight children. Malaysia is an interesting case because it has identified as a common problem the prevalence of both underweight and overweight children in the country.

Three countries (Cambodia, Lao PDR, and Philippines) consider water- and sanitation-related illnesses as a major SHCN concern. This ties in with SEAMEO-REFCON's conclusion that worm infestation continues to be a major health problem in the region.[36] A slightly different subset also composed of three countries (Brunei Darussalam, Cambodia, and the Philippines) has also identified dental problems as very common.

Problems with the eyes, ears, nose, and throat (EENT) rank third among the list of common SHCN problems, while Malaysia is the only country which identified the prevalence of skin diseases as a major health concern.

35 Drupadi H.S. Dillon, "Nutritional Status of School Children in SEA Region," (paper presented at the Regional Research Workshop on School Health Care and Nutrition in Southeast Asia, Manila, July 29-31, 2013)

36 Ibid.

SUPPORTING SHCN AT THE NATIONAL LEVEL

National and local governments of Southeast Asian countries have worked closely with schools and other implementing partners for decades in order to protect the health and well-being of their young citizens. The manner with which SHCN programs have been planned, funded, executed, and monitored may vary from country to country, but one thing these programs share is that they are often enabled by specific provisions in the constitution, administrative orders and memoranda released by the MOE, MOH or high government officials, and laws on health and education together with their implementing rules and regulations. These government-issued resolutions make up the national policies on which school-based health initiatives are anchored. This section delves into the legal bases for supporting and implementing SHCN programs in Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, the Philippines, and Thailand. The nature of the various SHCN programs implemented in these countries as a result of these laws and policies is also explored.

Brunei Darussalam

The Ministry of Education is also referred to as Kementerian Pendidikan, and is the agency primarily responsible for Brunei Darussalam's education system. It aims to achieve the country's vision of providing "quality education towards a developed, peaceful, and prosperous nation" by fulfilling its mission to "provide holistic education to achieve fullest potential for all."[37] The MOE's Strategic Plan 2012-2017 further states that quality and holistic education involves developing not only the intellectual and spiritual capacities of Bruneian children but also their physical attributes. In particular, the MOE hopes to nurture each student to have "a healthy body and mind."[38]

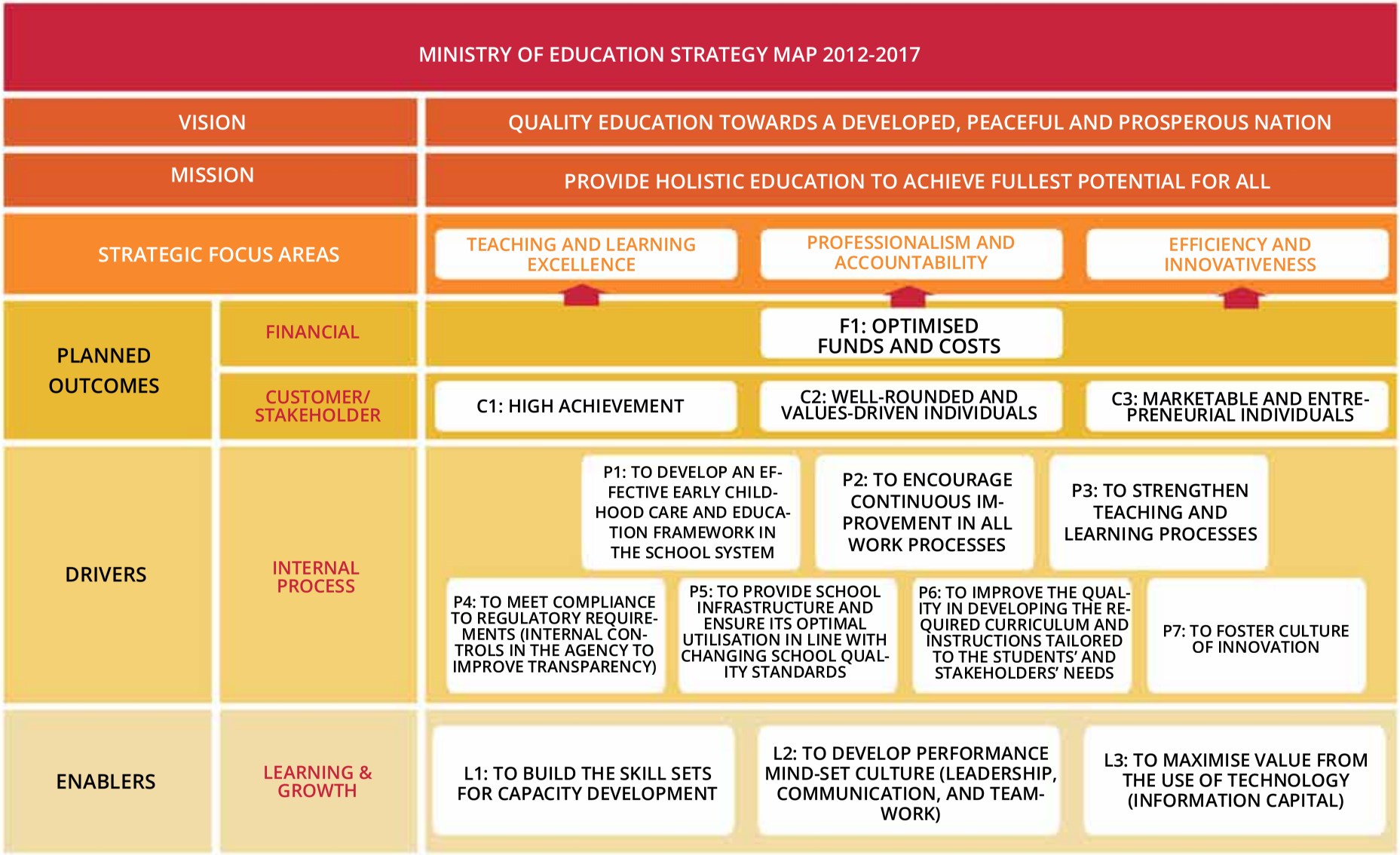
(CIA, 2015)

Figure 3 presents the core features of Brunei Darussalam's five-year strategic plan for education, which states that the MOE hopes to form individuals who are "well-rounded and values-driven."

37 Strategic Management Unit, Department of Planning, Development and Research, "The Ministry of Education Strategic Plan 2012-2017," (Brunei Darussalam: Brunei Darussalam MOE, 2012), 6-7, http://www.mosbn.com/strategicplan.pdf

38 Ibid.

Figure 3. Brunei Darussalam's Strategic Plan 2012-2017



Strategic Management Unit, Department of Planning, Development and Research (2012), *The Ministry of Education Strategic Plan 2012-2017*, Brunei Darussalam.

The ministry specifies the mastery of self-management skills as crucial to achieving this planned outcome, and to this end, it envisions schools as places where children can learn how to manage stress, lead a healthy lifestyle, and become more emotionally resilient.[39] Although school health care and nutrition is not explicitly stated in Brunei's current strategic plan for education, it is implied in the aforementioned references to health and mental wellness.

Several agencies of Brunei Darussalam's Ministries of Education and Health work together to administer SHCN programs. Units within the MOE include: 1) the School Feeding Scheme Unit of the Department of Administration and Services, 2) the Co-Curriculum Department, 3) the School Health Promotion Unit (*Sekolah Mempromosikan Kesihatan* or SMK) under the Department of Schools, 4) the Counseling and Career Guidance Section, and even 5) the Department of Planning and Estate Management. As for the MOH, the following agencies play a role in administering school-based health care: 6) the P*usat Promosi Kesihatan* or Health Promotion Center, 7) the School Health Services Unit, and 8) the Department of Dental Services.

Because SMK is in charge of working with other agencies in developing, administering and monitoring school-based health programs in public and private primary schools as well as in colleges and higher institutions, it has a crucial and overarching role in implementing SHCN in Brunei Darussalam. SMK coordinates with the Ministry of Health, Ministry of Development and other government agencies in rolling out programs on health promotion and school safety, and it also conducts surveys on the effectiveness of the programs implemented with the help of the unit.

The rest of the agencies and the SHCN components they address are summarized in the table below and discussed in the succeeding paragraphs.

39 Strategic Management Unit, *The MOE Strategic Plan 2012-2017*, 27.

Table 6. Brunei Darussalam Agencies in Charge of SHCN Implementation

SHCN Component	Agency/ies in Charge	
	MOE	MOH
Healthy and Safe School Environment	Department of Planning and Estate Management	
Health Education	Co-curriculum Department	Health Promotion Center Department of Dental Services
Physical Education	Curriculum Development Department	
Nutrition Services	School Feeding Scheme Unit	
Health Services		School Health Services Unit Department of Dental Services
Counseling, Psychological, and Social Services	Counseling and Career Guidance Section	

Since the Department of Planning and Estate Management manages the construction and upgrading of school buildings and facilities, it contributes to the institution of a healthy and safe school environment by ensuring that the school is a safe place for everyone in the school community. The Co-curriculum Department, Health Promotion Center, and the Department of Dental Services address the physical education component by making students more aware of beneficial and healthier lifestyle options through campaigns, events, and promotional materials on the most pressing health and nutrition issues.

The Curriculum Development Department, on the other hand, is in charge of organizing matters pertaining to physical education (PE) in primary schools - from making guidelines for PE teachers to developing student fitness tests and developing the PE curriculum for the primary years of schooling. Currently, lower primary students have hour-long PE sessions while upper primary students attend 1.5-hour PE classes every week.

Brunei Darussalam's MOE also has a Feeding Scheme Services Unit whose main objective is to improve nutrition for all students in public schools by giving them daily access to free nutritious snacks or lunch. While the Department of Dental Services delivers oral health programs that promote good oral hygiene, particularly in public schools. In addition, the MOH's School Health Services Unit is in charge of administering general check-ups for Year 4 and Year 6 students. It also conducts annual health screenings following the extensive schedule outlined below.

Table 7. Schedule of Screening Activities of the School Health Services Unit

Year	Screening Activity
1	Anthropometric screening Distance vision screening Medical check-up Completion of immunization
2 & 3	Review of weight problems and borderline distance vision
4	Anthropometric screening Distance vision screening Audiometry screening Medical check-up Health talk (Dental and personal hygiene)
5	Review of weight problems and borderline distance vision
6	Anthropometric screening Distance vision screening Scoliosis screening Health talk (Diabetes)
7	Anthropometric screening Distance vision screening Colour vision screening Health talk (Diabetes) HPV Vaccination Programme (for female students only)

Duraman, H.J.H. and Jeriah, H.J. (2013)."Country Report on School Health Care and Nutrition Services." Negara, Brunei Darussalam.

Finally, MOE's Counseling and Career Guidance Section partly addresses the counselling, psychological, and social services component of SHCN, because part of its mandate is to help students become more well-rounded and keep them from getting into illegal drugs and smoking.

Although only six of the eight SHCN components considered for this study is covered in the school-based health and wellness programs mandated by the central government, Brunei Darussalam's efforts to protect and promote the health of its primary students can already be considered comprehensive especially when compared to those of its neighboring countries. Moreover, their SHCN programs also tend to be more sustainable since their delivery is not dependent on external funding.

Cambodia

The School Health Department, which is under the Ministry of Education, Youth and Sport (MoEYS), is the primary implementing unit for Cambodia's SHCN programs. However, they work closely with an interministerial school health working group made up of representatives from MoEYS, MoH, the Ministry of Rural Development, and other relevant government agencies and nongovernment organizations. The legal bases for the many school-based health initiatives in the country and the corresponding SHCN components they address are listed in Table 8.

(CIA, 2015)

Table 8. National Policies Supporting Components of SHCN Programs in Cambodia

SHCN Component	Policies Supporting SHCN in Cambodia	Related SHCN Program/s
Healthy and Safe School Environment	Policy on Child Friendly Schools Circular on Banning Alcohol Use in Public and Private Schools	Child Friendly School Program Fit for School (FFS) Water, Sanitation and Hygiene (WASH) Program
Health Education	Policy on Life Skills Policy on School Health Policy for Curriculum Development	Life Skills Education Food Safety and Nutrition Integration of health, hygiene and nutrition into the school curriculum and national textbooks

SHCN Component	Policies Supporting SHCN in Cambodia	Related SHCN Program/s
Physical Education	Policy on School Health Policy for Curriculum Development	Physical Education
Nutrition Services	Policy on Child Friendly Schools	Child Friendly School Program School Feeding Program
Health Services	National Policy for Helminth Control	National School Deworming Program FFS Healthy Schools Pilot Project
Health Promotion for Staff	Policy on School Health	Life Skills Education Communicable Diseases Prevention Environmental Protection School Hygiene

The 2006 Policy on Child Friendly Schools lays down a framework for ensuring that schools offer quality education and uphold the basic rights of Cambodian children.[40] The framework also encourages schools to work with families and the school's immediate community in creating a safe and healthy environment so that children may achieve optimal learning and development.[41] Of the six dimensions making up the Child Friendly Schools (CFS) Framework, it is the dimension covering students' health, safety and protection which is most pertinent to this study. Core activities chosen by the MoEYS for this dimension of the Child Friendly Schools Program include those that touch on protecting and promoting students' rights and keeping the school and community violence-free, monitoring the food sold in school canteens, improving child health care and access to clean food and drinking water, and ensuring "hygienic conditions in schools."[42] Public primary schools and local governments across Cambodia have been implementing the Child Friendly Schools Program, and these efforts are sustained by technical assistance and funding coming from the national governments, UNICEF and other development partners.

The 2009 Policy on School Health was enacted by the Kingdom of Cambodia and is being implemented through the Department of School Health, MoH, the Ministry of Rural Development, and the Ministry of Agriculture, Forestry and Fisheries. SHCN programs such as Life Skills Education and Health Education find their legal basis on this comprehensive policy which has the following objectives:

- To improve the health status of school children, students, primary school teacher trainees, secondary school teacher trainees, and other school staff in all public and private educational institutions and communities;

40 Cambodia MOEYS, *Child Friendly School Policy*, (Kingdom of Cambodia, December 2007), 1, http://www.nepcambodia.org/images/stories/Documents/Ministries/policy%20on%20child%20friendly%20schools%20english.pdf.

41 Ibid.

42 Ibid.

- To improve the capacity and skills of all members of all public and private educational institutions and communities on the prevention of diseases and accidents;

- To encourage and provide concerned institutions, especially communities, with opportunities to get involved in promotion of school health; and

- To assure equitable access to health education services.

In general, programs anchored on this policy seek to help keep everyone in the school community safe and healthy so that education outcomes can improve in line with the country's National Plan of Education for All and the Millennium Development Goals (MDGs). The integration of PE into students' regular schedule at school also contributes towards this end. Funding comes from various sources such as the national government, the United Nations Population Fund (UNFPA), Gesellschaft für Internationale Zusammenarbeit (GIZ) and WB.

Lastly, the 2002 National Policy for Helminth Control aims to improve the health status of schoolchildren through deworming programs, employ Health Education (HE) to educate students on proper hygiene and sanitation in order to prevent soil-transmitted helminth (STH), and reduce STH contamination and infection among children. Through this policy, the government hopes to eliminate lymphatic filariasis in the country, remove schistosomiasis from the list of public health concerns, and reduce STH-related morbidity. The key implementing government units for the National School Deworming Program are the MoH, MoEYS, and the Ministry of Rural Development. However, they work with and are funded by a variety of partners, from nongovernment organizations (NGOs) to corporations, international organizations, and donor agencies:

- WHO
- UNICEF
- Dokkyo University
- Tsukuba University
- World Vision Australia
- Johnson & Johnson (J&J)
- Korea Association of Health Promotion (KAHP)
- Sasakawa Memorial Health Foundation (SMHF)
- IDRC (International Development Research Centre)
- Swiss Tropical and Public Health Institute (Swiss TPH)
- United States Agency for International Development (USAID)

Indonesia

(CIA, 2015)

Four ministries work together to implement the Usaha Kesehatan Sekolah (UKS) or the School Health Program in Indonesia, and each has a particular role to play. The Ministry of Education and Culture and the Ministry of Health are in charge of developing, implementing, supervising, and evaluating the SHCN programs rolled out in schools. The Ministry of Religious Affairs, on the other hand, is expected to perform similar functions but in relation to Muslim schools in the country, while the Ministry of Internal Affairs is tasked with facilitating the human resources, budget, and infrastructure needed for implementation. It also supervises program monitoring and evaluation.

UKS's main objective is to increase the quality of education in Indonesia by protecting the health of pupils and providing them with a good environment so that they can focus on learning. Many of the program's aspects as outlined in the program's objectives also address specific components of SHCN, as shown in the table below.

Table 9. Components of SHCN and SHCN Programs Implemented in Indonesia

SHCN Components	Related SHCN Program/s
Healthy and Safe School Environment	Sanitation of classrooms, rest rooms, and school yard Garbage disposal system Ergonomic school equipment Hand washing Anti-smoking and anti-drug programs
Health Education	Hand washing, toothbrushing Intra-curricular lessons integrated into other subjects Extra-curricular activities that target health and wellness (camping, picnics, related workshops)
Nutrition Services	School feeding

SHCN Components	Related SHCN Program/s
Health Services	Deworming Nutritional assessment and monitoring First aid provision in schools Dental health assessment Disease control and prevention Information campaigns against smoking, alcohol, illegal drugs, and early/unprotected sex
Counseling, Psychological, and Social Services	Mental health promotion

UKS was re-launched in 2003 in an effort to improve the quality of child health at school. The purpose of UKS is to improve the quality of education and student learning achievements by increasing healthy life skills of students through creating a healthy school environment, improving knowledge, changing students' attitudes and maintaining health through preventing and curing diseases.

UKS has the following major components, collectively referred to as *Trias UKS*:

1. Health education

Health education is intended to be included in activities within the curriculum and in extra-curricular activities, such as health education sessions to students, teachers and parents. Health education sessions are delivered through health workers from the local *Pusat Kesehatan Masyarakat* or *Puskesmas* (Indonesia's Primary Health Care Center) based on a regular schedule. Activities aim at promoting positive health behavior and avoidance of health risks. The UKS cadre or "little doctor" (the name and tasks depend per school) are other conceptual elements of health education aiming to actively involve students in the school health activities. To become a "little doctor" appears to be a competitive process in most schools. Little doctors are expected to be agents of change and are trained to model, maintain and improve good hygiene and health behavior in schools. The little doctor is equipped with a little bag containing a set of cleaning tools, books, pens, soap, towels, toothbrushes and toothpaste.

2. School health services

The programmatic focus of UKS is on school health services. They are intended to maintain, improve and detect early health problems in students and teachers. These clinical services are conducted by a team of health workers from the local Puskesmas in collaboration with the school UKS coordinator. Ideally, the services include medical examination, intelligence tests, immunization, detection of cases or screening, dental school health program, and basic medical treatment and referral to health facilities. The program relies on strong links between Puskesmas and the schools. Every participating school is expected to have a UKS room.

In 1996, the government of Indonesia launched a school feeding program for elementary school students called (*Pemberian*

Makanan Tambahan pada Anak Sekolah (PMT-AS) with the objective to improve school attendance, physical stability and community participation. Prior to decentralization, this was a major national program which did not have any relation with UKS. Since decentralization, however, the budget for programs is now shared by the different levels of government. Moreover, implementation has been the responsibility of the district/city government since 2006. Not all districts implement the program, though.

The program delivers food to children in primary schools, and this food should meet the following requirements: (1) food should be in the form of a snack, not a complete meal, (2) use local foodstuffs, and (3) should be a snack commonly consumed by the community, (4) given around break time which is from 9-10 a.m. Snacks are about 300-400 calories and they contain at least 5-9 grams of protein. The food preparation involves community, teachers, and nutritionists from health centers. The school-feeding program also provides deworming tablets twice a year.

In the year 2000, the school-feeding program covered more than 50 percent of the total primary school children in Indonesia. Since 2001, however, only 30 percent of districts across Indonesia implement the program because of budget constraints and the limited capacity of communities to sustain program implementation. The snack was initially planned to be distributed to the children at least for 108 days per year, but is currently given out for 90 days or less due to budget constraints.

To monitor school children's nutrition status, the Department of Health has been implementing a program called "school children's height measurement" since 1994. The measurement is conducted by schoolteachers in a sample of schools and among first-grade elementary students. This periodic "health screening" at school includes some form of health check-up in collaboration with the nearest health centre, and height and weight monitoring twice, quarterly or sometimes on a monthly basis. Child health and growth charts are used for growth monitoring and also to track immunizations and the results of the health checks.

3. Healthy school environment

The third pillar of the UKS program is the improvement of the school environment. It is defined as comprising the physical, psychological and social environment, but emphasis is usually on the physical environment only. Activities are related to the implementation of cleanliness and comfort in schools as well as the development of cooperation between teachers, students, school staff, parents and the community in general.

However, program implementation varies among schools as these are located in different areas, municipalities, and provinces. There are no school-based health initiatives for some schools, while others are able to take part in feeding and iron supplementation programs, growth monitoring, and the UNICEF-funded Water and Sanitation in Schools (WASH) program.

Lao PDR

To strengthen the commitment of Laos to its Education Vision 2020 and Health Vision 2020, the MDG goals, and the goals of Health for All (HFA) and EFA, Laos established the National School Health Taskforce in 2003. Composed of representatives from the country's Ministry of Education and Sports (MoES) and MoH, it formulated the National School Health policy in 2005 with the help of WHO, UNESCO, and Japan International Cooperation Agency (JICA).[43] Its main objective is to improve the health status, increase enrolment, and reduce absenteeism and dropout rates for pre-primary and primary students.[44] The National School Health Policy was revised in 2010 and is currently made up of seven components that address particular SHCN components and support specific SHCN programs, as outlined in Table 10 below.

(CIA, 2015)

43 Ly Foung, Phoungkham Somsanith, and Phandouangsy Khatthanaphone, "School Health in Lao PDR: Strengthening the School Health Initiative," in *Case Studies in Global School Health Promotion: From Research to Practice* ed. Carmen Aldinger and Cheryl Vince Whitman (Springer Science & Business Media Education, April 9, 2009).

44 Ibid.

Table 10. Lao PDR's National School Health Policy and Related SHCN Components and Programs

National School Health Policy Component	SHCN Component/s Supported	Related SHCN Programs
Personal Hygiene and Life Skills	Health Education Health Services Healthy and Safe School Environment	Fit for School (FFS) Water, Sanitation and Hygiene (WASH) Program Child Rights The Blue box Oral Health Program
Physical School Environment	Healthy and Safe School Environment	Community Integration for Education Development (CIED) Kato Project WASH
Psycho-social School Environment	Healthy and Safe School Environment Counseling, Psychological, and Social Services	Child Rights

National School Health Policy Component	SHCN Component/s Supported	Related SHCN Programs
Disease Control and Prevention	Health Services	FFS WASH Child Rights Deworming Program Oral Health Program
Health Care Services	Health Services	FFS WASH Program Child Rights
Nutrition Promotion	Health Education Nutrition Services	School Lunch
Cooperation between School and Community	Family and Community Involvement	CIED

The National School Health policy of Laos is comprehensive and covers every SHCN component except for Health Promotion for Staff and Physical Education. However, it must be noted that regular PE classes are already part of the primary school curriculum.

SHCN programs in Laos are implemented with specific health objectives in mind and are implemented mainly through the MoES or the National School Health Taskforce. Depending on the scope of the program, these agencies could be working with provincial and district governments, communities around the school, international agencies, and/or nongovernment organizations. For example, FFS, WASH and the Oral Health Program are approaches to integrated school health aimed at improving water and sanitation facilities in schools and instilling good hygiene practices[45] such as regular handwashing with soap and daily tooth brushing with fluoride toothpaste. Under the FFS Program, students also undergo deworming twice a year.[46] FFS is supported by GIZ, WASH is a flagship program of UNICEF, and the program promoting oral health is implemented in partnership with multinational company Colgate-Palmolive.

Laos has also partnered with UNICEF in developing and updating The Blue Box, a resource kit for teachers containing visual aids, game boards, comic books, compact discs, and teaching manuals which are used to teach children about health and sanitation. Various deworming programs have also been implemented in partnership with WHO and the Asian Development Bank (ADB). The feeding program dubbed School Lunch, on the other hand, aim to combat malnutrition among primary students and are implemented using funds and assistance from the World Food Programme (WFP).

The CIED and Kato Projects are supported and funded by the JICA and Education for Development Fund - Lao (EDF-Lao), respectively. The expected outcome of both

45 UNICEF, "Water, Sanitation and Hygiene - Introduction," http://www.unicef.org/wash/

46 Gesellschaft für Internationale Zusammenarbeit (GIZ), "Fit for School - Effective School Health Programme," http://www.giz.de/en/worldwide/14407.html

initiatives are school environments which are safe, comfortable, and conducive to learning.[47] This can be achieved by ensuring that schools have enough physical structures, education materials, and good teachers.[48] In addition, Child Rights is an initiative of Save the Children International (SCI) whose aim is to improve students' experience of school by promoting respect and non-discrimination among members of the school community, while regular school feeding programs which are funded by various international donors and local communities have been put in place to combat malnutrition.

47 The Education for Development Fund - Lao, "Education for All - School Construction Project," http://www.edflao.org/en/Projectview.aspx?ProID=5

48 Japan International Cooperation Agency (JICA), "What is the CIED Project?", http://www.jica.go.jp/project/english/laos/0608978/02/index.html

Malaysia

(CIA, 2015)

The following laws and policy documents form the legal framework for implementing SHCN in Malaysian primary schools: a] The Education Act of 1996 (revised in 2010); b] policy documents on Health Promoting Schools, a health promotion program which was later on rebranded as the 3K (Kebersihan, Kesihatan, Keselamatan which stand for Cleanliness, Health and Safety) Program; and c] The National Education Blueprint 2013-2025.

Chapter 12 of the Education Act of 1996 mandates the Malaysian government to provide for the periodic medical and dental services of students in public or government-aided schools. Moreover, it makes medical and dental inspections compulsory for pupils attending schools funded by the government.[49] Policy documents on the 3K

49 Government of Malaysia, "Act 550: Education Act of 1996, Malaysian Legislation," http://www.commonlii.org/my/legis/consol_act/ea1996104/.

Table 11. SHCN Components and Related SHCN Programs in Malaysia

SHCN Components	Related SHCN Program/s
Healthy and Safe School Environment	Safe School Program
Health Education	The 3K Program Healthy Kids Program (HKP)
Physical Education	One Child One Sport
Nutrition Services	RMT (Rancangan Makanan Tambahan) Program, Malaysia's School Feeding Program Nutrition Month Malaysia (NMM)
Health Services	Integrated School Health Program (ISHP)
Counseling, Psychological, and Social Services	Counseling and Guidance Program
Family and Community Involvement	Healthy Kids Program

Program include a) the establishment of a Health Promoting School (HPS) committee made up of representatives from the MOH and MOE in 1998 (renamed the National 3K Committee in 2008); b) the Policy on Safe Schools implemented since 2002; and c) the development of guidelines for delivering school health services. Lastly, the National Education Blueprint 2013-2025 aims to make parents and communities more aware of the role they play in the child's education and help schools drive parental and community engagement.[50] Table 11 lists some of the SHCN programs resulting from these laws and policies as well as the particular SHCN components that they address. As the name suggests, the Safe Schools Program aims to create schools where students can feel safe because they are free from violence, discrimination, and abuse.[51] In addition, the program was instituted to maintain peace and security in the school's immediate community. This initiative is funded by the Malaysian government and is implemented with the help of local councils, agencies, and parent-teacher associations (PTA). The 3K, Healthy Kids, and One Child One Sport programs, on the other hand, address the health education and physical education components of SHCN. The 3K program aims to develop in Malaysian students a positive attitude towards cleanliness, health, and safety while the Healthy Kids Program (HKP) promotes healthy eating and active living through health education modules delivered with the help of an interactive website (www.healthykids.org.my). HKP also responds to the SHCN component on Family and Community Involvement because it gives parents resources such as meal plan templates and easy but nutritious recipes which can use to keep their children healthy. On the other hand, One Child, One Sport ensures that pupils regularly carry out physical activities and enjoy doing so. The National 3K Committee works with partners from nongovernment organizations and the private sector in implementing and funding

50 Malaysia MOE, Preliminary *Report: Malaysia Education Blueprint 2013-2025*, 7-21, http://www.moe.gov.my/userfiles/file/PPP/Preliminary-Blueprint-Eng.pdf.

51 Malaysia MOE, "Education in Malaysia: A Journey to Excellence," 2008, 61, http://www.slideshare.net/Fadzliaton/education-in-malaysia.

such programs. HKP, in particular, is implemented with help from the Nutrition Society of Malaysia. It is funded by multinational company Nestlé and is part of the wellness brand's Healthy Kids Global Program.

The RMT Program is Malaysia's school feeding program, which provides nutritious meals to children coming from poor families while they are in school. The national government has been implementing and funding this program with the hope that it will improve students' overall health and make them more attentive in class. Nutrition Month Malaysia (NMM), on the other hand, is a month-long campaign to promote proper nutrition and nourishment among school children. Spearheaded by the Nutrition Society of Malaysia, NMM initiatives include activity workbooks for children and guidebooks for parents, resource materials for teachers to use inside the classroom, and NutriFun school roadshows to promote proper and adequate nutrition among pupils.

Under Malaysia's Integrated School Health Program (ISHP), students are given access to a host of health services meant to protect their overall health and wellness and encourage them to lead healthy lives.[52] Mobile health and medical teams monitor students' health, give dental and medical treatment, administer deworming and vaccination programs, and even check the visual acuity of students. The ISHP is a collaboration between the MOE and MOH.[53]

Lastly, Malaysia's Counseling and Guidance program is implemented and funded by the national government. The initiative helps address the psychological needs of students by requiring all primary and secondary schools to hire a full-time counselor to head the school's Counseling and Guidance Unit. Besides counseling students, counselors can also organize talks and courses to help students stay positive and motivated.[54]

52 Ibid, 57.

53 Ibid.

54 Ibid, 64.

Philippines

(CIA, 2015)

For the Philippines, there are two crucial national policies when it comes to SHCN implementation. One is Section 11, Article 13 of the 1987 Philippine Constitution which mandates the government to promote and protect the physical, intellectual, psychological, and social well-being of its citizens, including the youth.[55] Executive Order 117 s. 1987, on the other hand, established the Health and Nutrition Center (HNC) under what was then the Department of Education, Culture and Sports (DECS), now the Department of Education (DepEd). As part of a recent organizational restructuring in DepEd, HNC is now the School Health Division - Bureau of Learner Support Services (SHD-BLSS), which is primarily responsible for delivering health and nutrition education and services to students and ensuring that they attend clean, healthy, and drug-free schools. SHD-BLSS works with other DepEd offices, agencies of DOH and the Department of Agriculture (DA), other government agencies such as the Dangerous Drugs Board (DDB) and the National Disaster Risk Reduction and Management Council, local government units (LGUs), international aid agencies, and private donors in achieving these goals.

The policy-enabling environment for implementing SHCN in Philippine primary schools is particularly strong, with a web of laws, executive orders, and Department of Education (DepEd) orders and memoranda addressing all eight SHCN components. Table 12 lists some of these legal documents.

55 Article XIII, The 1987 Constitution of the Republic Of The Philippines. (1987). http://www.gov.ph/constitutions/the-1987-constitution-of-the-republic-of-the-philippines/the-1987-constitution-of-the-republic-of-the-philippines-article-xiii/

Table 12. National Policies Supporting Components of SHCN Programs in the Philippines

SHCN Component	Policies Supporting SHCN	Policy Title/Related SHCN Program
Healthy and Safe School Environment	DepEd Order 10, s. 2016	Policy and Guidelines for the Comprehensive Water, Sanitation and Hygiene in Schools (WinS) Program
	DepEd Order 5, s. 2014	Implementing Guidelines on the Integration of Gulayan sa Paaralan, Solid Waste Management and Tree Planting Under the National Greening Program (NGP)
	DepEd Memo 152, s. 2011	Preventing Dengue in Schools
	DepEd Memo 219, s. 2006	Implementation of Measures to Ensure the Safety of Schoolchildren in Public and Private Schools
Health Education	DepEd Memo 17, s. 2013	National Dental Health Month
	DepEd Memo 184, s. 2012	National Handwashing Day
	DepEd Memo 206, s. 2012	Drug Abuse Prevention and Control Week
Physical Education	DepEd Memo 127, s.2005	DepEd *Palarong Pambansa* (National Games)
	DepEd Memo 48, s. 1999	National Workshop on the Teaching of Physical Education
Nutrition Services	DepEd Order 51, s. 2016; DepEd Order 33, s. 2015; DepEd Order 37, s. 2014	Implementation of the School-Based Feeding Program
	DepEd Order No. 52, s. 2008	Compliance with DepEd Policies on Food Safety in Schools
Health Services	DepEd Memo 165, s. 2010	Adoption of the 2007 World Health Organization - Child Growth Standards (WHO-CGS)
	DepEd Memo 234, s. 2007	Extended Universal Medical and Dental Check-up
	DepEd Order 44, s. 2004	DepEd's TB Prevention and Control Program
Counseling, Psychological, and Social Services	R.A. 9258	Guidance and Counseling Act of 2004
Health Promotion for Staff	DepEd Order 63, s. 1998	*Bantay Presyon Para sa Guro* (Monitoring Teacher's Blood Pressure) Project
Family and community involvement	DepEd Order 39, s. 2003	Advocacy on SARS and Other Public / School Health Issues
	DepEd Order 5, s. 2003	Promulgating the Implementing Rules and Regulations (IRR) of the "Comprehensive Dangerous Drugs Act of 2002"

SHCN programs supported by the policies under the Healthy and Safe School Environment component all use local funds and are implemented by schools and DOH with the help of LGUs and Municipal Health Offices. Dengue prevention efforts include massive information campaigns and referral of students and school personnel exhibiting symptoms of disease, while the drive to ensure the safety of children in schools involves assessing the physical structures in schools and implementing necessary repairs. Apart from these programs, DepEd also partnered with FFS for the Essential Health Care Package (EHCP) program which instilled good hygiene practices in children such as daily hand washing and tooth brushing. Twice-a-year access to deworming was also part of the EHCP. Just this year, DepEd has replaced the EHCP with the Comprehensive Water, Sanitation and Hygiene in Schools (WinS) Program, which now also covers sanitation, food handling and preparation, and capacity building, among others.

Policies under the health education component aim to raise awareness on a range of health concerns, from oral hygiene to hand washing, drug abuse, and teenage smoking. Schools hold coordinated campaigns against drugs and cigarette smoking with the help of the Philippine Drug Enforcement Agency (PDEA), DDB, DOH, and Australian Aid, while FFS and the Philippine Dental Association (PDA) help schools in teaching pupils to regularly practice good hygiene in the hope that this could reduce absenteeism and improve student learning.

Two of the DepEd memoranda tackling the Physical Education component of SHCN are also hereby listed. DepEd Memo 127, series of 2005 is regarding the Palarong Pambansa, which is an annual sports event for student-athletes all over the country. The earlier DepEd Memo 48, series of 1999, on the other hand, announces a national workshop for PE teachers of all levels.

Apart from the DepEd-funded School-Based Feeding Program (SBFP) which is mentioned under the Nutrition Services component, other supplementary feeding programs meant to address malnutrition and hunger among poor children have been held in the country. There is the Busog, Lusog, Talino (roughly translates to "Full Tummies, Healthy Bodies, Bright Minds") program funded by local business Jollibee Foods Corporation, the Pasiglahin ang Estudyanteng Pinoy (PEP, which in English roughly means "Revitalize the Filipino Student") program implemented with help from Mead Johnson Nutrition (MJN) Philippines and NGO Kabisig ng Kalahi Foundation, and emergency feeding programs done in partnership with the World Food Programme (WFP) and other donors and NGOs. Meanwhile, the canteen management program requires school canteens to sell and serve food that is not only nutritious but also complies with DepEd's policies on proper food handling and preparation.

DepEd works closely with DOH and local medical and dental associations in delivering health services as well as in controlling and preventing the spread of disease. The programs supported by the policies listed under Health Services involve a combination of information campaigns, medical and dental check-up and primary treatment and nutritional assessment. Aside from these efforts, there are also mass deworming initiatives, distribution of dental kits to students, and targeted management of endemic diseases such as malaria and rabies. Government agencies work with organizations such as The Global Fund and healthcare companies Colgate-Palmolive Philippines, Inc. and GlaxoSmithKline (GSK) in delivering some of these health services.

The Guidance and Counseling Act of 2004 was crafted to professionalize the practice of guidance and counseling in the country by mandating the creation of a regulatory board who will then be in charge of accrediting guidance counselors. Apart from having completed a relevant undergraduate degree, the law also requires guidance counselors to obtain a master's degree in guidance and counseling and pass a licensure exam.

Under the Health Promotion for Staff component, a number of programs also exist. Apart from monitoring the blood pressure of teachers and other school personnel, there is also the Teachers Health Welfare Enhancement Program implemented by DepEd. This initiative includes the assessment, diagnosis, and management of school employees with non-communicable and communicable diseases.

Lastly, programs implemented because of policies listed under the Family and Community Involvement component aim to make families more engaged in the health and education of their children. For example, DepEd Order 39, series of 2003 instructs schools to disseminate important information about Severe Acute Respiratory Syndrome (SARS) and other health issues in public schools. Aside from this, DepEd also works with the Philippine Mental Health Association in teaching mothers and fathers effective parenting skills as part of the National Drug Education Program. It has also teamed up with DA and agricultural company East-West Seed Philippines in encouraging schools and families to grow vegetables in their own backyards via the Gulayan sa Paaralan (Vegetable Patch in Schools) program.

Thailand

(CIA, 2015)

SHCN programs in Thailand are implemented mainly by the MOE in collaboration with the Ministry of Public Health (MPH) and with help and support from other government agencies, national and international organizations, and nonprofit groups. In particular, the MPH's Department of Health (DOH) is in charge of helping schools in Thailand become health promoting schools. This shift towards a greater emphasis on health education and environmental sanitation in schools is done in accordance with recommendations from the WHO. Thailand defines an HPS as "a school constantly strengthening its capacity as a healthy setting for living, learning, and working."[56] Schools are therefore instructed to help students, school staff, parents, and local community members to have the knowledge and values towards health and wellness.

Other school-based initiatives have been implemented in Thailand, and the table below lists them together with the SHCN components they address.

56 Thailand DOH and MOE, "The Health Promoting School," http://eng.anamai.moph.go.th/main.php?filename=02_thps.

Table 13. SHCN Components and Related SHCN Programs in Thailand

SHCN Component	Related SHCN Program/s
Healthy and safe school environment	We Can Do - Lavatory Sanitation Component
Nutrition services	School Lunch Program School Milk Project We Can Do - Food Safety Component
Health services	Sweet Enough Eat Your Veggies We Can Do - Food Safety and Dental Hygiene Components

We Can Do (โครงการเด็กไทยทำได้) targets three SHCN components and emphasizes lavatory sanitation, food safety, and dental hygiene. The lavatory sanitation aspect aims to campaign for the proper management and use of restrooms and other sanitation facilities in schools. For food safety, the goal is two-fold: first is to supervise the environment in which food served in schools is prepared and handled, and second is to arm students with knowledge on food and nutrition, healthy consumer behavior, and gastrointestinal disease control. Lastly, the dental hygiene component aims to help students get into the habit of brushing their teeth after every meal and controlling their sugar intake.

Two programs fall under the Nutrition Services component. The MOE has funded and implemented the School Lunch Program (โครงการอาหารกลางวัน) and the School Milk Project (โครงการนมโรงเรียน) for both pre-primary and primary school students. The survey done by DOH and the MPH showed that malnutrition among students decreased as a result of the School Lunch Program, while a study conducted by the same agencies found that the weight and height of students increased and were within the healthy range after being part of the School Milk Project.

Lastly, as part of the Health Services component of SHCN, two campaigns have been rolled out in schools in Thailand: Eat Your Veggies (โครงการกินผักทุกวันเด็กไทยทำได้) and Sweet Enough (โครงการเด็กไทยอ่อนหวาน). DOH launched the first one in partnership with local markets, health food companies, and nonprofit Thai Health Organization in order to instill healthy eating behavior in children. DOH also worked with MOE and Mahidol University's Institute of Nutrition in holding cooking demonstrations and workshops for students and implementing professional development programs for nutrition services managers in schools. On the other hand, Sweet Enough is a campaign that aims to reduce sugar consumption and is initiated by the Thai Health Foundation. Apart from campaigning for food control policies and promoting health awareness and disciplined food and beverage consumption, the program's proponents have also advocated for banning the sales of carbonated sugary drinks in public schools.

Conclusion

Table 14 is a summary showing which of the components of SHCN have been or are being addressed by the legal frameworks for SHCN in seven Southeast Asian countries:

Table 14. SHCN Components Supported by National SHCN Policies in Southeast Asia

SHCN Components	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Philippines	Thailand
Healthy and Safe School Environment	X	X	X	X	X	X	X
Health Education	X	X	X	X	X	X	X
Physical Education	X	X	X	X	X	X	X
Nutrition Services	X	X	X		X	X	X
Health Services	X	X	X	X	X	X	X
Counseling, Psychological, and Social Services	X		X	X	X	X	
Health Promotion for Staff		X				X	
Family and Community Involvement					X	X	

The table shows that all countries included in this survey have legal policies supporting the implementation of SHCN programs addressing the components of *Healthy and Safe School Environment, Health Education, Physical Education,* and *Health Services.* Policies, laws and other legal documents also exist in support of *Nutrition Services* for six countries. Given that the three most common SHCN problems in the region are underweight, water and sanitation-related illnesses, and dental problems, the data suggest that there is alignment between the SHCN policies and the most pressing health concerns in the region.

Five of the seven countries have policies to support SHCN programs related to *Counseling, Psychological, and Social Services*, while *Health Promotion for Staff* and *Family and Community Involvement* are given the least attention in the surveyed countries based on their current health and education policies.

Although it is encouraging to see all eight components covered or explored in some manner by existing policies and education frameworks, it is equally important to note that there seems to be a gap between SHCN as envisioned by these government-issued documents and actual SHCN implementation at the district and school levels. Many of these policies are guided by good political intentions and have the potential to effectively address the region's SHCN problems, but MOE representatives and school health experts consulted for this study during the regional workshop reported that the implementation of school-based health and nutrition initiatives can be quite fragmented in practice. The next section explores to some extent the nuances of this disjoint between intended and actual SHCN implementation in Southeast Asian primary schools but, more importantly, chronicles some of the good and commendable SHCN programs and practices at the school level which can be adapted or replicated in other sites.

Photo credit: SEAMEO INNOTECH

Photo credit: SEAMEO INNOTECH

GOOD PRACTICES FROM THE SCHOOL CASE STUDIES

A policy environment that is supportive of school-based health and nutrition initiatives is important but forms only half of the picture. A closer look at how these policies and programs play out in schools is just as important, especially because implementation may vary among schools in different countries and contexts.

Moreover, education or health ministries and even individual schools seeking to improve the status of SHCN in their respective school systems and educational institutions may benefit from a rich and more detailed documentation of how schools with varied contexts and backgrounds have been successful in implementing SHCN program.

This section of the study presents a selection of case studies of primary schools located in six countries in Southeast Asia: Indonesia, Myanmar, Philippines, Singapore, Timor-Leste, and Vietnam. Schools were identified by the respective education ministries, with the exception of one school in the Philippines which was identified with the help of UNICEF Tacloban. It bears reiterating that the data featured in this section is based on limited and qualitative data gathered from the school visits and interviews with school heads, teachers and students who have experienced participating in the programs either as implementers, beneficiaries, or both. The following school case studies are documented for illustrative purposes only and are not meant to be representative of all good practices in the region. Moreover, it is recognized that there are good SHCN practices evident in other countries in Southeast Asia that are not documented in this report.

Indonesia

1 SDP N Tulangampiang Denpasar City, Bali

2 SD Cipta Dharma Samarinda City, East Kalimantan

(CIA, 2015)

Indonesia is a low-middle income country with a population of 252 million people spread over a land area that covers 17,000 islands. Substantial economic growth over the last decade has reduced general rates of poverty, but 28 million people still live below, and close to half of all households around, the poverty line.[57] Huge regional differences remain between the affluent urban centers of the west and the poor rural areas of the eastern parts of the country.

Notwithstanding the economic progress of the country, there are persisting challenges in health status with a high burden of preventable hygiene-related diseases in children. Over a third of children suffer from stunting and malnutrition, and 162,000 children die from diarrhea each year. The prevalence of stunting in children six to 15 years old varies from about 20 percent to more than 50 percent in some provinces, with general trends for higher rural malnutrition and child mortality; the prevalence of stunting is highest in the eastern part of the country. Among children aged six to 14, more than 12 percent are categorized as thin or underweight.[58]

The coverage of improved sanitation and clean water supply, particularly in the remote and rural areas and the school setting, is below the regional average. 70 million people defecate in the open every day and the rates of intestinal parasites are very high.[59]

The Indonesian school system is immense and diverse. With over 50 million students and 2.6 million teachers in more than 250,000 schools, it is the third largest education system in Asia and the fourth largest in the world (behind China, India and the United States). Two ministries are responsible for managing the education system, with 84 percent of schools under the Ministry

57 World Bank, "Overview: Indonesia," https://www.worldbank.org/en/country/indonesia/overview.

58 FANTA, "Indonesia Nutrition Profile," http://www.fantaproject.org/sites/default/files/download/Indonesia-Nutrition-Profile-Apr2014.pdf.

59 Ibid.

of Education and Culture (MOEC) and the remaining 16 percent under the Ministry of Religious Affairs (MoRA). For primary school, net enrolment rates are below 60 percent in poor districts while well-off districts have a close to universal enrolment.[60]

The National *Usaha Kesehatan Sekolah* (UKS, Indonesia's school health program) is the Indonesian government's main comprehensive and integrated effort to support the development of healthy living habits and behavior in school-age children. UKS aims at improving education quality and learning achievement of students by improving their health status and health behavior, including their hygiene habits. UKS supports the creation of a healthy school environment to allow for optimal growth and development of children.

UKS is based on an inter-sectoral agreement between the Ministry of Health (MOH), Ministry of Education & Culture (MOEC), Ministry of Home Affairs (MOHA), and the Ministry of Religious Affairs (MORA). The main UKS policy is defined in the 4 Ministries Joint Decree (2003) on school health, which is supported by the MoH National strategic plan 2010-2014. As has been discussed in the previous chapter, UKS has three main components: health education, school health services, and healthy school environment.

While UKS and its policies are the core of school health in Indonesia, there are numerous other related government policies that are either connected with UKS or run independently. For example, there is a national policy to improve water and sanitation at schools, including hand washing facilities and toilets in every school. International organizations like UNICEF and the West Java office of GIZ are supporting this endeavor.

The two schools from Indonesia chosen by MOEC for the case studies are both located in Denpasar, the capital of Bali. They are located in a middle-income neighborhood in an urban setting. Following the recommendation of MOEC, Tulangampiang Public Elementary School and Cipta Dharma Private Elementary School were visited and interviews were conducted with school principals, teachers, pupils and staff.

60 Indonesia MOEC, *Indonesia Educational Statistics in Brief 2014/2015*, (Indonesia: MOEC Indonesia,2015), http://publikasi.data.kemdikbud.go.id/../isi_0BCC909B-1F8E-43E5-BB98-4AE4E0C97BB3_.pdf.

SDP N Tulangampiang (Tulangampiang Public Elementary School)

Tulangampiang Public Elementary School has a total of 640 pupils aged six to 12 (M=310 and F=330). The average class size is 34 children. Staff population is composed of 32 teachers and 8 non-teaching staff. Electricity and water (though not potable) are available 24/7. The school is equipped with hand washing facilities, separate toilets for boys and girls (four each), a school canteen and a school clinic. The school does not serve any school meals but children bring their own breakfast.

Parents are not paying any school fees, but are encouraged to donate regularly, and since most children come from middle-class families, these additional financial resources are collected from 75 percent of all parents.

Absenteeism is estimated by teaching staff to be around 1 percent, but according to sports teachers, this is significantly higher (10 percent) on days when physical education classes are held, with toothache, fever and flu reported as the most common reasons.

The following are some of the successful SHCN-related activities in Tulangampiang Public Elementary:

- A strong emphasis is placed on the regular communication of health safety policies to students, parents, staff members and visitors. Before classes start in the morning, the principal is addressing all staff and pupils and routinely covers a topic concerning health education, like the necessity of hand washing before and after meals, the benefits of healthy food and regular physical activity. Additionally, health and hygiene-related topics feature prominently during bi-monthly Parent-Teacher Association (PTA) meetings.
- Every two months, there is a call for a general Parent-Teacher Assembly, where issues concerning parent sponsorships (donations), cleaning activities, and general school management issues are discussed and decided upon. Besides contributing financially to the schools maintenance and operations, groups of parents regularly meet on weekends on the school premises in order to engage in cleaning and repair activities to make the school environment healthier and more pleasant.
- The provincial UKS team in Bali holds coordination meetings biannually. The recurring topics of such meetings are the Healthy School Competition (LSS), and orientation on UKS for new staff. Other topics are discussed as they arise (e.g., the hot topic for 2014 is mental health). The city/district UKS teams meet once or twice a month and minutes are

Photo credit: SEAMEO INNOTECH

provided for documentation. UKS activities in Bali feature, amongst others, annual Healthy School Competitions, which proved to be a strong incentive to improve and intensify activities, especially concerning physical education.

- All children bring their own food or buy meals and snacks at the school canteen. A school canteen manager and two staff members offer a variety of nutritious, affordable and appealing snacks and hot meals, the latter being prepared on the premises, using local foodstuffs. The offerings range from rice, beans, meat, bananas to cookies and candies. With no nutrition services manager employed, the canteen manager cooperates closely with teachers and the PTA in order to decide on the products to be sold in the canteen.

Among these, however, two of Tulangampiang Public Elementary School's SHCN programs stand out: Little Doctors and their physical education program.

Little Doctors

The concept of Little Doctors is an important element of health education at Tulangampiang Public Elementary which aims to actively involve students in the school health activities. They are usually fourth and fifth graders who meet a set of criteria and have been trained to participate in efforts maintain, improve and promote health within their school. They practice good hygiene and try to encourage their peers to do the same.

Apart from this, the Little Doctors always try to make the school environment healthier, assist teachers and health staff, and play an active role in efforts to improve health within the school. Some activities performed by the little doctors are: observing their peers' hygiene, encourage good hygiene, promote proper hand washing with soap and tooth-brushing , and observe sanitation practices at the canteen. In doing their tasks, they are given a Little Doctor's diary which is filled with notes and reports of their activities.

Additionally, the Little Doctor is equipped with a little bag containing a set of cleaning tools, books, pens, soap, towels, tooth-brushes and toothpaste, which gives him/her a feeling of pride and significance. Moreover, they are sometimes asked by the principal to deliver some information about hand washing with soap, defecation, and brushing teeth during the flag ceremony in the morning.

Physical Education Program

Physical education is a very strong area in Tulangampiang Public Elementary. Two experienced and qualified (with an appropriate college degree in line with national standards and requirements) PE instructors offer a variety of mainly outdoor sports activities, with every pupil being instructed for four hours weekly. The school has a spacious yard where these exercises can be held. Most popular among the boys and girls are ball games and competitive exercises.

Once a month, the school also offers swimming lessons at a nearby beach.

SD Cipta Dharma (Cipta Dharma Private Elementary School)

Cipta Dharma Private Elementary School accommodates 1096 pupils (M=536 and F=560) from grades 1 – 6. The average class size at this school is 40 children. 46 teachers and 15 non-teaching staff comprise the school's full-time staff. Electricity and water are available 24/7, the school is equipped with hand washing facilities, separate toilets for boys and girls (eight each), a school canteen, and a school clinic.

The school does not serve any school meals but children bring their own breakfast, usually rice and bread and healthy snacks. Lessons start at 7:15 a.m. and finish at 12:45 p.m., when children go home for lunch.

The school is a private institution financed by Foundation for Education, and parents are paying 300.000 IDR (about US$25) in school fees per month. Subsequently most children come from upper and middle class families. In Bali, 20 percent of primary schools are privately-owned and operated.

Absenteeism is estimated by teaching staff to be very low, with religious holidays or fever being the most obvious reasons students miss school. In collaboration with a local faculty of dentistry, dentists come in twice a year to check up on the entire school population.

The most notable and successful SHCN-related activities in Cipta Dharma Private Elementary are, among others:

- A lot of emphasis is placed on healthy and safe school environment efforts. Judging by the self-assessment of staff at Cipta Dharma Private Elementary the school is implementing most of the essential programs and practices that make schools safe and secure for children. These include the strict prohibition of tobacco use among school staff members and visitors alike. All products that are sold by the school canteen meet strict nutritional standards. Through a well-established cooperation with the local *Puskesmas*, a list has been developed of those products and items that may be sold on the school premises. Canteen tenants regularly meet up with a nutrition expert from the Primary Health Centre in order to update this list as to ensure that healthy food and beverage choices are available for all children. Local representatives from the MOH regularly check the quality of food on offer.

- Additionally, a strict no-bullying-or-harassment policy is in place. Teachers and pupils alike are regularly sensitized to the cause. Before classes start in the morning, the principal addresses all staff and pupils and routinely covers a topic concerning bullying and harassment. If teachers are made aware of

Photo credit: SEAMEO INNOTECH

any incidents (which are pretty rare in this particular school), the principal is immediately informed and appropriate action is taken. Parents are involved if deemed necessary.

- The Little Doctors program, representing an element of health education in UKS aiming to actively involve students in the school health activities, is also well-established in Cipta Dharma Private Elementary, too. There is strong competition among fourth and fifth graders to be selected and trained, and they carry their office with dedication and great pride. This significance is typified by their little doctor's bag containing their diary and hygiene articles like toothbrushes and toothpaste. One of their tasks is to act as a "hygiene guard," i.e., to observe the hygiene behavior of their peers (e.g. hand washing after use of toilet and before and after meals) and lead by good example. This often proves to be a lot more effective than mere health education lectures from teachers. Additionally, they check on the hygiene quality of the school canteen and are sometimes asked by the principal to deliver some information about hand washing, proper defecation, and toothbrushing during the flag ceremony in the morning or health education classes.

- Due to a strong family and community involvement, the school is able to create a healthy environment with a rich and lively agenda of health-related activities. As a private school, Cipta Dharma Private Elementary has access to sufficient resources to begin with, but these are complemented by additional commitments from individual members of the community. For example, many parents regularly take part in refurbishment and beautification work on weekends. In addition, an ardent member of the PTA, for example, is a renowned dentist well-connected to the medical faculty at the University of Denpasar and thus, organizes bi-annual dental check-ups for all pupils.

This strong link with the community, plus a good health promotion and protection program for the school's faculty and staff, are among the school's best SHCN practices.

Partnership with Local *Puskesmas* (Primary Health Center)

There is no licensed medical or health staff assigned to the school, but the school is still able to effectively deliver health services to its students via its solid partnership with the nearby *Puskesmas*. In case of illness or emergency, children are taken there immediately and are treated free of charge. The center has a database of all the student's health records, all of which are updated at the beginning of the school year, when students routinely undergo their annual medical check-up. Staff from the local *Puskesmas* also make use of the school's clinic whenever they visit Cipta Dharma Private Elementary twice a year to administer deworming to the students and staff.

Another important aspect of the well-established cooperation is health education. Health education sessions are delivered through health workers from the local *Puskesmas* based on a regular schedule. Activities revolve around promoting healthy behavior, observing proper hygiene, and avoiding health risks.

Health Promotion for Staff

Compared to many other primary schools in Southeast Asia, Cipta Dharma Private Elementary appears to be giving very good attention to health programs aimed at protecting the health and well-being of their teaching and non-teaching staff. The sports teachers offer bi-monthly activities for staff such as badminton and gymnastics classes, which are always well attended.

In cooperation with the neighboring *Puskesmas*, the school also extends support for tobacco-use cessation and healthy eating/ weight management to its staff if required or requested. Meditation classes are also on offer as a means to manage and relieve stress. Additionally, all teachers get regular first aid training and refresher courses.

Factors that lead to success

Both Bali schools, Tulangampiang Public Elementary and Cipta Dharma Private Elementary, have put in considerable resources and efforts into ensuring that their pupils and staff thrive in a healthy and safe environment that is conducive to learning. Several factors lead to the success that both schools enjoy as regards their respective SHCN programs:

- The involvement of parents and the wider community has strengthened collaboration and ownership of parents and it can be expected that the ongoing activities facilitate further community involvement, which is at the core of school-based management. Parents actively engage in improving school infrastructure and facilities and take active roles in PTA and school committee meetings.
- Qualified and highly motivated teaching staff have proven to be vital to successful health-related interventions in both schools.
- Different stakeholders perform different, well-defined roles with clear defined responsibilities and accountabilities. Children are not only the beneficiaries but also partners in making their school a healthy place. Teachers empower children to take leadership roles and responsibilities, while the school principal establishes links with local governments and ensures the regular agenda setting of health and nutrition issues during PTA meetings and other advocacy activities. The sub-district level ensures monitoring of activities and compliance with national strategies like UKS.
- Inter-sectoral cooperation between the education and health sector (i.e. the respective school with the local PUSKESMAS) has resulted in effective and efficient delivery of health services with little to no cost to the school.

Challenges and Recommendations

Although much has been achieved in these schools in the area of SHCN implementation, many challenges and areas for improvement remain as regards infrastructure, funding and human resources:

- In some instances, there are gaps between education or instruction, implementation on the school premises, and subsequent behavior change. According to teaching staff, tooth brushing twice a day and hand washing with soap are

constantly recommended by educators, but group activities cannot actually be practiced since the school does not have enough group sanitation facilities to make this possible. Even if dental kits are provided for in Cipta Dharma Private Elementary, for example, not enough sinks are in place and so skills-based hygiene activities are impossible to implement. In addition, toilet-to-student ratio is at 1:69-80. There is a clear need for more investments into such sanitation facilities, particularly because water- and sanitation-related diseases among schoolchildren are one of the most common health problems in Southeast Asia.

- Even though Tulangampiang Public Elementary and its canteen successfully implement a mainly-healthy-foods-and-snacks policy, stores outside the school mostly do not offer healthy food and beverage items, thus tempting children into a sugary diet once they leave the school grounds. In such cases, schools may seek the help of Denpasar's local officials so that the sale of such food items near schools may be monitored or controlled.

- Both schools do not have access to a full-time guidance counselor or social worker, which is common among primary schools in Southeast Asia. There is also no full-time nurse assigned to Tulangampiang Public Elementary. Given that schools often do not have access to such personnel, what schools can do for now is send their teachers to undergo first aid training and short courses on counseling or child psychology.

- The inadequacy of funds is another constant challenge faced by both schools chosen for this study, even if one is public and another is private. Parents of children studying in Cipta Dharma Private Elementary, in particular, expect better health services given that they are paying for school fees. However, the amount is generally not sufficient to cover all SHCN programs, and so principals and teaching staff need to establish and strengthen the school's links with the community in the hope that such partners can help bring in the resources needed to sustain effective SHCN implementation.

- Lastly, Cipta Dharma Private Elementary hopes to encourage its pupils to engage in physical activity by riding their bikes to and from school but is aware that given the school's location (on a major urban arterial road with heavy traffic), it may be risky for children to do this. In this case, schools can organize more events in school which will get students to move more, possibly during break time or before or after class hours.

Conclusion

The cases of Tulangampiang Public Elementary School and Cipta Dharma Private Elementary School show how dedicated teaching staff, guided by a comprehensive national framework for school health, can promote and foster healthy and hygienic behavior and lifestyles. These schools demonstrate that even with limited resources, well-defined interventions can improve the education quality and learning achievements of primary students by improving their health status and health behavior, thus ensuring the creation of a healthy school environment to allow for optimal growth and development of children in Bali.

Myanmar

The Republic of the Union of Myanmar is considered the largest country in mainland Southeast Asia with a land area of 677,000 square kilometers. In 2010-11, the total population was estimated at 59.78 million, with those in the 0-14 age group comprising 29.4 percent. There are over 130 ethnic groups or nationalities in the country, of which the Bamar race is the biggest.[61] It is a largely rural country which is administratively divided into seven states, seven regions and one Union Territory. A civilian parliamentary government has been at the helm since 2011.

Poverty continues to be a major challenge as more than a quarter of the population lives below the poverty line.[62] The rural areas, relative to the urban ones, experience a higher level of poverty. To help address this, Myanmar welcomes the spate of assistance from foreign aid donors and their implementing partners. There are around 20 multilateral and bilateral international donors funding development projects in Myanmar.[63] Additionally, there are 59 listed international nongovernmental organizations working in the country. Myanmar received $4.5 billion in aid in 2013, a 788 percent increase from the $504 million it received in 2012.[64]

The government has initiated and implemented a number of political, economic and social reforms. The educational system is one aspect that the government, through its Ministry of Education (MOE), is intent on reforming and improving; thus, educational reforms are being implemented, including the aspiration for free and compulsory primary education. To help realize this, the

1 No. 3 Basic Education Primary School Yangon City, Yangon

2 No. 1 Basic Education High School Yangon City, Yangon

(CIA, 2015)

61 Myanmar MOE, *Education for All 2015 National Review Report: Myanmar* (Author, March 2014), http://unesdoc.unesco.org/images/0022/002297/229723e.pdf.

62 Ibid.

63 Christine Dugay, "Top global development NGOs in Myanmar: A Primer," last modified May 12, 2015, https://www.devex.com/news/top-global-development-ngos-in-myanmar-a-primer-85786

64 Ibid.

government has increased expenditure on education from 0.7 percent of GDP (2010-11) to 2.1 percent (2013-14).[65]

Most schools are government-operated, although with the enactment of the Private School Registration Law in 2011, there has been an increase in privately-funded schools. In Myanmar's basic education system, five years are spent in primary school (Grades 1-5), four years in lower secondary (middle) school (Grades 6-9), and two years in upper secondary (high) school (Grades 10-11).[66] This 5-4-2 structure, which totals 11 years, is under review and will eventually be replaced by a 6-4-2 system.[67] Children officially begin primary school at 5 years old, although many who enter Grade 1 are over six.[68]

There are a number of legal bases for the education sector policy of Myanmar: 1) Article 28 and Article 366 of the *Constitution of the Republic of the Union of Myanmar* (2008); 2) the country's Vision Statement on Education; 3) Basic Education Objectives; 4) Basic Education Programs; 5) Myanmar National EFA Goals; and 6) Policy Guidance on education provided by the Head of State.[69]

School health has been enshrined in Myanmar's first People's Health Plan of 1977-78, although it was only in 1996 when Myanmar officially adopted the Health Promoting School (HPS) as a strategy for school health when it took part in the Global School Health Initiative. Essential elements of the HPS strategy include policies on school health, the physical and social environment of schools, health education, school-based delivery of health services, and community partnerships. Every township hospital has a school health team which helps ensure that schools within its area promote health. Four years ago, the country's MOH and MOE also launched the School Health Week and designated the second week of August for this annual celebration.[70]

The National Comprehensive Development Plan (NCDP) for the health sector covering the periods 2010-11 to 2030-2013, which serves as the long-term vision plan and a guide on the development of short-term national health plans, also identified as one of its strategies the implementation of public health programs in school health, nutrition promotion, food safety, and adolescent health among others.[71]

Myanmar's curriculum at the primary level also includes Life Skills Education (LSE), an initiative jointly implemented by the Ministry of Education and UNICEF. The Primary School LSE Curriculum, revised in 2004-05, was introduced as part of the curriculum initially in three townships in 2005 and eventually covered all schools at the primary level.[72] It has a focus on health promotion, HIV prevention, and other social topics deemed relevant and appropriate for primary school-age children.

65 World Bank, PID Appraisal Stage: Myanmar Decentralizing Funding to Schools (P146332), https://www.worldbank.org/content/dam/Worldbank/document/EAP/Myanmar/MM_Decentralizing_Funding_to_Schools-PID-March_2014_consultation_English.pdf.

66 UNESCO-IBE, *World Data on Education: Myanmar* 7th ed., http://www.ibe.unesco.org/fileadmin/user_upload/Publications/WDE/2010/pdf-versions/Myanmar.pdf

67 Martin Hayden and Richard Martin, "Recovery of the education system in Myanmar," *Journal of International and Comparative Education* 2, no. 2 (2013): 47-57.

68 UNESCO-IBE, *World Data on Education: Myanmar* 7th ed

69 MOE Myanmar, *Education for All 2015 National Review Report: Myanmar*

70 WHO Regional Office for Southeast Asia, "Health in Myanmar 2012," http://www.searo.who.int/myanmar/documents/healthinmyanmar2012/en/

71 Myanmar MOH, "Health Policy, Legislation and Plans," http://www.moh.gov.mm/file/HEALTH%20POLICY,%20LEGISLATION%20AND%20PLANS.pdf.

72 UNICEF, "Myanmar: Programme Document 2011-2015," http://www.unicef.org/about/execboard/files/Myanmar_final_approved_CPD_9_Sept_2010.pdf.

Table 15. Revised Life Skills Curriculum at the Primary School Level

Thematic Area	No. of Lessons
Social Skills	24
Emotional Intelligence	8
Healthy Living	14
Disease and Drug Prevention	16
Environmental Education	12

Source: MOE, 2014

The LSE covers five thematic areas, namely, social skills, emotional intelligence, healthy living, disease and drug prevention, and environmental education. A Secondary School LSE Curriculum was implemented nationwide as a compulsory co-curricular subject in lower secondary schools in 2013 and in upper secondary schools in 2015.[73]

For this case study, MOE Myanmar chose two primary schools in Yangon, the largest city in Myanmar. These are No. 3 Basic Education Post-Primary School in the township of Bahan and No. 1 Basic Education High School is located in the township of Dagon.

73 MOE Myanmar, *Education for All 2015 National Review Report: Myanmar*

No. 3 Basic Education Post-Primary School

No. 3 Basic Education Post-Primary School is situated in Bahan Township, Yangon. It has a land area of about 4,116 square meters. The school was established in 1964 as a primary school but was awarded post-primary status in AY 2013-14. A total of 1248 students are enrolled from grades 1 to 8 in AY 2014-15, but grade 1-5 students comprise majority of the school's student population. The break-down is detailed in Table 2. The total number of grade 1 to 5 students is 1120 (M=561 and F=559), while the teacher-to-student ratio for the entire school is 1:60.

Photo credit: SEAMEO INNOTECH

Table 16. Student Population in No. 3 Basic Education Post Primary School: 2014

Grade Level	Male	Female	Sub-Total
Grade 1	112	115	227
Grade 2	131	129	260
Grade 3	106	124	230
Grade 4	123	91	214
Grade 5	90	100	190
No. of Students in Primary Level	561	559	1120
Grade 6	16	18	34
Grade 7	31	26	57
Grade 8	21	16	37
No. of Students in Secondary Level	68	60	128
Total	629	619	1248

Source: School Brochure 2014-15

Twenty-eight employees comprise the school's staff, including the headmistress. The school has 25 junior assistant teachers, one primary assistant teacher, and one general worker.

School facilities include a playground, separate toilets for males and females, a "health corner" or clinic, and areas for hand washing. There is no canteen in the school. Classes start at 9:00 a.m. and end at 3:00 p.m., while lunch break is from 11:30 a.m. to 12 noon.

Some of the health care and nutrition practices and norms at No. 3 Basic Education Post-Primary School are as follows:

- Topics on Health Care and Nutrition are integrated in the Life Skills Education (LSE) subject. LSE is taught thrice a week, with each period lasting 30 minutes. For grades 1 to 5, it is the class teachers themselves who handle LSE. Table 3 shows a sampling of age-appropriate LSE content for every grade level, with topics becoming more complex as the students go higher.

Table 17. Sample Thematic Areas and Topics in Life Skills Curriculum at the Primary Level

Grade Level	Thematic Areas	Topics
Primary (Grades 1 -5)	Healthy Living	• Proper personal hygiene (hand washing and tooth brushing) • Sanitation and nutrition practices (healthy eating habits) • Safety practices (crossing the streets) (Grades 1- 5)
	Emotional Intelligence	• Mental fitness (values such as honesty and kindness) (Grade 4)
	Disease and Drug Prevention	• Drugs (Grade 4)

Source: Focus Group Discussion with the teachers and principal of No. (3) Basic Education Post- Primary School; Research Studies Unit, SEAMEO INNOTECH; Discussion conducted in Sept. 2014

Training courses on the implementation of curriculum and classroom management are undertaken. Primary school teachers are required to attend teachers' training and capacity-building courses on the core subjects in the curriculum. They need to attend intensive courses such as those in English, Math, and Life Skills Education. These are usually conducted during the summer months from March to May. All teachers must have completed an Education degree.

- Physical Training (PT) or Physical Exercise (PE) for primary school students is taught four (4) times a week, with each period lasting for 30 minutes. Physical exercises for primary students include walking and sports such as football and tennis. These are mostly participated in by male students. Poems and songs are also integrated in the curriculum. In December, primary school students play games such as pick-up-the-potatoes and running. Sports competitions are also held every December. Traditional games are also played during this time of the school year when it does not rain often, but football is played during the rainy season.

  Students also participate in regional and national sports-related competitions such as soccer. They are informed about safety practices during PT classes as part of civics. The principal also reminds the students about safety practices during general assemblies.

- There is no full-time nurse assigned to the school clinic. All teachers are equipped to handle minor or mild cases needing first aid. The regional health center gives a course on first aid every year. The students interviewed said

that on rare occasions where they got ill or had minor bruises while playing, it was their class teacher who attended to them. In case of a health situation necessitating immediate medical attention, the class teacher would first inform the parents about their child's situation before accompanying the student to the hospital.

- Bullying or fighting rarely happens in primary school, but just the same, a mechanism is in place to address such a concern. Given there is no resident guidance counsellor, the principal formed a committee composed of teachers. If there is a violation, students are called and asked to express that they would not do it again. In cases where harmless bantering between students results in someone getting irked, students know that they can ask the class teacher to intervene.

Among all the SHCN initiatives at No. 3 Basic Education Post-Primary School, it is its overall health and nutrition program which has been most highly commended.

Health and Nutrition Program

Every year since 1990, the school has regularly received awards from the regional and township government agencies (e.g., Ministry of Health) for its Health and Nutrition Program. Every year, ten schools which have shown commendable performance are chosen and awarded. Some of the criteria to gauge exemplary performance include cleanliness of the school and the existence of health and nutrition programs.

Although the school has no cafeteria/canteen, it still tries its best to instill the importance of eating nutritious food among the students. Students bring their lunch and snacks to school, but the class teacher checks the content of their lunch boxes. Every July, the class teacher also orients the parents on nutritious food that their children need. The class teacher also calls the attention of parents who allow their children to bring soda in school by writing them a notice. In addition, students can only buy from the food stalls outside the school premises before and after class. These stalls are also visited by the school to check if they sell unhealthy food and drinks. In cases of violation, the stall owners/vendors are warned. Twice or thrice a year, big private corporations like Ovaltine and Milo give free drinks to students. UNICEF, in partnership with the township education department of MOE, provides free milk to every primary and post-primary student every month.

The school hails its program on improving the health of students as the most successful. There has been progress in the height and weight of students as monitored by both the doctors and the mobile medical team in charge of the Yangon region. The school attributes the success of the program to the strong support from government entities and UNICEF.

No. 1 Basic Education High School

Established in 1884, No. 1 Basic Education High School is located in Dagon Township, Yangon. In AY 2014-15, a total of 3288 students (M=1820 and F=1468) are enrolled in school at the primary levels of pre-primary to Grade 5, the breakdown of which is in Table 3.

The school's teaching workforce consists of 154 full-time teachers, and this brings the teacher-to-student ratio to 1:52 for the primary level. The school also employs full-time non-teaching personnel. Three doctors work part-time at the school while one registered nurse works full-time.

School facilities include a school canteen with food stalls, clinic, toilets with running water, soap and hand dryer (46 for males and 32 for females), playground, football ground, tennis court, basketball court and a school garden. Classes in the primary level last from 12 noon to 5:00 p.m. and are divided into two sessions.

The school adopts a vision to promote the health of all students through its school health promotion program. It aims to promote the health standards of the entire studentry, as well as the skills and knowledge needed for adopting a healthy lifestyle. All

Photo credit: SEAMEO INNOTECH

Table 18. Student Population in No. 1 Basic Education High School from Pre-Primary to Grade 5, AY 2014-15

Grade Level	Male	Female	Sub-Total
Pre-primary	290	216	506
Grade 1	254	180	434
Grade 2	267	254	521
Grade 3	309	253	562
Grade 4	314	252	566
Grade 5	386	313	699
Total	**1820**	**1468**	**3288**

Source: Survey on School Health Care and Nutrition Programs in Primary Schools in Southeast Asia, SEAMEO INNOTECH,2014

their activities are anchored on the nine health-promoting school components, namely: health education, healthy school environment, disease control, nutrition and food safety, school health services, community outreach, counselling and social support, training and research, and physical education fitness and sports.

Below are some of the SHCN practices and initiatives at No. 1 Basic Education High School:

- Life Skills Education is taught to primary students for 35 minutes once a week. The school implements the national curriculum, which has no examination component. Topics subsumed under Healthy Living include personal hygiene (i.e., hand washing, tooth brushing, hair care, fingernails care), sanitation and nutrition practices, clean environment, and healthy lifestyle (i.e., no smoking, no drinking of alcoholic beverages). Topics under Emotional Intelligence cover good relationships and friendships, how to be good and kind to other people, how to avoid bullying, and emotional intelligence. The topics are more on instilling values. HIV/AIDS and dangers of smoking are discussed in Disease and Drug Prevention. Topics on Social Skills include safety practices (i.e., nature and human-made threats to safety such as fire and dangerous and risky activities such as playing in the street, swimming in the lake, swinging in the tree trunks). There is also a topic on human trafficking (i.e., dealing with strangers, do not eat food given by strangers).

- Physical Training is taught twice a week, and each period takes 35 minutes. For Grades 3 and 4, there are aerobic exercises and play-based activities. Students are aware of the safety practices during PT since the LSE curriculum includes a demonstration of safety practices. Sports taught include football, gymnastics and acrobatics. Wushu is taught not only in the primary but also in the middle and upper levels. Badminton and swimming are taught in middle and high school. PT classes are more on outdoor activities and less on lectures. During inter-school competitions, the student representative of the school is sent. The school shoulders the expenses of the student joining the competition.

- Health facilities and services include a clinic with three part-time doctors who come in shifts and a registered nurse. The health service providers (i.e., doctors and dentists) from the township medical office visit the school once or twice a year to check the height and weight of all students. Deworming is done twice a year. This is in keeping with the national government policy that all schools should implement the deworming program. The school involves the students' parents in its health and nutrition program by sending a number of parents to the regional medical office to learn about good nutrition. This is held twice a year.

- The school strives for a safe and conducive learning environment for students. The school is mosquito-free, drug-free and a no-smoking zone. Once a week, on Saturdays, the entire school is sprayed to eliminate mosquitoes. Emergency response orientation is practiced, and there are fire and earthquake drills. Modules on good relationships with friends, classmates and families are taught in the moral and civics subject, and these are supplemented

by once-a-week assembly talks wherein topics such as being friendly and avoiding fights are discussed. Although bullying rarely happens in primary school, mechanisms are in place to handle such cases. The class head (or the head teacher of every grade level) is in charge of handling and investigating cases of bullying, while a committee composed of teachers and the principal oversees the class heads and helps address and resolve the issue. The committee also monitors and tracks the behavior of the student and talks to his or her parents when necessary.

School Canteen

The school canteen is the school's most successful SHCN program, as evidenced by the top award (first prize) given to the school by the Yangon City Development Council (YCDC) and the Health Care Committee. The award is in recognition of the canteen's sanitation and food safety practices. According to the teachers, the canteen has received the award several years in a row. The selection process is stringent as it involves an ocular visit from the Health Care Committee officials and interviews with students to verify that safety and cleanliness are strictly enforced. Such visits occur twice or thrice a year.

The school canteen/cafeteria is owned and operated by the staff of the school. The pooled amount from rent is allotted for canteen maintenance and renovation, if necessary. They sell fried rice, fried noodles and sandwiches among many others. The Food and Drug Association (FDA) controls the kind of food that should be sold in the canteen (e.g., no candies; soda is allowed but expiration dates are closely monitored).

The School Health Committee is fully committed to the nutrition program by ensuring that all food stalls in the canteen offer food items from the three main food groups. Stall inspections are held every day. In addition, all township school teachers have to attend the intensive program on nutrition and health conducted by the Township Medical Office. In addition, canteen staff undergo medical check-up before the start of the school year, and are required to have certificates of good health from the township Health Department. They also receive talks and trainings as conducted by the doctors from the Department of Health in the Yangon region.

Factors That Lead To Success

The following factors facilitated the effective implementation of the program in both schools:

- Strong policy support plays a pivotal role in the success of the school's SHCN programs. The overarching goal of upgrading the quality of education in the country is anchored on the country's larger vision statement for education: "To create an education system that can generate a learning society capable of facing the challenges of the Knowledge Age." Major policies, strategies and interventions for education and learning are aligned and in keeping with the vision statement. Upgrading the quality of education necessitates enhancing the capacity of teachers. In line with the goal, the Ministry of Education enforces and implements capacity building and enhancement programs (township-based primary school teachers' training and

intensive courses during summer vacations) for teachers. In addition, it was a government directive that instituted LSE as a separate subject and mandated its inclusion at the primary and secondary levels.

- The involvement of multiple stakeholders is a strong pillar of the school health and nutrition programs. For instance, apart from the parents' participation in the nutrition program (ensuring that the children's lunchboxes contain the three food groups), parents provide assured funds to the school through school fees levied on enrolled students. The school also depends on parents for voluntary contributions to shoulder the cost of extracurricular activities such as sports competition and school celebrations. The YCDC maintains the drainage system, and collect sewage and garbage. The police are engaged to give talks on topics like traffic accidents the dangers of narcotics. The township doctors help chlorinate water tanks and treat linen cloths with mosquito repellants. The regional doctors are tapped to give health education talks and conduct inspection tours in schools. NGOs provide some resources and aids to the schools.

- Fostered partnership and close collaboration between and among government agencies have resulted in the full-on and effective implementation of particular programs, most notably the canteen services at No. 1 Basic Education High School. United in the national agenda of realizing Education for All (EFA) goals, township and regional offices of MOE and MOH are determined to deliver and contribute to the overall national targets.

Challenges and Recommendations

The following challenges and recommendations emerged from the focus group discussions:

- Both schools identified inadequate resources/funding as a hindering factor in implementing the programs more effectively. Respondents recommend lobbying and campaigning for increased government funding for education. The challenge/ problem of inadequate facilities, services and resources (as raised by the two schools) is rooted in the relatively small budget allocation for education. It is important to highlight that better facilities and services result in improved student learning.

- The large number of primary students vis-à-vis the number of school staff poses a challenge in implementing the nutrition program (lunchbox program). Since addressing this reality would require additional funding as well, what schools can do for now is organize nutrition classes for parents across all primary grade levels to sustain heightened awareness of and solicit continuous support for the health care and nutrition program of the school.

- Although stakeholders are already coordinating with each other, SHCN program implementation can be even more successful if collaboration between and among agencies is further intensified. Respondents suggest that the Health Care Department and the MOH hold monthly coordination meetings, while more nongovernmental organizations can be asked to help raise public awareness on school-based health care and nutrition programs. Benchmarking visits can also be organized so that

other schools can come and observe practices of schools worthy of emulation and replication. For example, teachers interviewed for this study wanted to explore innovative and interactive ways of teaching PT.

- Because monitoring and evaluation is currently done only on a per-activity basis, schools have no way of assessing their overall SHCN performance. As such, regional and township offices may consider developing a comprehensive monitoring scheme to evaluate the health and nutrition initiatives of the schools under their jurisdiction. In particular, teachers suggest reviewing the time allotment for lunch, as 20-30 minutes may not be enough time for the students to eat.

Conclusion

In conclusion, the health care and nutrition programs implemented in both No. 3 Basic Education Post-Primary School and No. 1 Basic Education High School have achieved significant gains, most especially in the area of health and nutrition. This is evident in the recognition and awards given to both schools on a yearly basis. However, challenges to program implementation remain, the most pronounced of which is the inadequacy of facilities and services due to very limited funding support for the education sector. While this is a tough challenge to contend with and hurdle, the two schools are still able to implement SHCN successfully because of strong policy support, strong community support, and inter-agency collaboration.

Philippines

The Philippines is an archipelagic country with 7,107 islands grouped into three main island groups: Luzon, Visayas, and Mindanao. This setup has made it more challenging for the government to provide basic social services to all—especially to those in rural and remote areas. This may be why various health and nutrition programs are being rolled out in the 48, 186 primary schools throughout the country, as they give DepEd and DOH a better way to reach the almost 14.5 million children who are currently in elementary.[74]

One of the flagship SHCN programs in the Philippines is the Essential Health Care Package (EHCP) program, which covers daily hand washing, toothbrushing, and deworming. International organizations

1 Francisco Benitez Elementary School Makati City, Manila

2 Padre Jose Burgos Elementary School Manila City, Manila

3 Banuyo Elementary School Mercedes, Eastern Samar

(CIA, 2015)

74 PSA (formerly NSO), *The Philippines in Figures 2014* (Philippines: National Statistics Office, 2014).

such as UNICEF and GIZ have helped DepEd establish, develop, and institutionalize EHCP, which is why it is similar to the WASH program implemented in other Southeast Asian countries. The prescribed curriculum for the combined subject covering Music, Arts, Physical Education, and Health (MAPEH) reinforces and builds on these personal hygiene lessons as well.

Many feeding programs are also being implemented in the Philippines with the help of NGOs, INGOs, local government, and civic groups. At the national level, the School-Based Feeding Program (SBFP) is funded through DepEd's School Health Division SHD-BLSS). Both help address malnutrition, hunger and severe wastage among students in the country. Schools with students whose parents are beneficiaries of the government's conditional cash transfer program also get funding to feed these children while they are at school. Much of the proceeds from the school canteen must also be utilized to support SHCN programs, as outlined in the table below at the bottom of the page. The harvest from the school's vegetable garden—if it has one—and a part of the money it is able to raise through other income generating projects (IGPs) can also be used to sustain or augment various feeding programs.

To help keep schools clean and safe for the students, teachers, parents, and other members of the community are engaged to take part in *Brigada Eskwela* (School Brigade), wherein they help clean and repaint rooms as well as fix areas of the school in need of repair. More recently, DepEd and DOST have also joined hands to place ovicidal/larvicidal traps in schools to combat dengue.

The schools from the Philippines which were initially chosen for this study are Francisco Benitez Elementary School-Main (F. Benitez-Main) in Santa Cruz, Makati and Padre Jose Burgos Elementary School (PBES) in Sampaloc, Manila. Both schools are located in urban areas in the country's national capital region (NCR). F. Benitez-Main is near one of the Philippines' business districts and is beside one of the main cemeteries in NCR. On the other hand, PBES is located near residential *barangays* (villages) but is also close to one of the main roads in Manila, the country's capital.

Upon consultation with UNICEF Tacloban, Banuyo Elementary School (Banuyo ES) was identified as another school with good SHCN practices and programs and thus, was also visited for this phase of the study. Banuyo ES is a school located in Mercedes, a fourth class municipality in Eastern Samar, Region VIII.

Table 19: Fund Utilization of Proceeds from the School Canteen

Components	Percentage share
Supplementary feeding for identified undernourished pupils/students	35%
Revolving capital	15%
Improvement/procurement of HE facilities	20%
School clinic fund	5%
Food production fund (in support of feeding program)	10%
School share	15%

Source: DepEd Order 17, s.2005

Francisco Benitez Elementary School-Main (F. Benitez-Main)

F. Benitez-Main has a total of 1,759 students (M=915 and F=874) and 77 staff members. Of the 77, 55 are directly involved in teaching students while some of the non-teaching staff run the canteen and clinic, keep the common areas clean, and tend to the vegetable garden in school.

The school's buildings are three stories high and there are 31 classrooms and 6 comfort rooms that students can use. There are 15 toilets for female students and nine toilets as well as another nine urinals for boys. Electricity, running water, and potable water are available 24/7, and hand washing facilities are also available on every floor and in the comfort rooms. A school canteen and a medical-dental clinic are located on the ground floor. The school is fortunate to have a full-time nurse, although the dentist comes to the school only twice a week to evaluate students' dental health and conduct simple treatments. Physicians from the nearby barangay health center visit the school occasionally.

Because F. Benitez-Main is an old school, some of its buildings were being demolished and reconstructed at the time of the school visit. As such, the school operates on a two-shift schedule, with classes starting as early as 5:50 a.m. and lasting until 6:20 p.m.

Some of the SHCN initiatives at F. Benitez are as follows:

- The medical-dental clinic is open from 8 a.m. to 5 p.m., even during lunch break.
- Every room has a first aid kit and there are designated first aid teachers for every grade level.
- A canteen manager leads a dedicated staff of three members in preparing and cooking healthy food for both paying students and feeding program beneficiaries. Examples of food available at the canteen are boiled eggs, boiled peanuts, bananas, fresh fruit juice, porridge, rice cakes, and macaroni soup. Parent volunteers are tapped to bring the food to the classrooms so that students will not have to waste time lining up to purchase snacks.
- An exercise program dubbed "Zumbaxercise" has been put in place to encourage teachers, overweight students and parents to increase their physical activity. Hour-long sessions are held either before or after classes, thrice a week for every shift. This means there are six "Zumbaxercise" classes held at F. Benitez-Main every week.
- All students at F. Benitez-Main (and in all public schools in Makati, for that matter) have accident insurance coverage and can make claims if they encounter an accident—even if the accident did not happen in school or in Makati.

Photo credit: SEAMEO INNOTECH

F. Benitez-Main has also been exemplary at implementing EHCP for years now. In addition, relevant and engaging activities comprise the school's annual Nutrition Month celebration in July, and other school-based programs targeting malnutrition are likewise launched in the same month to maximize impact. Lastly, there is a high level of community and stakeholder engagement in the planning, implementation, and monitoring of the school's various SHCN programs at F. Benitez-Main. These best practices are discussed in more detail below.

EHCP Implementation

EHCP at F. Benitez-Main is similar to EHCPs in other primary schools in the Philippines in that it covers the basics: lessons and drills on daily toothbrushing and hand washing, and twice-a-year access to deworming. Dental kits funded by the city government are distributed primarily to grade 1 students at the beginning of every year, but because the school gets additional funding for EHCP from the barangay from time to time, there are extra kits which the school dentist distributes to selected grade 2 to 6 students. This helps encourage students in the upper primary levels to continue brushing their teeth after meals and at home. The city government also provides public schools in Makati with liquid hand soap which students can use when washing their hands. It is the school nurse who distributes the liquid hand soap bottles to class advisers. During recess, students form a line in front of the hand washing facility and obtain some hand soap from the teacher prior to washing their hands.

F. Benitez-Main is also an advocate of no-rinse toothbrushing, a method wherein students are encouraged only to spit out the toothpaste foam and not rinse their mouths with water after brushing so as to maximize the benefits that come from using fluoride toothpaste. This also makes it possible for students to brush their teeth even if clean water is not available, although the school dentist warns that this could be potentially messy so students should also be trained to brush their teeth over the bathroom sink or group hand washing facilities at school.

91 percent of students at F. Benitez-Main also undergo deworming twice a year, well over the 85 percent accomplishment rate which DOH requires of primary schools in the country. In fact, the school's accomplishment rate used to be only 82 percent, and so to raise and maintain this figure, the school nurse began distributing consent forms twice a year instead of only at the beginning of the academic year and started going from one classroom to another to follow up with students whose parents have not signed the consent forms yet. Another effective strategy is to talk to the parents about the benefits of deworming during the parent orientation and give them the option to sign the consent forms there and then.

It is worth noting that EHCP at F. Benitez-Main greatly benefits from the presence of a full-time school nurse who can focus all her energy on planning, managing, and implementing SHCN programs in just one school.

Nutrition Month Celebration

F. Benitez-Main celebrates Nutrition Month in July each year with an array of activities for students and the community to enjoy. The principal heads the SHCN committee which oversees the month-long celebration, but it is the school nurse who is more directly involved in the planning and preparation. Activities would be laid out and teachers-in-charge would already be identified months

in advance. There would also be parent representatives from the General Parent-Teachers Association (GPTA) for major activities such as a) the Community Parade wherein students showcase their nutrition month posters, b) contests for making nutri-jingles and nutrition month slogans, c) a Nutri-cook Fest wherein parents learn about how to cook nutritious food at home, and d) All-Veggie Fridays or Meatless Mondays, both of which encourage students, teachers and staff to take a break from eating meat at least once a week.

Many of the feeding programs are also launched in July, and this gives SHCN at F. Benitez-Main a boost because programs end up more integrated and coordinated for that month. 472 boys and girls—about 12 percent of the student population—benefit from the school's feeding programs whose funding comes from different sources. The national and local government feed 168 and 204 students, respectively, via SBFP and Project Food for Excellent Education and Development (Project FEED). Meanwhile, the Rotary Club of Makati - North (a civic organization) prepares and provides lunch for 100 students as part of DepEd's adopt-a-school program. The school's canteen manager adds that they make sure to chop the vegetables in their dishes very finely so that the students end up eating them instead of separating them from the meat and leaving the vegetables on their plates.

The DepEd division of Makati has also made the monitoring and evaluation of the school's nutrition services more engaging by holding competitions related to nutrition-related services in schools. For example, they hold an annual Division Search for Outstanding Supplementary Feeding Program Implementer as well as a Search for Outstanding School-Managed Canteen. Samples of evaluation forms DepEd Makati uses to rate schools in their division are in Appendices B and C.

Community and Stakeholder Engagement

Another exemplary practice that is evident but not exclusive to F. Benitez-Main is its active membership and participation in two community-based groups related to child health and nutrition: the Barangay[75] Nutrition Council (BNC) and the Special Committee for the Protection of the Child (SCPC). The school's officer-in-charge (OIC) represents the school in these groups and reports that the school has greatly benefited from its good working relations with other stakeholders at both the barangay and city levels.

The BNC is headed by the barangay captain,[76] who is assisted by a kagawad (barangay councilor). Apart from the school OIC and/or principals, student representatives from the student government or student council and parent representatives from the GPTA also attend monthly meetings wherein stakeholders plan projects and share information on how health and nutrition initiatives are implemented at the school-level.

The SCPC, on the other hand, regularly convenes at DepEd Makati to ensure that children living in Makati are kept safe from abuse and exploitation.[77] It is composed of teachers, student government representatives, parents, *barangay* officials, and representatives of religious groups.

75 the smallest administrative unit in the Philippines and may refer to a village or a district

76 the highest elected official or leader in a barangay

77 Philippine Department of Justice, *Annual Report CY 2008*, http://www.doj.gov.ph/files/2008Annual.pdf

In his personal capacity, the OIC of F. Benitez-Main has also networked with other civic groups based in Makati such as the local office of the ICRC and the Rotary Club of Makati - North. Both groups have sponsored basic life support training for the teachers of F. Benitez-Main.

Padre Burgos Elementary School (PBES)

PBES is a much larger school with 4,224 students (M=2,211 and F=2,013), but as there are primary schools in Manila with more than 7,000 students, PBES is still considered a medium-sized school. Student population is diverse, as PBES also has departments dedicated to teaching talented and gifted children, children with learning disabilities, and youth catered by DepEd's alternative learning system (ALS). However, majority of their students still attend mainstream schooling. PBES has 142 full-time staff, 8 of which do not have any teaching load and are either in administration or in the pool of utility personnel.

Photo credit: SEAMEO INNOTECH

The school's multiple buildings are two to four stories high, and 75 instructional rooms are available for students to use. However, the rooms are shared by different classes, with the first shift lasting from 6 a.m. to 12nn while the second shift is from 12nn to 6 p.m. There are comfort rooms for boys and girls on every floor, and although one of its old buildings is now being reconstructed after it burned to the ground in 2013, there are enough hygiene facilities for boys (40 toilets and 6 urinals) and girls (39 toilets) to use. The school has group hand washing facilities plus 24 more faucets in the comfort rooms. Electricity, running water, and potable water are available 24/7. The school also has a canteen, a clinic, a counseling room, and a covered court where PE classes are held simultaneously.

A nurse is assigned to the school but is not working there full-time, although it is worth noting that assigning a nurse to handle multiple schools is standard practice in the Philippines. A physician also comes every other week to check on the children, but students are able to benefit from having a full-time guidance counselor and a school dentist.

Some of the school-based health and nutrition initiatives being implemented at PBES are as follows:

- DRRM drills are done regularly and students learn about common diseases during the rainy season. These activities are important particularly in the context of PBES because the low-lying areas surrounding the school and the streets leading to the school get flooded during the rainy season.

- Every month, the water at PBES is collected and checked for organism contamination. This is the case not only for PBES but for all public schools under DepEd Manila.
- Because it has a full-time counselor, PBES is able to conduct psychological examinations for its students and more closely monitor their mental and socio-emotional well-being.
- Through the initiative of NGOs and civic groups, teachers at PBES are able to take advantage of discounted rates for particular vaccines and prescription eyeglasses. Annual eye check-ups are provided free of charge as well.

PBES also has impressive feeding programs and monthly health and nutrition celebrations, and these will be discussed in the sections below.

School-based Feeding (SBF)

Unlike other primary schools, PBES has provisions to employ two canteen managers: one who takes care of finance and administrative matters, and another who oversees food preparation and feeding operations. Such a set-up has worked well for the school, as both canteen managers are able to focus on the aspects of canteen management assigned to them. As a result, the school is able to raise enough funds from canteen sales to provide lunch for 61 students from kindergarten to grade 6 for the entire school year.

The local government also provides snacks in the form of a nutri-bun (vitamin-enriched bread) and a small carton of milk to 151 students, while DSWD gives PBES a daily budget of P4500 (about US$100) to provide lunch (composed of rice, a main course, and a serving of fruit) to 300 malnourished or poor students for 120 days. This brings the total number of feeding beneficiaries at PBES to 512, or about 12 percent of its student population. Because one of the canteen managers can give her full attention to the management of daily feeding, the school is able to consistently prepare nutritious food for such a large number of student beneficiaries. Moreover, she is able to stay at the feeding areas as the children are fed and is thus also able to get student feedback regarding their preferred dishes. The school principal has also assigned additional teachers, non-teaching staff and student interns to help distribute food to the students and ensure that they finish the food on their plates.

To expedite the identification of beneficiaries and monitor the impact of the feeding program on their health, the school nurse also trains PBES teachers on how to evaluate the nutritional status of their students.

Economic status is also taken into consideration, and because teachers are the ones who stay with the students in the classroom, they are in the best position to know which of their students do not bring food or money for lunch and/or snacks.

Monthly Health and Nutrition Celebrations

As part of its pupil development program, PBES also conducts celebrations every month to increase pupil and parent awareness of various aspects of health and nutrition. Topics are scheduled to coincide with official celebrations throughout the country, and are outlined in the table in the next page.

Table 20: SHCN-related Celebrations at PBES (S.Y. 2014-2015)

Month	Topic
June	Preventive Nephrology (good grooming, personal hygiene, hand washing)
July	Nutrition
August	Vision/Lung Month
September	World Health Day Anti-Smoking Week
October	School Health Education Month
November	Drug Abuse Prevention and Control Week Population and Family Planning Week
December	World Aids Day
January	National Cancer Consciousness Month
February	Heart Month Dental Month
March	Fire Prevention Month

Source: Padre Burgos Elementary School Action Program, S.Y. 2014-2015

The school nurse and the nurse interns from nearby nursing/medical tertiary institutions go from class to class—including those composed of gifted/talented and differently-abled students—to give talks related to the topic/s for that month, and parents are also given 30-minute seminars on the same topic/s as well. Whenever possible, celebrations end with a culminating activity that engages the community, such as an out-of-school parade and a sports fest.

Banuyo Elementary School (Banuyo ES)

Banuyo ES is a rural multi-grade school located in Mercedes Municipality, Eastern Samar, and is attended by 75 students (M=43 and F=32), all of whom live within a few kilometers from the school. A head teacher and her three teachers comprise the full-time school staff, but volunteer parents help in maintaining the cleanliness and upkeep of the school. The district nurse and dentist assigned to Banuyo ES take care of students in other schools as well and comes only once a month and twice a year, respectively, but the school is easily able to ask for help from the nearby *barangay* health center, wherein some of the parents of their students work as *barangay* health workers.

When it comes to the school's buildings, only the bungalow building where the three classrooms and one multi-purpose hall (MPH) are located is being put to good use. Each classroom has a working toilet and a water dispenser from which students can get potable water, and the MPH generates some

income for the school whenever GOs, NGOs, and international organizations rent the space to hold meetings. Electricity is available 24 hours, but running water is only available for eight. Fortunately, the school has a water tank to which its group hand washing facilities are connected so students still have access to water throughout the day. In addition, the school has a vegetable garden and a playground with a concrete slide and a set of pull-up bars. Most of the school's other structures such as the school canteen, the principal's office, and the assembly hall were either razed in a fire or ruined when Typhoon Haiyan left parts of the Philippines devastated in 2013. However, reconstruction was already in full swing when the school visit occurred in early 2015.

Students stay in school from 7:30 to 11:30 a.m. and from 1:30 to 4:30 p.m. The two-hour lunch break makes it possible for students to go home for lunch. This was the case even when the school had a canteen, as the latter only sold snacks and beverages.

The following are some of the SHCN-related features about Banuyo ES and its programs:

- Each teacher keeps a first aid kit in her respective classroom. Although the kits were initially donated to the school by Plan International, the head teacher has made arrangements with the nearby barangay health clinic and the rural health unit to replenish the medical supplies whenever they run out.

- Before classes start, students and staff take part in *Hataw*, the Filipino term for "give it one's all" and the name of the school's 15-minute exercise program. During Hataw, older students perform various exercises as they recite the multiplication table while the lower primary students just work on the movements. Sessions are held early in the morning instead of at noon so that the students can perform the exercises in the open field but still avoid the midday heat.

- Because the school has no support staff, parent volunteers are tapped to help prepare both food to be sold in the canteen and food to be given to feeding program beneficiaries. The head teacher reports that because parents know that their children will eat the food they prepare, they are motivated to cook clean and nutritious food.

Of the many SHCN-related initiatives of Banuyo ES, Project *Batang malinis at Ayos ang NUtrisyon Yaman ng Organisasyon* (Project BANUYO) and their Pupil-Led Total Sanitation Project (PLTS) stand out because they make use of student health ambassadors who encourage not only their fellow students but also members of the community to continue observing proper hygiene in school and at home. Both projects are relevant given that Typhoon Haiyan destroyed many homes in Mercedes and other parts of Eastern Samar.

Photo credit: SEAMEO INNOTECH

Project *Batang malinis at Ayos ang NUtrisyon Yaman ng Organisasyon* (Project BANUYO)

Project BANUYO is Banuyo ES's own response to the increase in health and nutrition problems that teachers observed in their students in the aftermath of Typhoon Haiyan, and it is one of the 45 school-based management (SBM) projects funded by UNICEF Tacloban in the area of water, sanitation, and hygiene (WASH). The directive to propose WASH programs came from the Deped Region VIII office, as malnutrition among children in the region rose from 7 percent to 16 percent after Typhoon Haiyan devastated parts of the region. Teachers also noticed that children were coming to school in soiled clothes, with untrimmed fingernails, without having taken a bath, and with no footwear.

To address the poor health status of students, teachers at Banuyo ES decided to create a module on proper hygiene composed of lessons on toothbrushing, good grooming, and hand washing. Teachers decided that a modular approach would work best in light of the successful pilot implementation of the IMPACT learning system in their school. Developed by SEAMEO INNOTECH, IMPACT is a system which heavily relies on self-learning modules and is supplemented by audio and video materials.[78] Although the project also has a feeding program component to combat malnutrition and UNICEF also funded the construction of hygiene protection facilities at Banuyo ES, the packaged module on good hygiene promotion is at the heart of Project BANUYO.

Student leaders were chosen to be school health ambassadors, and were given training on how to use the module. The module lays down key aspects of the learning process in a mix of English, Filipino, and Waray (the local language)—from what materials to prepare for each lesson to what spiels must be delivered during the demonstration and what questions to ask their classmates to check for understanding. This way, it is the students themselves who facilitate learning among their peers, hence the project's tagline "Kids Teaching Kids Home Hygiene Basics."

Monitoring continues throughout the year and is pupil-facilitated as well. Health ambassadors use a checklist similar to the one below to document whether their classmates are able to observe proper hygiene every day. Checking happens twice during the day, once during the morning assembly and once more before afternoon classes start.

78 SEAMEO INNOTECH, "IMPACT Learning System," http://www.seameo-innotech.org/projects-ongoing/e-impact/.

Figure 4. Banuyo Elementary School's WASH Promotion Checklist

Banuyo Elementary School
Mercedes District

WASH Promotion Checklist

Hygiene (clothes/uniform, nails, toes, footwear)

Name	Morning				Afternoon			
	clothes	nails	toes	footwear	clothes	nails	toes	footwear
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

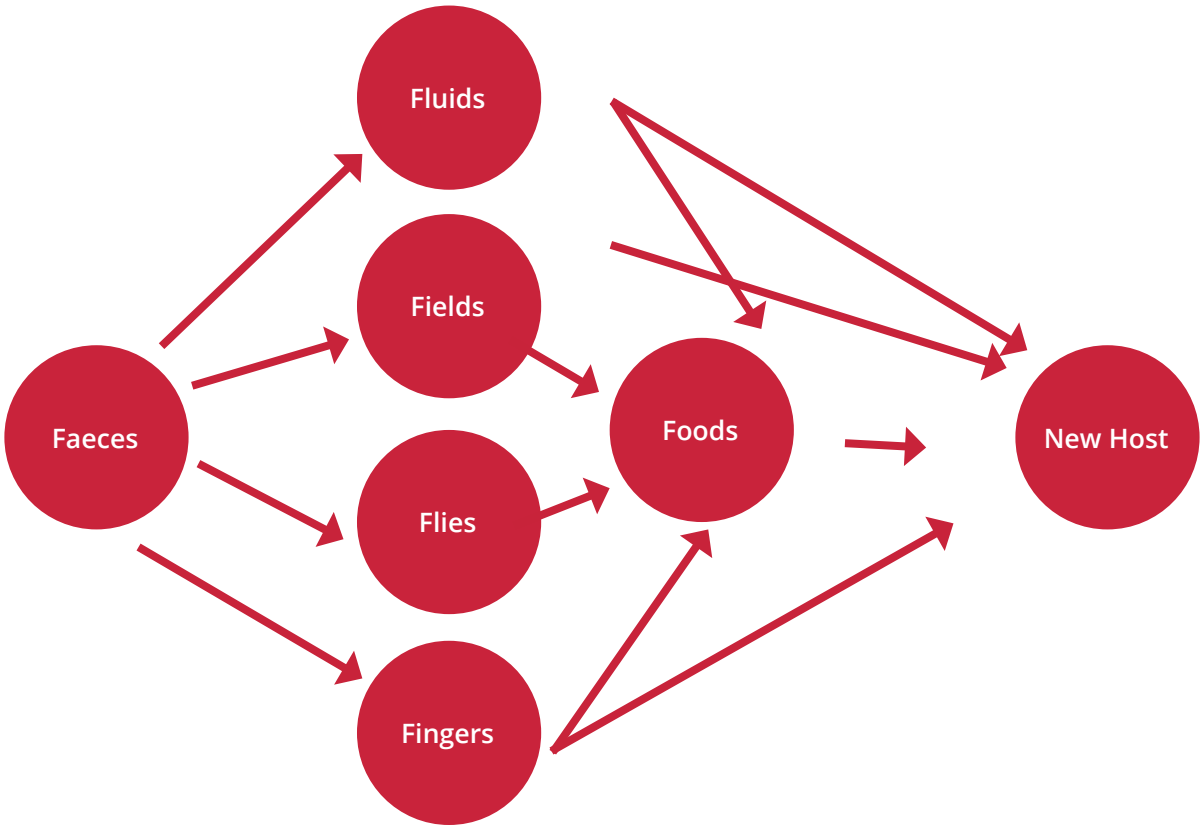
Source: Banuyo Elementary School

There are also separate student monitors who check if classmates bring water, a face towel, and a toothbrush to school.

Pupil-Led Total Sanitation (PLTS)

Since Typhoon Haiyan destroyed many of the homes in Banuyo, the practice of open defecation in the *barangay* worsened. The teachers at Banuyo ES felt the need to discourage this practice which could further worsen the health status of students and their families, so they organized a WASH club to spearhead the PLTS. The club went around the neighborhood to map the post-Haiyan sanitation status of the different homes in their *barangay* in order to determine how many functional bathrooms and toilets can be used by the community. The teachers once again adopted the modular approach and drafted a multi-lingual module featuring the F-diagram, a tool commonly used by international organizations to explain the adverse effects of human waste to one's health (Figure 5).

Figure 5. F-diagram



Source: UNICEF, "Towards a better programming: A Manual on Hygiene Promotion," *Water, Environment and Sanitation Series* 6 (1999): 34, accessed November 5, 2015, http://www.unicef.org/wash/files/hman.pdf

As with Project BANUYO, student health ambassadors were also trained to use the module, but this time around, they were trained to educate not only their classmates but especially their parents, friends, and elders in the community. Using Waray as the medium of instruction, they talked to families on the importance of practicing good hygiene at home. To increase impact, student health ambassadors brought materials to demonstrate the f-diagram. Side by side, they would lay in front of their audience some human waste, a plate of food, and a basin of clean water. In no time, flies would swarm around these samples and move from one sample to another. Through this strategy, members of the community could immediately see for themselves that they are endangering their own health by defecating in the open.

The modules are still being used in Banuyo today as part of its EHCP. The division office of Borongan, to which Banuyo ES reports, has revised and turned the modules into an official DepEd module on home hygiene basics which other primary schools in the region have begun to use.

Factors that Lead to Success

The success of various SHCN programs at F. Benitez-Main, PBES, and Banuyo ES in the Philippines can be attributed to a number of factors:

- SHCN programs benefited from solid support not only from the students but also from the school community and other stakeholders. Student leaders are engaged to support pupil-led initiatives, and civic and religious groups also extend some assistance. The head teachers and principals in all schools underscored the importance of networking and maintaining good working relations with partners in and beyond the community, as they are located near the school and are in the best position to offer immediate help when the need arises.

- Although funding and human resources may not always be adequate, these three schools are able to effectively implement SHCN programs, thanks to staff who are generous with their time and energy and who embody what one principal calls "a can-do attitude." Banuyo ES, which has a much smaller student population and less funds for operations, has tapped parent volunteers and other health workers in the community. What is clear is that a harmonious working relationship among the teachers and staff leads to schools with successful SHCN programs, and that strong leadership from the top administrators and the school nurse is crucial to the establishment of this positive school culture.

- SHCN has been successful in these schools because class advisers and subject teachers are trained to administer first aid, evaluate the health status of the students, and provide counseling. Such a setup makes it possible for medical staff to focus on the more technical or difficult cases, as they do not have to attend to every child with a health or nutrition problem.

- The monitoring and evaluation component of the SCHN programs in these schools also help drive the programs forward. Principals who go to feeding areas themselves, for example, are able to more quickly identify gaps in implementation and make the necessary arrangements to remedy them. In addition, the division-wide search for schools with exemplary SHCN implementation introduces the element of healthy competition in the monitoring and evaluation process and promotes increased engagement from the school.

- Lastly, it is worth highlighting that the three schools have some form of documentation—a training module, action plans, photos and videos of previously rolled-out programs—to ensure continuity of the SCHN programs even after school nurses or principals get reassigned to other schools.

Challenges and Recommendations

On the other hand, focus group discussion (FGD) participants have also noted a number of challenges which they have encountered in the implementation of SHCN programs:

- Despite the success with which the three schools are able to implement their SHCN initiatives, staff respondents from F. Benitez-Main say that the small size of their clinic sometimes makes it difficult for them to pay enough medical

attention to simultaneous cases. As such, they recommend that the size of the school and the student population be taken into consideration when constructing school clinics.

- At present, school nurses in the Philippines are employed by DOH, and most of them serve schools in fixed terms, go back to the nurses' pool, and then get assigned to a different school or set of schools. Staff respondents believe there could be wisdom in giving school nurses permanent assignments so that they can become more familiar with the school's networks and SHCN-related problems and will know how to best implement or customize a program to fit the school's particular context. Given that the students themselves are the ones most likely to attent the same school for years, students can also be tapped to support and even lead SHCN initiatives. Doing so may also make success more likely, as studies have shown that student engagement in school-based initiatives has led to greater acceptance of programs among the school community and an increase in available human resources since students now share ownership of and responsibility for these programs.[79]

- Keeping schools in operation during or in the aftermath of natural hazards and calamities has also been difficult for teachers, especially since they themselves are often calamity victims. In such instances, it is crucial for the principal to exhibit strong leadership and strength of character so that schools can be reopened as soon as possible, as in the case of Banuyo ES which resumed operations 15 days after Haiyan left Eastern Samar. It is also important for local and central DepEd offices and other aid agencies to provide adequate financial and even technical assistance during times of disaster, if necessary.

- Lastly, respondents feel that they could benefit more from additional SHCN-related training and technical assistance, as in the case of Banuyo ES which was able to develop Project BANUYO with the help of international organizations and the DepEd division office in Borongan, Eastern Samar.

Conclusion

The cases of F. Benitez-Main, PBES, and Banuyo ES show that SHCN programs and practices can be successful regardless of school size and in both urban and rural school settings for as long effective, multi-stakeholder systems are in place to support program development, customization, implementation, and monitoring and evaluation. These mechanisms may take various forms: established school-based and community-based committees, documented processes and protocols, self-learning modules, inter-school contests, and even pupil-led programs that allow students to contribute instead of just being passive recipients of SHCN in their respective schools. Lastly, the schools are a testament to the importance of resilience, as these schools have remained exemplary in the area of SHCN even while parts of the school are being reconstructed and even in the aftermath of a calamity.

79 Adam Fletcher, "*Meaningful Student Involvement: Guide to Students as Partners in School Change,*" 2005, 9, https://soundout.org/wp-content/uploads/2015/06/MSIGuide.pdf.

Singapore

The city-state of Singapore is an island country divided into five administrative districts. With a land area of 718.3 square kilometers and a population of about 5.47 million as of 2014,[80] it is the most densely populated country in Southeast Asia. Most of the country is highly urbanized, and majority of its residents are part of vertical communities residing in mid- to high-rise public housing, condominiums and apartment dwellings. These flats are part of self-contained satellite towns with schools, clinics, hawker centers, supermarkets, play areas, and other recreational facilities. As such, primary schools in Singapore are always within two kilometers of housing facilities and other major buildings. According to the latest available figures, there are 182 public primary schools attended by 244,045 students in Singapore.[81]

Singapore's MOE and MOH work closely with schools to promote and protect the dental and medical health of its young citizens. Student health data are uploaded to a centralized student management system called the "school cockpit," and this makes it easier for the government to track and analyze health data even if students transfer to another primary school or are promoted to high school. According to the Singapore MOE, the three most common SHCN problems in Singapore are overweight students, myopia, and dental problems.

Primary schools must also pass sanitation, safety, and quality living environment standards set by the School Safety Unit under the MOE and the National Environment Agency (NEA), a statutory board under the Ministry of the Environment and Water Resources (MEWR). Apart from these ministries, the

1 Endeavor Primary School

2 Pei Tong Primary School

following are some of the inter-ministerial and inter-divisional groups which lead the development and implementation of Singapore's SHCN programs:

- National Coordinating Committee for Tobacco Control (NCCTC),
- NCCTC Community Workgroup,
- Healthy Living Master Plan Implementation Steering Committee, and
- National Myopia Prevention Program Steering Committee.

There is also a Schools Division Health Committee which works with MOH's Health Promotion Board (HPB) on areas that directly impact students such as the sale of food and beverages in schools, annual health screening and vaccination programs, and the management of underweight and obesity cases.

At the school level, part of the duties of teachers and staff is to serve in various committees and the table in the next page lists some of the groups whose work or mandate is related to SHCN.

80 Singapore Department of Statistics, "Statistics: Latest Data," accessed 2015, http://www.singstat.gov.sg/statistics/latest-data#14

81 Ibid.

Table 21. SHCN-related Committees at the School Level

Department Committees	Working Committees
• Character and Citizenship Education • Physical Education/Health Education / Co-curricular Activities • Pupil Well-being	• Canteen Committee • Case Management Team • School Safety Committee • School Staff Well-Being Committee • Senior Teacher Taskforce • Sports Day / Primary 5 Camp / Program for Active Learning

Because Singapore takes a school-based management (SBM) approach, committees vary among schools and depend on their respective contexts and needs.

Various national policies are in place to support the implementation of most SHCN components in primary schools in Singapore. Except for Family and Community Involvement, all other components are well-supported by various policies which not only institutionalize the school-based health and nutrition initiatives but also ensure funding for program implementation and evaluation. The table below highlights some of the major SHCN-related policies in Singapore:

Table 22. National SHCN Initiatives in Singapore and Implementing Agencies

SHCN Component	SHCN Initiative	Implementing Agency/ies
Healthy and Safe School Environment	External Safety Validation (ESV) Exercises Risk Assessment Management System (RAMS)	School Safety Unit (SSU), MOE
Health Education	HE Syllabus	Physical and Sports Education Branch (PESEB)
Physical Education	PE Syllabus	PESEB
Nutrition Services	School Canteen/Cafe/ Vending Machine Guidelines	Health Promotion Board (HPB), Canteen stallholders
	School breakfast program	Finance Division, MOE
	School Canteen Committee	Finance Division, MOE
Health Services	School Health Services	HPB
Counseling, Psychological, and Social Services	Policy on Counseling	Guidance Branch, Student Development Curriculum Division, MOE
Health Promotion for Staff	School Staff Well-being Committee	Schools

Both External Safety Validation (ESV) and Risk Assessment Management System (RAMS) advocate a more structured approach towards school safety. As part of ESV, representatives from the MOE's School Safety Unit (SSU) visit schools every three years to validate the safety practices of schools and suggest areas for improvement where applicable. RAMS, on the other hand, provides schools with a tool to systematically identify possible hazards in the conduct of school activities and work processes and take measures to reduce or eliminate the risk factors.

As with many other countries in Southeast Asia, the primary curriculum in Singapore already includes mandatory physical education (PE) and health education (HE) lessons. The new syllabus being progressively implemented since 2014 has been renamed Physical Health & Fitness (PHF), as HE and PE lessons are now packaged together and delivered in four or five 30-minute sessions, depending on the students' grade level. P4 and P6 students also undergo the National Physical Fitness Award (NAPFA) test, a series of five stations which students must take on the same day plus a 1.6 kilometer walk/run which they must take within two weeks of going through the other stations, which are as follows:

- Sit-ups
- Standing Broad Jump
- Sit and Reach
- Inclined Pull-ups
- Shuttle Run[82]

Students are given grades ranging from A to E for their performance on each of the stations, with A indicating excellent performance and E constituting a pass. A grade of F grade means that the student failed in that test item, but it should be noted that one's NAPFA grade does not count towards promotion to the next level.

A number of policies and programs on nutrition services in schools also ensure that canteen stallholders consistently cater to the nutritional needs of students and sell healthy food at reasonable prices. Guidelines are set by the HPB, and the school canteen committee helps the principal manage and monitor the food and beverage stalls. Meanwhile, through the school breakfast program, the government provides financial assistance to children from needy families so that they can buy food from the canteen and not be disadvantaged at learning because of hunger.

Among the school health services which primary schools in Singapore offer their pupils are medical screening, immunization, blood grouping, basic dental services, and oral hygiene promotion. It is also primarily through schools that MOE and MOH correspond with and keep track of students with health problems. For example, students with high body mass index (BMI) are sent letters through their schools and are asked to report to HPB's student health center. If students fail to make it to these appointments, follow-up letters are coursed through schools as well.

Each primary school is also assigned at least one guidance counselor to provide intervention support to help students manage socio-emotional and behavioral problems that may interfere with their learning. As for staff well-being, there is a school-based committee that organizes recreational activities for staff throughout the year, although participation in these activities is usually voluntary.

82 St. Hilda's Primary School, "NAPFA: National Physical Fitness Award," http://shpspe.weebly.com/napfa.html.

For this case study, MOE Singapore chose Endeavour Primary School (EDP) and Pei Tong Primary School (PT), both of which are government-owned and operated and are felt to represent the average primary school in the city-state.

Endeavour Primary School (EDP) was founded in 2008 and is located along Admiralty Link in the Sembawang district, in one of the more recent urban developments in Northern Singapore. It is half a kilometer away from the Sembawang train station and is surrounded by high-rise public-housing buildings which locals call HDB, after the Housing and Development Board that manages them.

On the other hand, Pei Tong Primary School (PT) has been in the district of Clementi in Western Singapore since 1945, when it was founded by civic-minded people to cater to the schooling needs of children in the area after the liberation of Singapore that same year. PT is celebrating its 70th anniversary this year, although records would show that it was officially established only in 1948. PT is close to Clementi train station and is also near HDB dwellings.

Photo credit: SEAMEO INNOTECH

Endeavour Primary School (EDP)

EDP has 1,395 students (M=726 and F=669) attended to by 117 full-time and two part-time staff. Students are divided into 40 primary 1 (P1) to primary 6 (P6) classes which are handled by 105 teaching staff. The non-teaching staff work in the general office (administration), manage the printing office, and provide operations support. One of the two guidance counselors works only four days a week, while the school dentist holds clinic at EDP thrice a week. The thrice-a-week schedule for school dentists is standard practice for primary schools in Singapore, but each school dental clinic is part of a small network of dental clinic buddies. On days when the dental clinic at EDP is closed, students requiring immediate dental treatment are brought to one of EDP's nearby dental clinic buddies.

The school's buildings are three to four stories high and group hand washing facilities, drinking fountains, and separate toilets for boys and girls are available on every floor. Campaign posters reminding students to wash their hands properly, keep the toilet seats clean, and use hand dryers are posted in or near these hygiene promotion facilities. Liquid hand soap dispensers are also mounted on the wall for the children to use. In addition, there is a steady supply of electricity, running water, and potable water at EDP.

The school canteen at EDP has eight stalls occupied by commercial stallholders serving a variety of healthy snacks, beverages, and meals. The school's dental clinic is open on Tuesdays, Thursdays, and Fridays. Although there is no medical clinic at EDP, there is a sick bay at the general office for students who figure into accidents or are not feeling well. For this reason, many school staff assigned to the general office have first

aid certification. This is the usual case in Singapore, as there is oftentimes a clinic near the school where children who need immediate medical attention or treatment may be brought. Because Singapore is a very small country, even big hospitals are just minutes away from most schools.

Like the average public primary school in Singapore, EDP has its own multi-purpose hall for assemblies; a fenced-in grass court where children can play during PE, recess, and after school; and an indoor sports hall where up to two PE classes can be simultaneously held. There are many laudable health and nutrition initiatives at EDP, many of which reflect how national SHCN policies are implemented or adopted in this particular school:

- Cleaners in charge of maintaining the cleanliness of common areas are contracted by MOE and assigned to EDP. It is also MOE that contracts vendors which can provide pest control services for the school. Although officially contracted by MOE, these service providers answer to the school operations manager. This streamlines the bids and awards process for maintenance services needed by all schools.

- Following the recent MOE directive to install automated external defibrillators (AEDs) in all government and government-aided schools,[83] a number of defibrillators have been installed at EDP and members of the PE department have undergone training on how to use them. A defibrillator is a life-saving device that delivers therapeutic doses of electrical energy to "jumpstart" the heart in the event of cardiac arrest. Many public places in Singapore are already equipped with defibrillators.

- PE teachers are on monitoring duty during recess and are assigned to the common areas and grass court to ensure student safety.

- All beverages and food packets sold at the canteen carry the Healthier Snack Symbol (HSS), which signifies that these items are packed in recommended serving sizes and have less salt, fat, and sugar in them.

- The government-funded Swimsafer program, which is mandatory for all P3 students, is implemented at EDP to equip pupils with basic safety measures to help them be safe and feel confident around bodies of water. External vendors which are duly certified to hold the Swimsafer classes for schools are contracted for this program.

"Healthier Choice Symbol Programme," Health Promotion Board.

83 Singapore MOE, "MOE in the process of equipping schools with AEDs," *Forum Letter Replies,* last modified January 23, 2015, https://www.moe.gov.sg/news/forum-letter-replies/moe-in-the-process-of-equipping-schools-with-aeds.

- School counselors create a letter box in which students can drop letters to encourage them to ask help from the right people. These boxes are placed in highly visible and easily accessible areas in school such as the school canteen or at the door of the guidance counselor's office.

- EDP has replaced anti-bullying campaigns and programs with programs that focus on character education. Lessons cover building positive relationships, conflict management, and other socio-emotional skills needed to relate well with people. HPB offers an array of assembly talks which EDP brings to the school, and form teachers use resource packages from MOE to follow up on what students learn from these talks during the guidance period.

- Even if school dentists do not stay in one school for the entire week, schools have identified buddy dental clinics—open clinics located in schools or communities nearby — to which students at EDP could be rushed in case of dental emergencies. Students from these schools can also be brought to the EDP dental clinic on days when the EDP dental clinic is open and their buddy dental clinics are closed.

- Implementation of other SHCN initiatives follows a needs-based approach. Each school's principal and teachers decide which lesson packages, assembly talks, and media resources developed by HPB and/or MOE to use in their respective schools. Decisions are based on perceived needs of students and teachers' previous experience on working with these resources.

In addition, there are also a couple of good practices initiated by EDP's administrators:

- Every school staff member is assigned to only one committee throughout the year so that they do not have to attend many committee meetings. School committees at EDP are therefore smaller, but every committee member is expected to focus on and do more for the committee to which he or she is assigned.

- The open court is accessible to students early in the morning but is closed from 10:00 a.m. onwards because staying under the sun at this time of day could be harmful to student health.

- The faculty lounge has an electric massage chair which teachers can use.

- There are two microwaves in the faculty lounge, and one is exclusively used for halal food.

As a school with exemplary SHCN practices, EDP has successfully implemented the Chapteh Challenge and the Endeavour Program for Active Learning (E-PAL). It has also developed a more systematic way to monitor accidents in campus. Details on these programs which other schools may want to implement or adapt to their own contexts are presented in the next sections.

Chapteh Challenge

The Chapteh Challenge was organized by EDP's PE Department last school year not only to encourage physical activity among children during recess but also to promote traditional games among Singapore's youth. Chapteh is a traditional Asian game in which players can use all parts of their bodies except for their hands to keep a weighted shuttlecock—called chapteh—in the air. The objective of the game is to keep the chapteh in the air for as long as possible.

The program was conceptualized by the PE department as a way to introduce structured playtime into students' daily routine, particularly because many of them hardly engage in any physical activity outside school. Chapteh was chosen over other sports because it is relatively easy to learn and master, is fun to play, brings a lot of health benefits, and requires minimal equipment.

EDP acquired chaptehs using money from the school's health education fund (HEF), and students were introduced to the game during PE class so that everyone could have the chance to try out the sport first before playing it in front of more people during recess. This approach made the program more inclusive, as many of the students playing chapteh during recess were those who could successfully keep the chapteh in the air.

PE teachers were in charge of managing the play sessions during recess over a three- to five-week period, in which students and staff played chapteh with each other every day. Only 100 chaptehs were brought out at a time to encourage students to share the chaptehs and take turns when playing. Students were also taught how to fix the chaptehs whenever the feathers would fall from the metal disc during play.

Accident Statistics

Another good practice at EDP is how they gather statistics on accidents in school for monitoring purposes. Data on the type of injuries as well as when and where the injury was acquired are collected and tallied in a table such as the one in the next page.

Using the data in this table, EDP can easily determine the most common injuries students incurred at school as well as the most accident-prone areas on campus. It also provides EDP administrators with solid information to help them choose which common areas need to be more closely monitored by PE and form teachers during recess and throughout the day. In addition, schools collecting such data can also more easily identify which faculty members need to undergo first aid training.

Lastly, the table also compares the percentage of students figuring into accidents in one school year with the percentage from the previous year. For EDP, the accident rate for 2013 was already very low at 2.84 percent, but this has further decreased to 2.7 percent in 2014. The comparison helps schools determine whether the accident rate on campus has increased and what improvements could be done to make the school even safer for students.

Table 23. Endeavour Primary School's Table for Collecting Accident Statistics

Name of School

Accident Statistics for S.Y.

Injury Type	Assembly	Recess	Dismissal	PE	CCA*	Curriculum	Total
Fracture							
Laceration							
Eye injury							
Head Injury							
Trip/Fall							
Others							
Total Injury							
Total enrolment							
Accident Rate (current S.Y. %)							
Accident Rate (previous S.Y. %)							
*co-curricular activities							

Source: EDP Accident Statistics for 2014

Endeavour Program for Active Learning (E-PAL)

The Endeavour Program for Active Learning is the school's adoption of MOE Singapore's Program for Active Learning (PAL). PAL has been progressively introduced in Singapore's primary schools since 2009 as a way to help students develop non-academic skills and values, particularly in the early primary years.[84] PAL modules are delivered weekly over a seven- to 10-week period, and the program exposes students to sports and outdoor education as well as performing and visual arts in a fun way.[85]

E-PAL is funded by MOE Singapore, with all eight modules handled by external vendors during the first year. However, form teachers and PE teachers were assigned to "shadow" the contractors as they conduct the lessons so that they could learn how to deliver the modules themselves. EDP's specialist teachers have also created modules for P1 and P2 students and trained form teachers on how to conduct these lessons.

All these efforts help make the program more sustainable in the long run especially because MOE funding for E-PAL is really

84 Singapore MOE, "Developing Skills and Values in Pupils — Another 24 Primary Schools to Implement Programme for Active Learning from 2011," http://www.moe.gov.sg/media/press/2010/09/developing-skills-and-values.php

85 Ibid.

meant to progressively decrease as school staff become more capable of handling the modules themselves. During E-PAL's first year, EDP engaged external vendors to handle all eight E-PAL modules. This year, however, seven of the eight modules are already handled by school staff. This arrangement also gives form teachers the opportunity to work on their relationship with their students.

Similar to other primary schools in Singapore, EDP invites E-PAL bids from contractors via an online centralized bidding system managed by MOE. Companies registered with MOE can check the contract price and requirements posted by EDP and place their bids through the system. After a set period, EDP then assesses the proposals and chooses an external vendor for E-PAL. In fact, this centralized bidding system is well-established and is also the same system schools use to find external vendors for their co-curricular activities and assembly talks.

Schools are also given the flexibility to adopt and customize E-PAL modules to cater to the needs and interests of their students. At EDP, for example, P1 and P2 students learn about fundamental movements and locomotor skills, rhythmic gymnastics, and orienteering during Term 4. Because the E-PAL modules on sports and outdoor education are designed to get students to move about, classes are held at EDP's halls or in the open areas inside the school compound. E-PAL leaves such a positive mark on the pupils that even P5 and P6 students interviewed for this study could easily recall the fun activities they had when they underwent E-PAL years ago.

Pei Tong Primary School (Pei Tong)

The PT school community is composed of 1,368 students (M=635 and F=733), 112 full-time school staff, and a part-time dentist. 93 of these school staff are part of PT's teaching workforce, while 17 are non-teaching staff who do administrative work or maintain the cleanliness and upkeep of the school. The school has two full-time guidance counselors and a dentist who visits the school thrice a week.

PT's buildings are three stories high, and students and teachers have access to electricity, running water, and potable water all day. The school also has its own indoor sports hall, fenced-in grass court, and multi-purpose hall. Apart from these amenities, PT also has a school canteen with six commercial stalls selling various healthy food and drink items, a school bookstore, a center providing after-school care, and a counseling room. As in the case of EDP, PT also has group hand washing facilities, drinking fountains, and separate toilets for boys and girls on every floor. The faucets for hand washing at PT are equipped with sensors and can be operated hands-free. Liquid soap dispensers are also mounted on both ends of every group hand washing facility. Hygiene promotion posters—both

Photo credit: SEAMEO INNOTECH

created by teachers at PT and provided by HPB—line the walls near the hand washing facilities or the bathroom mirrors.

As in the case of EDP, many of the noteworthy SHCN practices at PT form part of the school's adoption of particular national initiatives:

- The surface of each canteen table features a blown-up image of My Healthy Plate, a visual tool developed by HPB to provide Singaporeans with a simple representation of a balanced and healthy meal.[86] Big posters reminding students of the recommended number of servings for each food type are also mounted above each stall.

- Students can still access and play in the open court after school hours.

- PT uses three entry points to instill character and promote positive behaviors among their pupils: during assembly talks where children learn how to manage their anger, settle conflict, and be a friend; during PE lessons where they learn to work in teams; and during guidance period where form teachers use MOE-issued materials to promote camaraderie among their students.

- PE and HE teachers at PT use a variety of teaching strategies inside and outside the classroom, from simple discussions with students to reflective journals, books, active play, and interactive boardwork. At times, MOE-issued lesson packages are delivered to coincide with national celebrations. The PHF resource books have also been made smaller to make it easier for teachers and students to hold classes in the open court or halls.

- Every year, PT holds a sports carnival for all students. Each primary level focuses on a sport, with students training for the inter-class competition during PE class. To keep students motivated, the winning team goes against their grade-level teachers in a friendly game. Sportsmanship awards are also given to deserving students.

- The school identification cards (IDs) of students who are beneficiaries of the feeding program are loaded with S$1.50 (about US$1.10) every day which they can use to purchase food from the canteen. The ID functions like a typical swipe card, such that students can choose to buy food and drink items from various stalls. This new system gives student beneficiaries more freedom and accountability over their dietary choices.

- PT's food hygiene officer has undergone and passed a three-day training course on food hygiene.

Health Promotion Board, "My Healthy Plate."

86 Health Promotion Board, "My Healthy Plate," http://www.hpb.gov.sg/HOPPortal/health-article/HPB064355)

In addition, there are also a couple of good SHCN practices initiated by PT's top administrators:

- A horizontal climbing wall has been built along one of the walls of the school's indoor sports hall for the students to scale during their free time. Its base has also been lined with mats to provide enough cushion for students should they fall. This encourages students to take part in active play during breaks, but the horizontal orientation makes it a safer activity for students.

- PT has implemented additional nutrition guidelines for canteen stallholders to comply with. For example, the school requires sellers to use fat-free noodles in their dishes. At least 30 percent of the rice and bread sold at the canteen must also be composed of whole grains. The school has raised the benchmark for healthy eating in schools in Singapore and has been duly recognized by MOE for adopting these additional guidelines.

Apart from these initiatives, two innovative and low-cost SHCN programs at PT—Care Program and Active Recess—are documented in more detail in the sections below. These programs are highlighted particularly because they make use and maximize resources which are already at the school's disposal and therefore, would be easier for other schools and education systems to replicate.

CARE Program

PT's CARE Program was conceptualized by the school's PE department as a targeted response to the high percentage of overweight students enrolled at PT. CARE stands for "Children Active in Recreation and Exercise," and the program was introduced in 2013 with the objective of bringing down the percentage of overweight students from more than 14 percent to less than 12 percent (the upper limit set by MOE Singapore) through the promotion of a healthy and active lifestyle. Program funding comes mostly from the school's PE fund.

- To identify students who need to undergo the CARE program, data on the height and weight of students are collected twice a year: at the beginning of Term 1 in January and right after students return from the mid-year break in the latter half of June. These data are fed into the school cockpit and retrieved and analyzed by HPB. The school implements the CARE program in close coordination with HPB, as it is the latter which identifies students whose BMI is beyond normal and therefore need to be enrolled in the program. HPB drafts letters for the parents of these students to notify them that their child is required to set and attend an appointment with the HPB student health center. The school also asks parents to give their children permission to participate in the program while encouraging them to exercise with their children and prepare nutritious food at home.

Students who are enrolled in the CARE program take part in 20-minute exercise routines four times a week. Routines could range from steady morning runs to JUMP JAM sessions[87] or games and even fitness gym workouts. Sessions are handled by the school's PE teachers and are held either early in the morning or during recess. Students are divided according to grade levels, and this setup helps motivate students to come to

87 JUMP JAM is a 'Kidz Aerobix' resource kit created by Brett Fairweather which primary and intermediate students and teachers can easily follow. More information can be found at http://www.jumpjam.co.nz/singapore/.

the sessions as they see it as a way to bond with their peers. Once students are enrolled in the program, their height and weight are taken every month so that the school can more closely monitor their BMI. Students graduate from the program once their BMI falls within the healthy or normal range.

Currently, a separate CARE program class is held for every primary level at PT, such that the school's PE department designs and handles six CARE program classes throughout the day, four times a week. The percentage of overweight pupils enrolled at PT fluctuates especially after the long school breaks, but the school has, at some points, achieved its goal of reducing the percentage of its overweight pupils to less than 12 percent. Nonetheless, PT intends to continue implementing the CARE program in partnership with HPB.

Active Recess

The CARE Program is part of a much bigger school initiative to increase the time students spend on other activities and reduce the time they spend eating during breaks by changing their notion of what they should be doing during recess. Administrators at PT thought of Active Recess as a way to combat overweight and obesity among its students by promoting the idea that recess should not be just about food, and that a good portion of this scheduled break from school work can be better spent on other activities.

In addition to the members of the PE department who manage the CARE program and monitor the students as they play in the common areas, the school principal also taps other members of the school staff such as the librarian, subject teachers, the guidance counselors, Health Education (HE) teachers, and even specialist teachers handling art and music classes to create and develop activity booths or exhibitions which students can go to during recess. The goal is to present students with a range of activities and interests to take them away from the canteen table as soon as they are done eating so that they do not end up consuming more food than they should.

Booths are located near the canteen and feature a range of activities such as playing sports with one's friends, trying a musical instrument, solving math problems, reading books, answering interactive quizzes, and even playing with a life-size board game. The booths are easy to set up and pack up. At PT, for example, a giant snakes-and-ladders board game is painted on the floor, and the librarian chooses a theme for the day and sets up related books from the library on a table near the canteen. On some days, the music teacher takes out a number of instruments for the students to play. Booths need not be elaborate all the time, too. The health department at PT, for example, has recently put up an Active Recess mobile exhibit featuring information materials on littering provided by HPB. PT's principal notes that what is more important is that the booths are rotated and new booths are occasionally introduced to keep the students interested. Such a setup also makes it possible for Active Recess work to be more evenly distributed among members of the school staff.

Factors that Lead to Success

EDP and PT owe their effective implementation of SHCN to the following success factors:

- SHCN programs implemented In EDP and PT enjoy solid policy and funding support from the government. The country's school-based health and nutrition initiatives are not dependent at all on donor funding, and this gives the government and even schools

themselves much freedom to set goals and priorities depending on student needs. Programs which are backed by policies and are well-funded are also more sustainable in the long run.

- SHCN initiatives are also supported by strong inter-agency partnerships which have been well-established even before programs are first implemented. The collective and systematic efforts of key agencies in MOE, MOH, NEA, MCYS, and MSF lead to the success of various health- and nutrition-related programs implemented in schools. In addition, updated, centralized systems and data portals make coordination and monitoring easier for the different government agencies.

- The competent administrators of the schools in Singapore which were visited for this study are also able to make the most of the SBM approach implemented in Singapore's primary schools. Principals are able to prioritize particular programs based on the needs and interests of their respective students. They are also given the freedom to use school funds to strengthen particular programs and initiatives.

- Although teachers in Singapore also take on extra work to implement these SHCN initiatives, the teacher-to-student ratio in these two schools in Singapore is much lower compared to that of other primary schools in the region. There is also assured funding for teachers and other school staff who need to undergo training and certification so that they can competently support the implementation of SHCN initiatives at EDP and PT.

- Teachers at EDP take a reflective approach to choosing SHCN programs to adopt and implement. They are encouraged to take a step back and study the school's existing programs and SHCN initiatives before proposing more programs, and to complement what is already being implemented in schools instead of starting something completely new. Not only does this make successful implementation more likely, but it also makes the SHCN efforts of a particular school more integrated and focused.

- Lastly, EDP and PT are able to respond to the health and nutrition problems of their students because data on the students' medical and dental health are routinely collected and uploaded to a centralized database. PT, in particular, has created a database of the health status of each of their students, such that teachers have quick access to crucial information such as each student's diseases and allergies. With easy access to a wealth of data, school staff and government agencies are in a better position to identify students in need of targeted or additional interventions.

Challenges and Recommendations

EDP and PT also identified a number of challenges which they have encountered in the process of implementing SHCN programs in their respective schools:

- First, the centralized bidding system sometimes results in scheduling conflicts with other schools that would like to engage the services of the same external vendor on the same day. In particular, some SHCN-related assembly talks may be difficult to book, so school administrators recommend that these talks be booked as early as possible and

Photo credit: SEAMEO INNOTECH

that constant follow-up be done with the contractors until a booking is secured.

- Given that Singapore is a multicultural country, meeting all the socio-emotional and psychological needs of such a diverse student population may prove to be a challenge at times. This is where form teachers and year-level heads become crucial, as they are in the best position to customize messages based on their personal knowledge of their students.

- It can also sometimes be a challenge to sustain student interest In the SHCN programs. To help resolve this, school departments and committees as well as external vendors need to constantly evaluate their programs and come up with more creative and interesting ways to implement SHCN in their schools. The MOE, for its part, can ensure that teachers have access to professional development opportunities related to effective SHCN implementation.

- A unique challenge for Singapore is how to further decrease the incidence of obesity in its children. Like many primary schools in Singapore, EDP and PT have been intensifying their efforts to introduce what one of the teacher respondents called "structured free play" in the daily routine of their students in the hopes that they themselves will engage in physical activity regularly even when they are not in school.

- Lastly, respondents note that there is still room for improvement when it comes to SHCN programs targeting teachers and school staff, as many of the weekly physical activity sessions are initiated and sustained by informal groups who share the same interests.

Conclusion

SHCN programs and initiatives at EDP and PT show that program implementation is more likely to be successful and sustainable when schools have access to stable funding and receive constant support from the central MOE, and when teachers are given a wealth of well-crafted resource packages which they can use and customize to suit the needs and interests of their students. In addition, the case of Singapore is also a good example of how SHCN policies can be efficiently and jointly implemented and monitored by various government agencies with a stake on student health and well-being. Above all, the schools visited for this study are a testament to how a needs-based approach to SHCN implementation in schools supported by adequate resources can be effective in addressing students' health and nutrition needs.

Timor-Leste

The Democratic Republic of Timor-Leste is composed of the eastern half of the island of Timor, nearby islands Atauro and Jaco, and Oecusse, a coastal exclave within the northwestern side of West Timor, Indonesia. Located beside Indonesia and to the north of Timor Sea and Australia, Timor-Leste is home to a population of close to 1.2 million people.[88]

Timor-Leste is the youngest country in Southeast Asia. Prior to its independence in 2002, it was colonized by Portugal from the 16th century until 1975 and then invaded by Indonesia afterwards later in the same year.[89] The country has a lower-middle-income economy,[90] and has faced challenges in rebuilding infrastructure and job generation in the years immediately following its independence. Nevertheless, Timor-Leste has achieved annual growth rates between 8 and 12 percent for the last few years, and has intensively rebuilt its nation with help from many international organizations.[91]

Basic education in Timor-Leste has a duration of nine years and typically starts once the child reaches the age of six. The entire basic education cycle is compulsory, but only the first six years are classified as the primary levels. The academic year begins in October and ends in June. Of the 350,000

1 Escola Básica de Farol Dili City

2 Escola Básica 30 de Agosto Dili City

(CIA, 2015)

pupils enrolled in schools in Timor-Leste, about 242,000 or 69 percent are primary students.[92]

The 2013 global Joint Monitoring Programme (JMP) report estimated that only 27 per cent of rural Timorese households have access to an improved sanitation facility. Nearly 74 per cent of mothers dispose baby faeces unsafely and merely 1.2 per cent of mothers wash hands with soap after cleaning a child's bottom. These factors all contribute to diarrhoea and intestinal worm infections among rural children. Nearly half (46 per cent) of 1,259 primary schools in Timor-Leste do not have access to improved water sources and one-third (35 per cent) of them lack basic sanitation facilities. More than 50 per cent of rural Health Posts lack access to clean running water.

Preliminary findings of a food and nutrition survey conducted by UNICEF in 2014 showed that the prevalence of stunting, underweight and wasting among children aged 0-5 went

88 World Bank, "Population, Total (2013)," http://data.worldbank.org/indicator/SP.POP.TOTL.

89 Government of Timor-Leste, "History," http://timor-leste.gov.tl/?p=29&lang=en.

90 World Bank, "Country and Lending Groups," http://data.worldbank.org/about/country-and-lending-groups#Low_income.

91 Central Intelligence Agency, "Timor-Leste," *The World Factbook,* last modified August 15, 2016, https://www.cia.gov/library/publications/the-world-factbook/geos/tt.html.

92 Education Policy and Data Center, "National Education Profile 2014 Update: Timor-Leste," http://www.epdc.org/sites/default/files/documents/EPDC%20NEP_Timor%20Leste.pdf.

down from 58.1 percent, 44.7 percent, and 18.6 percent in 2009 to 51.9 percent, 38.1 percent, and 10.8 percent in 2013, respectively. Overall, though, under nutrition remains the biggest problem related to child development in Timor-Leste.[93] In response, the government has increased the allowance for its nationwide school feeding program from 15 to 25 US cents per student per day.[94]

The "Zero Hunger Challenge," a global campaign to end hunger and eliminate stunting in children two years old and below, has also been launched in Timor-Leste recently. In addition, the country's Ministry of Health (MOH) has been working with the World Health Organization (WHO) in order to finalize dietary guidelines based on food items which can be sourced locally.[95]

The 2014 global Joint Monitoring Programme (JMP) report also estimated that as of 2012, only 39 percent of rural Timorese homes in both rural and urban areas have access to improved sanitation facilities.[96]

Health has been laid out as a critical area in Timor-Leste's Strategic Development Plan 2011-2030,[97] and WHO reports that MOH Timor-Leste has developed a number of national strategies related to health. Among these are the National Strategy for the Prevention and Control of Non-Communicable Diseases (NCDs), the Reproductive Maternal Neo-Natal Child Adolescent Health (RMNCAH) Strategy 2014-2018; and the National Strategic Plan for School Health (2014-2018).[98] MOE Timor-Leste, for its part, has made the following commitments through the country's National Strategic Plan for Education 2011-2015:

- Address poverty and raise standards in child and maternal health through education, and

- Develop and implement special nutrition and health programs as incentives for parents and civil society groups to encourage enrolment in public and private pre-schools.[99]

For this research study, MOE Timor-Leste identified Escola Básica de Farol and Escola Básica 30 de Agosto. Both primary schools are located in Dili, the country's capital and lone major urban area. The schools were visited and interviews were conducted with school principals, teachers, pupils, and staff. Study findings are presented in the next sections.

93 UNICEF, "UNICEF Annual Report 2013 - Timor-Leste," http://www.unicef.org/about/annualreport/files/Timor-Leste_COAR_2013.pdf.

94 República Democrática De Timor-Leste, "State Budget 2014: Budget Overview Book 1," 2014, http://www.laohamutuk.org/econ/OGE14/Prop/OGE14Bk1Oct2013en.pdf.

95 Integrated Regional Integration Network, "More Investment Needed to Reduce Stunting in Timor-Leste," last modified May 29, 2014, http://www.irinnews.org/report/100147/more-investment-needed-to-reducestunting-in-timor-leste.

96 WHO and UNICEF, "Joint Monitoring Programme for Water Supply and Sanitation," http://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files.

97 Timor-Leste MOE, "Timor-Leste Strategic Development Plan 2011-2030," http://timor-leste.gov.tl/wp-content/uploads/2011/07/Timor-Leste-Strategic-Plan-2011-20301.pdf.

98 WHO, "A more inclusive health reform process in Timor-Leste," last modified July 14, 2014, http://www.uhcpartnership.net/a-more-inclusive-health-reform-process-in-timor-leste/.

99 Timor-Leste MOE, "Education Strategic Plan 2011-2030," https://www.moe.gov.tl/pdf/NESP2011-2030.pdf.

Escola Básica de Farol (Farol ES)

Farol Elementary School (Farol ES) accommodates 2,109 pupils (M=1,107 and F=1,102) aged six to 13 years old. The average class size is 60 children. With only 8 classrooms available, pupils are divided into groups and come to school to attend one of three different shifts, all falling between 8 a.m. and 5:30 pm.

The school hosts a spacious yard area where pupils spend their breaks, engage in all sorts of outdoor activities and play football after school hours. Most of the buildings are relatively new and are built mainly by United Nations military personnel in the early years of independence as part of re-building activities in the country.

50 teachers and 18 non-teaching staff comprise the school staff. Electricity is mostly available 24/7, but there is no regular water supply, be it for drinking or for hand washing. A self-contained system with an elevated bucket is installed on the premises, in order to provide water for the toilets and hand washing facilities. The school is equipped with eight toilets, four each for boys and girls. There is neither a school canteen nor a school clinic.

Parents are not paying any school fees, and cannot be encouraged to make donations since they are mainly not able to due to their socio-economic backgrounds. Government funding for students enrolled at Farol Elementary School amounts to approximately US$1 per child per month.

The following are some of the successful SHCN-related activities at Farol ES:

- Health Education is taught in all grades and is usually integrated in regular classes. Topics covered range from hygiene-related behaviors like hand washing, toothbrushing and the importance of personal cleanliness to nutrition. Proper hand washing with soap before and after meals and toilet use and toothbrushing techniques are taught from grade 1 onwards, but are limited to lectures and demonstrations due to lack of adequate facilities. These are expected to be acquired as habits, though. Starting at grade 3, nutritional aspects like the ingredients of a healthy diet, foodstuff that should be consumed in limited amounts or avoided entirely, and their effects on the human body are picked out as central themes. In that context, healthy food and beverage choices are promoted.


Photo credit: SEAMEO INNOTECH

- With the water, sanitation and hygiene (WASH) situation being quite challenging, Farol Elementary School is trying to focus its activities and resources on the maintenance and cleanliness of the existing structures. Even though facilities are not sufficient in number, washbasins and toilets are cleaned regularly by non-teaching staff assigned to that task and are thus kept visually appealing. This is a low-cost but very important aspect for making facilities widely accepted and appreciated.

- The Parent-Teacher Assembly, where issues concerning parent involvement, cleaning activities and general school management issues are discussed and decided upon, is convened every four months. During the occasion, the school principal and teaching staff seek to motivate different parents and members of the community to engage in cleaning and repair activities to make the school environment healthier, safer and more pleasant.

The school has focused considerable effort to implement its school-based feeding program, a good practice which will be discussed in more detail below.

School-based Feeding Program

Farol ES's school-based feeding program is integrated into the government's nutrition program. A budget of 25 US cents per student per day is available, and six highly-dedicated full-time kitchen staff are responsible for the purchase, preparation and distribution of the meals. The head of the team holds an academic degree and certification as a nutrition services manager, thus ensuring hygienic and health standards when overseeing food preparation and feeding operations. Another team member is concerned with financial and administrative matters, like purchasing meat and vegetables in local markets. The local government provides rice which is directly delivered to the school premises. Due to the three-shift system of the school, the snack breaks for each shift are scheduled at 10 a.m., 12 noon and 3 p.m., Monday to Saturday. According to anecdotal evidence from teachers, this seems to be the only major meal of the day for most children at Farol Elementary School.

Because all of the school kitchen staff give full attention to the management of daily feeding, the school is able to consistently prepare sufficient, healthy and nutritious food for a considerable number of pupils. Staying at the feeding areas during the meals (usually in an open space under the trees), they are able to get student feedback regarding their satisfaction levels and preferred dishes. Most pupils are highly satisfied with quantity, quality and diversity of meals offered.

Escola Ensino Básico 30 de Agosto (30 de Agosto ES)

30 de Agosto Elementary School (30 de Agosto ES) is attended by 1751 pupils (M=801 and F=950) aged six to 14. The average class size is 60 children. As the number of classrooms is not sufficient, pupils are divided into groups and are lectured in two different shifts: one lasting from 8 a.m. to 12:30 p.m. and another one lasting from 1 to 5:30 p.m.

The teaching staff is composed of 52 full-time and 7 part-time teachers and 12 non-teaching staff. Electricity is mostly available 24/7, and there is regular water supply for sanitation purposes, though not potable. It is based on a school-wide system where a central tank is built to service the facilities. Running water is hand-pumped when available and stored for future use. It is supplemented by collected rainwater. The school has nine toilets, with three each allotted for boys, girls and teachers, respectively.

There are no health services provided by a school nurse, nor a system for the identification and tracking of pupils with chronic health conditions in place. In case of illness or emergency, children are taken to a local clinic where they are treated free of charge.

The following are some of the successful SHCN-related activities at 30 de Agosto ES:

- Physical education is a very strong area. Two experienced and qualified (with an appropriate college degree, as required by national standards) PE instructors offer a variety of mainly outdoor sports activities, with every pupil being instructed for two to three hours weekly. The school has a spacious yard where these exercises take place. Most popular amongst the boys and girls are ball games like football and volleyball and competitive exercises. Before each sports activity, the PE teachers assess the physical state of the pupils in order to determine if they are fit for physical activities. Most common reasons for non-attendance are toothache, stomach pain or menstrual complaints.

- Just like Farol ES, 30 de Agosto is trying to maximize the benefits of the 25 US cents per student per day budget for the school-based feeding program. The school kitchen was renovated in 2014 with funding support from the American Embassy in Dili. Six trained cooks and five kitchen staff work full-time for the school and are tasked with the purchase, preparation and distribution of meals. They are supported by parents who volunteer to lend a hand during the morning and afternoon shifts, depending on their availabilities.

The head of the kitchen staff, with the help of selected kitchen staff, draft the menu based on the nutrition needs of the students. Rice, vegetables, fish, and meat are the staple food items in the menu. 30-40 minutes is generally allotted to pupils for taking the meals, which they either eat inside the classroom or under the shade of nearby trees. Kitchen staff and teachers regularly get feedback from students on the meals they serve.

Photo credit: SEAMEO INNOTECH

Most students report being satisfied with the quantity, diversity and quality of the meals.

Teachers also report that family and community involvement at 30 de Agosto ES is much stronger compared to many other schools in Timor-Leste. As such, good practices related to this SHCN component are described in more detail below.

Family and Community Involvement

Family and community involvement at 30 de Agosto ES includes active cooperation and financial and moral support from parents. During the quarterly parent-teacher assemblies, all issues concerning school management and the general well-being of children are discussed and decided upon. Through personal contacts with many members of the local community, the school principal and teaching staff are able to motivate different parents and other members of the community to engage in various activities to make the school environment healthier, safer and more pleasant. In particular, the school is successful in mobilizing the school community to help repair school facilities, paint the school's buildings, and help out in the school-based feeding program. Parents take turns in helping to prepare, cook and distribute meals to all children.

Factors that Lead To Success

Both Dili schools, Escola Básica de Farol and Escola Ensino Básico 30 de Agosto, are exerting a lot of effort to ensure that their children are spending their days in a healthy and safe environment that is conducive to learning. Although often faced by an uphill struggle as regards infrastructure, funding and human resources, both schools have successful SHCN programs because of the following:

- Both schools try to engage the local community in order to mobilize financial and human resources which the government is not yet able to deliver. Not being supported by any major donor-driven activities, they manage their own scarce resources, driven by a high degree of devotion and diligence from the entire school personnel.

- The schools visited for this study are able to adequately feed the student beneficiaries of their respective school-based feeding programs and thus ensure that the school population reaches a nutrition status conducive to educational success.

- All staff members concerned with SHCN implementation are focused, fully engaged and consistent in their tasks and functions because they have a common, unified motivation and understanding of the necessities and requirements.

Challenges and recommendations

However, both schools also face challenges to effective SHCN implementation.

- Some facilities are not big or adequate enough for all the students in both schools even if they already come to school in shifts. Canteens are not large enough to accommodate hundreds of students, so most end up taking their meals out in the open. The outdoor open spaces for physical education activities need to be bigger and equipped with more facilities, and play areas need to be tiled or glazed. Toilets are also limited, and there are also no group hand washing facilities for the children to use. These facilities are crucial for the effective delivery of SHCN services in both schools and therefore need to be upgraded or provided. For example, a simple self-contained group washing facility, making use of locally available materials, can be constructed. In order to achieve this, the active participation of students, teachers, the principal, parents and the community needs to be tapped.

- Both schools, like many in Timor-Leste, face the problem of open defecation. Even with a limited number of toilets, efforts into maintenance and daily supervised cleaning of toilets and provision of soap can encourage children to use them instead of defecating in the open or in the case of young adolescent girls, missing school altogether whenever they have menstruation.

- A major challenge for both schools and Timor-Leste in general concerns the very low salary of teachers, and the extremely low remuneration of staff engaged in school feeding activities.

Taking into account the high responsibility both groups have for the well-being and general health of children, they urgently need to be reviewed and upgraded, in order to keep current teachers motivated and attract qualified staff in the future.

- Some monitoring activity on the health and nutrition status of pupils could be considered. To expedite the identification of the neediest beneficiaries and monitor the impact of the feeding program on their health, schools can organize training sessions for their teachers on how to evaluate the nutritional status of their students.

Conclusion

The cases of Escola Básica de Farol and Escola Ensino Básico 30 de Agosto are typical examples of the difficulties that many schools in developing countries face, especially when faced with inadequate water, sanitation and hygiene facilities or no regular hygiene program. With varying degrees of community support, they still try to put in immense effort from the side of teaching and support staff in order to improve the education quality and learning achievements of primary students by improving their health and nutrition status and health behavior. With scarce resources in one of the poorest country of Southeast Asia, external support for effective SHCN programs remains absolutely vital and should be intensified.

Photo credit: SEAMEO INNOTECH

Vietnam

1 Kim Lien Primary School Hanoi City

2 Dang Tran Con B Primary School Hanoi City

(CIA, 2015)

The Socialist Republic of Vietnam is a uniquely-shaped country that borders the People's Republic of China (PRC) in the north, Lao People's Democratic Republic (Lao PDR) and Cambodia in the west, and the Pacific Ocean in the east. It is a densely-populated country with an estimated population of 93.4 million — around 1.3 percent of the world's population—as of July 2014.[100] Nearly a quarter of the country's total population are children from zero to 14 years old.[101] Around 98 percent of children of primary school-age are enrolled in primary schools in 2012-13, an increase of more than two percentage points since 2006-07.[102] Enrollment rates for girls are only slightly higher than boys.[103]

The education system in Vietnam is characterized by: 1) Early Childhood Care and Education (ECCE), including crèches, nursery, and kindergarten; 2) Basic education, composed of primary, lower secondary and upper secondary levels; 3) Vocational education with three levels: professional, secondary and vocational training; and 4) Higher education, which covers college, undergraduate, masteral and doctorate levels.

Five years of primary schooling is compulsory and typically begins at age six. This is in compliance with the implementation of universal education in Vietnam and as stipulated in

100 World Population Statistics, "Population of Vietnam 2014," last modified April 23, 2014, http://www.worldpopulationstatistics.com/population-of-vietnam-2014/.

101 CIA, "Vietnam," *The World Factbook,* retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/vm.html

102 Vietnam MOET, *Education for All 2015 National Review Report: Vietnam* (Author, 2015), http://unesdoc.unesco.org/images/0023/002327/232770e.pdf.

103 Ibid.

the Universal Primary Education Law 1991. There are five standard subjects throughout primary school: the Vietnamese language, mathematics, moral education, arts, and physical education. Aside from these, grades 1 to 3 students also take natural and social studies while fourth and fifth graders take up History and Geography as well as Science, on top of the five standard subjects.[104] To reduce the overlaps among the subjects, some integration was conducted in the primary curriculum. For instance, health education was integrated in natural and social studies.

The Ministry of Education and Training (MOET) has adopted a significant health care and nutrition program known as "Enhancing Health in the School." In the main, the program consists of key components such as health education (e.g., personal health care and hygiene and sanitation), nutrition program and services, and the provision of clean water. The program also includes sexuality education and gender education. In addition, the MOET is implementing a "School Dental Program." Implemented in 63 provinces and cities in Vietnam, this program is in partnership with the biggest dental hospitals in Vietnam. The Vietnamese government also apportions about 10.9 percent of total insurance funds for student health via a program known as "Caring for the Health of Students."

The primary schools that were chosen by MOET for this case study are Kim Lien Primary School and Dang Tran Con B Primary School. Both are located in Hanoi, Vietnam's capital, and have exemplary school health and nutrition programs that are worth citing. One of the country's major urban areas, Hanoi is home to 6.45 million people and is the second most populated city in Vietnam, next to Ho Chi Minh.[105]

Kim Lien Primary School

Kim Lien Primary School is one of the biggest primary schools in Hanoi. The teacher-to-student ratio is 1:45, which is higher than the national standard of 1:35. A total of 3,393 students (M=1,818 and F=1,575) are enrolled in the school in 2014, while the school's teaching workforce is composed of 90 full-time and five part-time teachers. Kim Lien Primary School also employs 15 non-teaching staff and two registered school nurses, bringing the total number of employees at Kim Lien Primary School to 112.

Unlike other primary schools in Vietnam, the school has a small stadium where students play football after school hours. The spacious layout of the school grounds dates back to 53 years ago, when Vietnam worked with the support of the North Korean government to ensure that there would be enough space in school for all indoor and outdoor activities. There is also a playground in the school premises. Other facilities and services include hand washing facilities, separate toilets for boys and girls, 24-hour potable water service; 24-hour electricity service; a school canteen; and a school clinic. Each class has a drinking station.

One hour is allotted for lunch time. After lunch, the students have an allotment of another hour for taking a nap. Classes start at 7:40 a.m. and end at 4:25 p.m. for all grade levels. But for two days a week, third to fifth graders have classes until 5 p.m.

104 UNESCO-IBE, *World Data on Education: Vietnam* 7th ed., http://www.ibe.unesco.org/fileadmin/user_upload/Publications/WDE/2010/pdf-versions/Viet_Nam.pdf.

105 GSO of Vietnam, "Media Release: The 2009 Population and Housing Census," 2010, https://www.gso.gov.vn/default_en.aspx?tabid=599&ItemID=9788

In the overall context of implementing its health care and nutrition program, Kim Lien Primary School has been performing well, as evidenced by the following SHCN initiatives in this school:

- Health education (HE) is integrated into the social studies subject and covers a wide range of topics such as eating on time and allotting enough time for meals, the parts and systems of the body, and gender and sex education. Hand washing and tooth brushing are also introduced in kindergarten in the hope that these will be acquired as habits. Hand washing is being taught in all grade levels, while tooth brushing is being taught in Grades 1 and 2. Gender and sex education, where topics like male and female bodies and fertility issues are discussed, is taught starting in Grade 4.

- Although Kim Lien Primary School has no dentist, its nurses, who undertook some dental training courses, are able to perform simple dental tasks. The more serious dental problems are referred to nearby hospitals and dental clinics. The school nurses also plan and teach lessons with social studies teachers, with the nurse providing the lesson resources while the teacher talks to the students about toothbrushing or flossing. Once a week, students also visit the clinic for dental flossing.


Photo credit: SEAMEO INNOTECH

- Bullying and harassment is strictly prohibited in school and are discussed in moral education, and although such incidents rarely occur, teachers take it upon themselves to address instances of bullying and harassment. Teachers make it a point to talk to the involved students and make them understand that such behavior is not allowed in school. For more serious altercations between students, the principal steps in and calls the parents of the students involved to seek their help and cooperation in resolving the matter. A "guarding team" composed of grade 4 and 5 students also monitor student behavior outside the classroom and report any unacceptable behavior to the teachers on duty.

- There are sports-related clubs for teachers at Kim Lien Primary School dedicated to badminton, table tennis, and dance. These groups usually meet twice a week. Yoga classes are offered to the school staff as well.

- Parents support their children's participation in sports clubs by giving financial assistance (voluntary donation) so that the school can join inter-school basketball and football tournaments at the district, provincial, and national levels. Kim Lien Primary School also organizes friendly inter-school sports competitions.

Among the school's many initiatives, the school's nutrition services and physical education programs stand out. As such, they are discussed in more detail below.

Nutrition Program

Kim Lien Primary School has figured prominently in this area, as teacher respondents explain that the school complies with stringent national standards and guidelines set by the MOET, the Ministry of Health (MOH), and the National Institute of Nutrition (NIN). In Vietnam, the MOET collaborates with the Safety Department of Health under the MOH to provide technical support to primary schools in terms of age-appropriate nutrition standards. Both government agencies collaborate and conduct trainings for school canteen/kitchen staff. The staff are required to attend these trainings.

The school has a canteen that caters to Kim Lien Primary School's student population, 94 percent of which stay in school all day. Most of them, if not all, take their lunch at the canteen, while about 200 students go home to eat lunch. The school canteen offers a number of choices. Breakfast usually includes sausage, bread, omelet, and fruit juices, while lunch usually consists of rice, vegetables, meat and fish. Afternoon snacks being offered are crepes, biscuits, fruits, yogurt and fresh milk. The canteen also stays open until the afternoon to serve students who have club-related activities.

The school canteen offers different kinds of food, and students who regularly eat at the canteen like the food being served. In a focus group discussion with some of the school's fifth graders, student respondents noted that they "like fish, meat, rice and eggs" served at the canteen. Additionally, the school provides free fresh milk to students every afternoon on a daily basis. The school canteen does not encourage students to buy soda and sells fruit juices and mineral water instead. Soda is sold at the canteen only during special occasions.

The school conforms to the rigorous procedural requirements in coming up with the menu plan for the school year. The head of the school's kitchen staff is in charge of setting the nutrition standards, while kitchen staff members identify the recipes and the corresponding ingredients of each meal. These meal plans must first be accepted by the principal and the teachers in the school, and are then sent to NIN for approval. Moreover, the school follows food supplies procurement procedures and standards set by the MOE. It only deals with companies/suppliers with permits from the city government and are duly licensed by MOE and MOH.

Undoubtedly, the nutrition program has had a positive impact on the health of the students. Teachers report that parents recognize the improvement in their children's height, weight, and overall physical wellness. Statistics gathered by medical health center representatives who go to Kim Lien Primary School every year to monitor student wellness also support this.

Physical Education

The school's physical education program is equally commendable. Physical education classes are held twice a week, with each period lasting 45 minutes. At the beginning of every semester, PE teachers provide an introduction about PE and discuss the definition and different kinds of energy with their students. They also regularly check on the physical state of their students before every class to determine if they are fit or not to take part in physical activities.

The PE curriculum is both knowledge-based and skills-based. The students do not only enhance their awareness of and understanding on physical fitness and wellness, but are also equipped with new skills. With the help of their PE teachers, pupils learn and play sports such as football, badminton, basketball, table tennis, and chess. All students take part in the PE classes and are comfortable and very active. The students' performances are closely monitored by the PE teachers since the school adheres to certain standards. PE teachers assess the students and are trained and well-equipped to do so. Parents are also encouraged to monitor their children's progress.

Additionally, there are school activities for all students on Mondays, Tuesdays and Thursdays. On the first day of the school week, for instance, students can play traditional games such as "bit mat bat de," (the Vietnamese version of hide-and-seek) where players attempt to catch a "goat" while blindfolded. It is an opportune time for all students to engage in cooperative play, so PE teachers are allowed to integrate traditional games such as this one in their classes even if it is not officially part of the curriculum.

It is a requirement for PE teachers in public schools in Vietnam to have at least a bachelor's degree, and Kim Lien Primary School conforms to this standard. Some of the school's PE teachers even have master's degrees. Professional trainings for PE teachers are also planned and provided. The school invites specialists from the Hanoi National University of Education to help PE teachers improve and enhance their knowledge and skills. All of the school's teachers have likewise taken training courses conducted by the MOET, the city government, and the district government. Training courses are held during the summer break (between June and September).

The school also encourages students to take part in the different sports activities and to join sports clubs. Kim Lien Primary School has student clubs dedicated to basketball, football, badminton, volleyball, dance, singing, arts, chess and table tennis. Clubs meet for an hour every afternoon, during school hours. It is also worth noting that the school is relatively successful in various district, city and national sports competitions.

Overall, the physical education program at Kim Lien Primary School provides a venue for socialization, recreation, and skills development. The program also engenders physical and mental stimulation, child-friendly supervision, a feeling of safety, and a deep sense of teamwork and camaraderie between and among students.

Dang Tran Con B Primary School

Dang Tran Con B Primary School is a primary school with a 1:53 teacher-to-student ratio which, similar to Kim Lien Primary School, is also higher than the national standard (1:35). A total of 1,634 students (M=871 and F=763) are currently enrolled in the school. The school has 52 full-time employees: 46 teachers, five non-teaching staff, a six-member team assigned to the kitchen, and a registered school nurse.

The school has a yard where daily morning exercises are held and where students can play after school hours. Other SHCN-related facilities and services include hand washing facilities, separate toilets for boys and girls, 24-hour potable water service, 24-hour electricity service, a school canteen, and a school clinic.

Lunch break at Dang Tran Con B Primary School lasts for only forty minutes, but students can taka nap in the next hour after

the lunch break. Classes start at 7:40 a.m. and end at 4:25 p.m. for all grade levels.

Dang Tran Con B implements the different components of their health and nutrition programs as follows:

- Health Education is integrated into the natural and social studies subject for grades 1 to 3 and social studies for grades 4 and 5, both of which are taught for 35 minutes every day. In the standard curriculum, ten of the 35 lessons for these subjects are allotted for health and nutrition education. There is no prescribed number of minutes for the ten lessons for as long as teachers follow the MOET-prescribed lesson plans. Topics include food and health, nutrition, the different food groups, disease prevention, and techniques on how to avoid being a victim of harassment. Sex education, which discusses issues on fertility, bodily changes, and sexually transmitted diseases, is taught in grade 5.

- The school clinic has a database of all the students' health profiles which are updated at the beginning of every school year, during the students' annual medical check-up. This keeps the school nurse equipped with the information she needs when attending to students. On most days, the nurse only attends to simple and common illnesses such as stomachaches and fever. Serious cases in need of immediate medical attention are referred to nearby hospitals and dental clinics, but parents are first notified of the condition of their child before the nurse brings him or her to the hospital. For emergency cases, the school immediately sends the student to the hospital for immediate treatment and calls the parents while their child is on his or her way to the hospital. Since this referral system has been put in place, no dental and medical problem at Dang Tran Con B Primary School has been left unattended.

- The school strictly prohibits bullying, and school staff keep close tabs on students who figure into petty quarrels as a result of teasing and childish banter, particularly because such behavior go against the children's lessons on moral education. Even if the school has no resident guidance counselor, the teachers know how to be conscientious, sensitive and respectful in handling such cases—even if they rarely happen. The principal may be asked to intervene for the more serious cases. All students also come together for "problem sessions," which often occurs at the start of every school week. During the session, teachers, the nurse, security personnel, and the school manager engage the students in a dialogue in order to resolve and even prevent conflicts.

Photo credit: SEAMEO INNOTECH

- Parents also give voluntary donations which are pooled together to fund students who represent the school in sports competitions at the school, district, city, and national levels.

Among the many SHCN initiatives at Dang Tran Con B, the school considers its effective programs on physical education as well as nutrition education and services to be two of the school's best practices when it comes to SHCN.

Health and Nutrition Education/Services

In keeping with the overarching intention to impart knowledge and instill healthy eating habits in its students, the school developed a blueprint that covers both aspects. The school conscientiously complies with MOET's curriculum standards and requires all teachers follow, deliver and teach the required lessons on health and nutrition. Lesson plans are tailored to be age-appropriate to ensure that students are able to understand the topics. Since the curriculum is not rigid on the number of hours for as long as all ten lessons are taught by the end of the school year, teachers do not feel restricted. As such, they have the space to be effective and creative in handling the lessons on health and nutrition.

The school offers food and drinks to primary school students at Dang Tran Con B during lunchtime and in the afternoon. After the children have taken their nap and before their afternoon classes begin, they are given another 15 to 20 minutes for snacks. The canteen caters to different diets and, at the same time, encourages healthy eating among students. Rice, vegetables, meat and fish are staple food items offered at the canteen. The canteen is prohibited from selling soda, a reflection of the school's serious firm refusal to sell unhealthy food and drinks. As part of its health and nutrition program, the school distributes fresh milk to students every day. This project is supported by a private company.

The chef manages day-to-day operations and leads the five-member kitchen staff to plan and organize the weekly menu. The chef is also in charge of ensuring that the school complies with MOET-issued nutrition standards. Members of the six-person kitchen team have likewise attended trainings on health and nutrition given by MOET and MOH. These annual trainings are usually conducted before the school year starts. Members of the six-person kitchen staff need to pass these training courses first before they can be issued a certification. Some seminars are also initiated by the school, and these are delivered by specialists from the National Institute of Nutrition in Hanoi.

Physical Education Program

Teacher respondents also noted significant achievements in the school's PE program. The two-pronged approach to physical health and wellness is implemented through lessons (knowledge and understanding of the techniques) and exercises (actual application and practice). PE classes are held twice a week, and each period last anywhere from 35 to 40 minutes. For grades 1 and 2, students are taught simple movements, but students in grades 3 to 5 need to tackle lessons which are more difficult in terms of the skills and techniques they are expected to acquire. Students can choose between two or three among the sports offered in the PE curriculum. At Dang Tran Con B, basketball is a popular sport among students. In addition, the PE teacher allots 10 minutes of every PE period to playing traditional games. The lessons being taught by the teachers give thoughtful attention to the level of comprehension and understanding of students.

Similarly, the exercises being taught by the PE teachers consider the capacity and body strength of students in different grade levels.

Aside from PE classes, the students are encouraged to participate in the different clubs such as sports, arts, music, and chess clubs. These clubs are handled by teachers but are not part of the formal academic schedule. However, students are still encouraged to participate. Other activities in the school that encourage students to be active include morning exercises and sports competitions. Before classes begin in the morning, students are required to do some singing, dancing and other exercises at the school yard. During the winter months, students do these rituals during their break time. Additionally, the principal and the teachers organize a lot of sports competitions from October up to December. Male students take part in football, while female students join aerobics and general exercises. All these school activities foster sportsmanship, camaraderie, teamwork, unity, and friendship. They also build and instill discipline, honesty, respect, perseverance and determination.

In terms of qualifications and competencies of the teaching personnel, the school strictly complies with the national standards on hiring and selection as well as human resource development. All PE teachers of the school, for instance, are college graduates. There are also training programs for teaching and non-teaching staff on health and nutrition such as courses or seminars on first aid, health care and nutrition education, injury prevention, and conflict resolution. Teachers also take turns undergoing training courses which are usually held in August by the city government.

Factors that Lead To Success

Both Kim Lien and Dang Tran Con B implemented a number of notable health and nutrition programs and activities for their students and school staff. A number of factors facilitated the effective implementation of these SHCN initiatives.

- The transparent and inclusive nature of the programs that allows multi-stakeholder involvement speaks of the commitment of the school and its allied stakeholders to instill a strong sense of ownership and unity in everyone. The conscientious and active participation of national and local government agencies, private entities, and communities affirms that common understanding of program goal and objectives engenders multi-sectoral collaboration. The strategic partnership forged between and among the stakeholders efficiently hastens the implementation process. It also reinforces the sustainability and replicability of the program in other primary schools, especially in the remote and far-flung provinces where SHCN programs and services are mostly needed.

- Clear-cut lines of responsibility and accountability among the government agencies involved contribute to the positive outcome of the programs. In addition, the officials from the MOET affirm that their cooperation with the Ministry of Health and the Ministry of Agriculture resulted in effective program implementation. The government officials' sense of duty and professionalism boosts the success of the program.

- The government authorities at the regional level put high premium on SHCN and consider it as a top priority. Authorities from the different departments of cities and provinces actively participate in the program.

- Financial and technical support provided by international development agencies and associations also plays a contributory role in bringing about the intended results of the program.

- Qualified and competent school staff play a significant role in ensuring smooth and timely program implementation. The schools take pride in its roster of teaching and non-teaching personnel.

- A functional and in-place monitoring scheme is an essential part of program management. The presence of benchmarks and targets at the beginning of implementation assures that the program is on track.

- The diligence of the entire school personnel in undertaking the health and nutrition programs is clearly reflected in the conscientious and high-standard (at par with the national standards) implementation of all aspects of the program. Despite challenges such as inadequate facilities, the schools are able to deliver high quality work and service to the students. They are focused, fully engaged and consistent in their tasks and functions because they have a unified and internalized understanding of the program.

Challenges and Recommendations

The following challenges and recommendations emerged from the focus group discussions and key informant interviews:

- While Kim Lien Primary School is one of the biggest schools in the city and although teachers at Dang Tran Con B take pride in the fact that they meet the country's existing standards for SHCN programs, respondents from both schools note that some essential facilities are lacking or need to be improved. For instance, the concrete flooring of play areas in Kim Lien poses a risk to students, while the canteen at Dang Tran Con B Primary School does not have enough seats for all its students. Limited government funding keeps Kim Lien from upgrading its facilities, while large class sizes at Dang Tran Con B result in cramped classrooms. There is a need to increase funding support so that schools can make the necessary upgrades to reduce the risk of injuries among students and make their school more conducive to learning.

- A major challenge, not only for Kim Lien Primary School but also for the whole country, concerns the salary of the teachers in general and of those teaching PE in particular. The salary of a teacher in Vietnam is only at 1.7 times the country's per capita GDP (gross domestic product), significantly lower than the Asian average of 2.4 times the mean income.[106] As such, the compensation package of teachers may need to be reviewed and upgraded.

106 Takashi Hamano, "Educational reform and teacher education in Vietnam," *Journal of Education for Teaching* 34, no. 4 (November 2008): 397-410.

- Dedicated guidance counselors can be assigned to both schools. The counselor can be the school's focal person when it comes to student well-being and can advise the school on other SHCN matters.

- To address the challenge of parents who lack the knowledge and skills they need to keep their children healthy and nourished even at home, the good practice of holding a parents' orientation at the beginning of the school year may be continued. Since health and nutrition topics are covered during the orientation, parents are able to pick up some useful tips which they can use to guide their children to make good health and nutrition choices.

Conclusion

The schools' health and nutrition programs have resulted in the improvement of the students' fitness, health and wellness. Essential elements such as strong and supportive stakeholders, clear-cut lines of responsibility and accountability, unified and common understanding of mandate, financial and technical support, qualified and competent staff complement, and in-place monitoring scheme contributed to the achievement of the program objectives.

Photo credit: SEAMEO INNOTECH

SUCCESSES AND CHALLENGES

Levels of implementation vary both within and among countries because geographical context and availability of resources vary among schools. As such, it would be good to look at particular factors that contribute to successful SHCN implementation and also at contexts and conditions that make program implementation challenging.

Successes

Respondents from all 11 SEAMEO member cited particular SHCN programs which have been successfully implemented in their countries and can be replicated in other sites.

School heads from Brunei Darussalam reported that their programs addressing oral health and promoting good eating habits and proper hygiene have been effective. Those representing Cambodia and Laos cited the Fit for School (FFS) program rolled out in partnership with GIZ and similar programs aimed at improving student oral health. Health initiatives in Malaysia which were considered successful revolved around preventing dengue and obesity as well as promoting nutritious diet, proper dental care, and adequate physical activity. Principals from the Philippines pointed out that school-based feeding programs and the EHCP - which is an offshoot of the FFS initiative - have been successfully institutionalized in their country. Meanwhile, Thai education officials highlighted various health and nutrition promotion campaigns and programs which have been implemented in their primary schools.

A number of exemplary SHCN programs and projects also stood out as noteworthy during the case study visits. Respondent schools in Indonesia have successfully adopted the nationwide UKS initiative as well as the Little Doctors program at the school level. In Myanmar, the two schools visited had good programs to promote proper nutrition among its students and staff. For Singapore, the schools visited were proud of their implementation of PAL and their own initiatives to get Singaporean kids to be more active and healthy. Schools in Timor-Leste are making the most of the resources and support available to them to provide healthy and nutritious meals to beneficiaries of their school-based feeding programs, while respondent schools in Vietnam reported that their PE programs and canteen services have been effective at improving the overall health and nutrition status of their students.

Table 24. Factors Contributing to the Success of SHCN Programs

Factor	Brunei Darussalam	Cambodia	Lao PDR	Malaysia	Philippines	Thailand
Strong Policy support			✓		✓	✓
Adequate funding support		✓	✓	✓	✓	✓
Strong community support			✓	✓	✓	
Strong leadership support	✓	✓	✓	✓	✓	
Adequate human resources		✓	✓	✓	✓	✓
Strong inter-agency collaboration			✓		✓	✓
Strong partnership with different stakeholders	✓		✓		✓	✓

Source: Survey on SHCN programs in primary schools in Southeast Asia-National Level

In addition, they were also asked to highlight conditions that made the success of these programs more likely. Ministry officials, school heads, and teachers underlined the importance of **effective collaboration between government agencies and strong partnership with different stakeholders.** Fostered partnership and close collaboration between and among government agencies support and sustain program implementation and help make it effective, while SHCN programs that engage multiple stakeholders – including parents, the immediate community, religious groups, and even private companies and individuals – Instill a strong sense of ownership not only of the programs but of their impact on student health and well-being as well. Together, these factors lead to a common understanding of program goal and objectives and have resulted in effective and efficient delivery of health and nutrition services via the school system.

Strong policy support and adequate program funding also go a long way in ensuring the success of the school's SHCN programs. When the overarching goal of ensuring that school-aged children are healthy and well-nourished is enshrined in the country's education policy or development agenda, this makes it more likely for the government to allot the necessary funding to make this happen and thus, make SHCN programs more sustainable in the long run. Particularly in the case of Southeast Asia, the financial and technical support provided by international development agencies and associations cannot be undermined, as this

also plays a contributory role in bringing about positive change in children's health and nutrition status.

Also worth noting is the combination of **strong leadership** and **adequate human resources**, as both are crucial to the success of SHCN particularly at the school level. Respondents find that when competent administrators are empowered to prioritize SHCN programs based on the needs and interests of their students and the school community, they can ensure that the programs they allocate resources to are most responsive to the immediate needs of the people they serve. In addition, low teacher-to-student ratio enables teachers to better focus on the socio-emotional needs of their students and take on more SHCN-related work on top of their teaching load. In cases when human resources are lacking, schools depend on trained or knowledgeable school teachers and staff who are generous with their time and energy to effectively implement school-based health initiatives.

Respondent schools and ministry officials also highlighted the need for **strong community support**, as their SHCN programs have benefited from solid backing from the school community and other stakeholders such as local officials and inter-school councils. Regardless of whether contact is initiated by the school or its community partners, head teachers and school principals interviewed for the study are in agreement regarding the importance of networking and maintaining good working relations with the different members of the community, as their proximity to the school enables them to be more aware of its needs and context and therefore, be more likely to know how they can best contribute to improving the health and nutrition of school-aged children in their community.

Another noteworthy feature of some of the SHCN initiatives in the schools visited is that they **empower students to take on leadership roles in SHCN program implementation**, instead of merely relegating them to the role of passive recipients and beneficiaries of health and nutrition programs in school. These young health ambassadors are able to teach and model proper hygiene to their peers and in some instances, even go beyond their schools to share what they have learned about health, sanitation, and hygiene to their families and communities.

Lastly, schools visited for the case studies mentioned that putting in place a **holistic and functional monitoring and evaluation (M&E) scheme** leads to successful SHCN implementation. M&E is an essential part of program management, and FGD respondents believe that the presence of benchmarks and targets even before program implementation commences keeps everyone aware of exactly what the program is trying to achieve and how successful implementation would look like. Moreover, M&E can be used to delineate the roles not only of schools but also of the agencies they work with. This means that each stakeholder would better know what it is responsible and accountable for.

Challenges

School-based health and wellness initiatives are planned with every hope that they will be successful, but respondents from all SEAMEO member countries report that they have encountered challenges and hurdles in the process of implementing SHCN programs. Although the contexts and resources of primary schools and national governments in Southeast Asia are varied, there are a number of similarities in the challenges they face during implementation. The most common difficulties cited by the ministry officials, school heads, and teachers surveyed or interviewed for this study and the ways by which they respond to these challenges are discussed in more detail below.

Limited or insufficient funding and human resources. Many respondents recognize that funds currently allotted for SHCN programs are barely enough or worse, not adequate to ensure successful implementation. This leads to gaps between the program's ideal implementation as envisioned by policy-makers and actual implementation at the school level, as principals are left to stretch limited resources to cover a number of SHCN programs and make concessions in the process. Some schools address the lack of program funding by implementing the program only to the extent that available funding for it permits, spending a portion of the school's maintenance and other expenses (MOE) fund on SHCN programs, holding fundraising activities and soliciting donations, and enlisting support from the PTA and other government agencies.

Inadequate facilities to support effective SHCN implementation. Some of the schools visited for Phase 2 of the study have high toilet-to-student or toilet-to-hand-washing-facility ratio, so even if teachers and school nurses constantly remind children to wash their hands with soap, for example, the latter are not able to practice and acquire the habit since the school does not have enough group sanitation facilities to make this possible. In addition, some respondent schools which were constructed or designed before school-based healthcare became popular may not have enough open spaces to encourage active play – be it a playground, a gymnasium, or open spaces on campus. To address this challenge, some schools implement rotation schemes or make use of other open spaces in the immediate community.

In addition, some of the old schools also tend to have small clinics because they were originally classrooms or storage rooms which have been repurposed to become clinics. In some cases, one room is even divided to serve as a nurse's station, a medical-dental clinic, and a guidance room. Staff respondents say that the small size of the clinic sometimes makes it difficult for them to pay enough medical attention to simultaneous cases. As such, they recommend that the size of the school and the student population be taken into consideration when constructing school clinics and designing school layouts in the future.

Large school/classroom-to-student ratio. For schools with large classroom sizes or student population relative to the number of supervising school staff, SHCN implementation and monitoring can also be a challenge. However, since addressing this reality would require additional funding as well, principals recommend enlisting the support of parent volunteers schools can do for now is organize nutrition classes for parents across all primary grade levels to sustain heightened awareness of and solicit continuous support for the health care and nutrition program of the school.

Low salary of school staff. A major challenge for countries such as Timor-Leste and Vietnam concerns the salary of the teachers and school staff, and so respondents recommend that the compensation package of teachers be reviewed and made more attractive to help keep current teachers motivated and attract qualified staff in the future.

Need for more SHCN-targeted professional development opportunities. Teacher respondents feel that additional SHCN-related training offered during school breaks can help them stay updated on the latest when it comes to child health and well-being and this, in turn, equips them with the knowledge they would need to promote and protect the health and nutrition of their pupils. School heads also hope to get more technical assistance on program implementation and management, as it was really with the help of international organizations that programs such as in the case of EHCP in the Philippines, FFS in Cambodia and Laos, and the Little Doctors program in Indonesia's and Myanmar were implemented on a national scale. There is also a need to strengthen the capacity of school heads on school-based management of effective school-based SHCN programs particularly because school systems in Southeast Asia are increasingly becoming more decentralized. SEAMEO INNOTECH's HEALTHeXCELS blended learning training program could be a good option for school heads, as its flexible delivery modality makes it possible for principals to acquire training without having to take a leave of absence.

Lack of full support from parents. Respondents for this study report finding it difficult to get and sustain parent support for SHCN programs. Challenges falling under this theme range from indifferent parents, parents with insufficient knowledge on protecting their child's health, parents who do not grant their children permission to take part in SHCN programs, and parents who cannot afford toiletries for their children. Schools which find it difficult to implement SHCN programs successfully due to a lack of support from the students' parents or even the wider community encourage more involvement by holding orientations, trainings and seminars for parents. Others also utilize social media to enlist support and send updates to the community.

Lack of success in achieving desired change in student behavior. Respondent schools also mention being challenged by the waning interest of their students in SHCN programs which, in turn, leads to a lack of observable and lasting change in the health- and nutrition-related behavior of their students. To address this, respondent schools continue to encourage pupils to practice good habits, engage them as peer mentors of other students, monitor them as they imbibe the habits taught in school, and reach out to parents so that desired behaviors can be reinforced at home. GIZ's FFS program is a good example to look into, as it introduces hand washing and toothbrushing to students in the early primary grades and reinforces such behaviors until they become part of the student's daily routine. Education and health ministries and even school staff themselves also need to periodically evaluate their programs to make sure that programs pique the interest of their students.

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PART 3
CONCLUSION

SUMMARY

Data from Phase 1 of this regional study on School Health Care and Nutrition (SHCN) programs in primary schools in Southeast Asia show that Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, and Thailand have existing national laws and policies in support of SHCN in primary schools that have been enacted either as part of a given country's national agenda or in response to calls from international organizations to support EFA goals or MDGs. The legal and policy paper trail generally indicates that although the final implementation rests with schools and local government agencies, the crucial decision to make health and wellness promotion and protection among the youth a priority is still made at the national level.

Specific references to school health can be found in either school health policies or strategic education plans, although it must also be noted that there is often a gap between policy and practice when it comes to SHCN. The degree to which countries have covered the different components making up SHCN varies from country to country. *Healthy and Safe School Environment, Health Services*, *Physical Education*, and *Health Education* are covered by laws in the aforementioned seven member states, while five of them have legal provisions in support of *Health Education* and *Nutrition Services.* Five have explicit laws and regulations addressing *Counseling, Psychological, and Social Services*, while *Health Promotion for Staff* and *Family and Community Involvement* are the components receiving

the least attention in the current health and education policies in Southeast Asia.

Meanwhile, findings from the school case studies from Indonesia, Myanmar, Philippines, Singapore, Timor-Leste, and Vietnam show that many of the programs implemented at the school level are driven and guided by national SHCN policies and strategies, but that the region's decentralized approach to school management allow principals and school heads to do the following:

- choose which programs to prioritize based on the health and nutrition status of their students,
- customize implementation to best address the school's and community's pressing needs, and
- craft and implement original SHCN programs to address health and nutrition concerns not covered in the national education or health agenda.

Good practices which emerged from the school case studies touch on almost all of the eight SHCN components, with most focusing on Nutrition Services, Health Services, and Health Education. On the other hand, there was no country good practice targeting the Health Promotion for Staff component, and most of the existing programs addressing this SHCN component are initiated by individual faculty or staff members instead of embedded in the school's overall SHCN plan.

Although SHCN varies both within and among countries because of different geographical, cultural, and socioeconomic conditions, the core components of the FRESH framework – enabling policies, simple and cost-effective services, health education, and school environment – are very much present in the schools considered for this study. Such an approach has helped ensure a more holistic approach towards SHCN. Respondents also agree on the following key factors that make SHCN programs successful: effective collaboration between government agencies, strong partnership with different stakeholders, strong policy support, adequate program funding, strong and competent leadership, adequate human resources, strong community support, and a holistic and functional monitoring and evaluation (M&E) scheme.

However, respondent education ministry officials and schools encounter a number of challenges in rolling out SHCN programs, with the following emerging as the most common among Southeast Asian countries: the need for a better coordination among government agencies, limited or insufficient funding and human resources, inadequate facilities to support effective SHCN implementation, large school/classroom-to-student ratio, low salary of school staff, the need for more SHCN-targeted professional development opportunities, lack of full support from parents, and lack of success in achieving desired change in student behavior. Schools resolve the challenges they encounter in different ways, from holding fundraising activities or income-generating projects to boost program funding, implementing rotation schemes to maximize limited spaces for active play, and enlisting the support of parent and community volunteers by holding periodic orientations, seminars, and coordination meetings so that desired behaviors can be reinforced even after students leave the school grounds.


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CONCLUSION

For decades, SHCN has been a core thrust in many of the national school health policies and strategic education and development plans in member states Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, and Thailand. Although the extent of coverage varies among countries, all eight SHCN components are addressed in both legal frameworks and policy documents in these Southeast Asian countries. In addition, the school case studies from Indonesia, Myanmar, Philippines, Singapore, Timor-Leste, and Vietnam are also reflective of the importance accorded to student health and nutrition at the school level—even if schools' definition of successful implementation varies depending on their location and context.

Results from both phases of the study show that in general, countries in Southeast Asia pay more attention to improving the physical health and well-being of students and less consideration for their psychological, emotional, and behavioral needs. Components of SHCN which are not targeting the students directly are also not given as much importance, and some programs implemented in primary schools do not have a parent-and-community-involvement component. Some schools have also yet to implement SHCN programs offering adequate professional development opportunities for teachers, nutrition services managers, and other school personnel. Lastly, the data show that there are considerably fewer health programs aimed at keeping teachers and other school staff active and healthy compared to those which are targeted at students.

Despite these limitations, SHCN implementation in Southeast Asia has generally benefitted from a strong policy-enabling environment and a decentralized approach to program management. There are also similarities and differences in the area of implementation, particularly when it comes to addressing the many challenges that go hand-in-hand with implementing large-scale programs. To give schools the possibility to learn from country experiences, this research report has documented what has and has not worked for particular schools and education systems in the hope that this would lead to a more nuanced understanding of how much the region has accomplished in terms of institutionalizing SHCN and how SHCN can be best implemented given the variations in cultural values, socioeconomic profile, and geography which characterize the region. It is hoped that this knowledge resource for Southeast Asian MOEs can help maximize the impact and effectiveness of implemented SHCN programs at a time when funding is often insufficient and achieving program sustainability can be a tall order.

RECOMMENDATIONS

Although countries in Southeast Asia have varied experiences when it comes to SHCN implementation, many of the recommendations which school principals, head teachers, and other top-level administrators believe would help improve school-based health and wellness initiatives fall under the following:

- **Foster a strong policy environment that encourages inter-sectoral collaboration and helps realize the sustainable development goals (SDG) on ensuring healthy lives, promoting well-being, and providing inclusive and quality education for all.** MOEs should work to establish a policy environment that engenders collaboration among stakeholders and active teacher and student involvement in program implementation. Moreover, the global commitment to take steps to provide adequate healthcare, particularly to the disadvantaged, should also be reinforced.

- **Improve SHCN implementation in the region's primary schools by strengthening operationalization of Focusing Resources on Effective School Health (FRESH), a widely adopted framework for utilizing primary schools as the main channel for delivering basic health and nutrition services to children.** Because funding for child healthcare in many countries in Southeast Asia is insufficient, it makes sense for governments to aim to craft and implement policies that promote and protect the health of everyone at school and ensure that they have access to a clean environment, skills-based health education, and simple yet cost-effective health and nutrition services delivered through the school system.

- **Thoroughly consider implementation concerns during policy formulation.** The facilitation of rapid and large-scale implementation of school-based health and nutrition programs should already be considered early on and throughout the policy formulation process instead of as an afterthought after programs are already being rolled out. Right from the start, MOEs should already be looking for strategies to ensure and maintain quality in the delivery of SHCN programs as they are scaled up.

- **Strengthen capacity-building efforts at the school level.** Representatives from each country's MOH can conduct workshops to adequately train school staff and teachers on their respective countries' national health standards. Training sessions on school-based management can also be held for school heads so they can hone their skills on designing, implementing, and managing SHCN programs and projects within education systems which are increasingly becoming more and more decentralized. Opportunities for knowledge sharing on SHCN among school heads through cluster meetings and other peer-to-peer learning exchanges should also be encouraged and supported.

- **Allot a bigger budget for school-based health and wellness initiatives.** Central governments should make the implementation of effective, timely, and cost-efficient school-based health programs a priority, and government funding allotted to SHCN should reflect that. For countries following a decentralized governance structure, provincial and/or district governments should allocate regular budgets to cover the

majority of material costs involved in delivering school health and nutrition interventions.

- **Strengthen efforts to integrate health promotion and wellness into the curriculum whenever possible.** Integrating health and nutrition topics into communication arts, science, or social studies lessons can reinforce what students learn about how to best take care of themselves and thus, help them retain this information. This approach may prove to be more effective in promoting health and wellness than conducting one-off community parades, sports fest, or contests which often require classes to be called off for a few hours or the whole day.

- **Expand on simple, scalable, and sustainable school-based health initiatives.** Many of the common health problems of grade-school children can be avoided if they consistently observe good hygiene, so there is a need to expand on SHCN efforts, such as or similar to the Fit for School (FFS) program, that promote hand washing, toothbrushing, deworming, and sanitary practices.

- **Engage pupils as active partners in implementing SHCN programs.** A good number of established and successful SHCN initiatives in the region provide students with opportunities to become health ambassadors and student leaders. Apart from the WASH in Schools program in which students are asked to help teachers supervise group activities such as handwashing and teach proper hygiene to their younger counterparts in school, programs such as Indonesia's "Little Doctors" and the Philippines' "Pupil-Led Total Sanitation" (PLTS) show that when students are given the chance, they can be effective change agents in their respective schools and communities instead of just being mere beneficiaries of the SHCN initiatives.

- **Encourage parents and other members of the school community to become more involved.** Efforts to enlist the support and increase the participation of all stakeholders should continue. Schools can work more with the PTA, local government officials, and other NGOs to increase parent and community engagement.

- **Strengthen school-based management (SBM) and inter-sectoral collaboration.** SBM can be an effective vehicle to implement responsive, quality SHCN programs, particularly if these are anchored on strong school-community partnerships as advocated by the FRESH framework. Involving stakeholders beyond those in the school and further intensifying collaboration with them can help make SHCN initiatives more effective and sustainable. Apart from education and

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health ministries, local government units (LGUs), nongovernment organizations (NGOs) and even sanitation and social protection agencies should also be engaged as partners as this could also help ensure successful SHCN implementation. The multi-stakeholder approach towards implementing SHCN would also give schools a wider support base from which to seek assistance and with which to share accountability. Representatives from the different agencies can hold quarterly coordination meetings, and a central online portal where everything can be updated, coordinated, and monitored may also help align efforts within and among government offices.

- **Strengthen monitoring and evaluation (M&E) systems and use data for benchmarking purposes as well as to plan and design SHCN program assessment.** To encourage accountability and further engage school administrators and project managers, countries should develop or enhance assessment systems to monitor and evaluate the impact and success rate of school-based health programs. A comparison of results among different schools can also be done in order to identify best practices and common pitfalls.

- **Conduct further studies to help stakeholders better overcome the challenges to successful SHCN implementation.** School heads and education ministry officials in Southeast Asia have reported finding it difficult to enlist genuine engagement from the community, generate enough funds, and sustain behavior change in their students. As such, future research endeavors can look into cases of particular schools and countries that have successfully overcome such hurdles in their implementation of health and nutrition initiatives from school-aged children. Education ministries can look into effective approaches to best support primary students in the region to translate their awareness of and learnings on health and wellness to good habits that they will continue to practice inside and outside of school.

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DATANG TERLAMBAT
MOHON TURUT MEMBANTU
KETENANGAN ANAK-ANAK BELAJAR

Photo credit: SEAMEO INNOTECH

APPENDICES

Appendix A. Survey on SHCN Programs in Primary Schools in Southeast Asia (Form 1 - National Level)

PART I. RESPONDENT'S PERSONAL INFORMATION

1. Name:	2. Country:
3. Employer:	4. Job Title/Position:

PART II. NATIONAL DATA

1. Please provide official statistics on the following:

   a. Number of Primary Schools for the last school year (SY 2012-2013)

Type of School	Number of Primary Schools for SY 2012-2013
Public Schools	
Private Schools	
Total	

   b. Number of Primary School Students for the last school year (SY 2012-2013)

Sex of Students	Public Schools	Private Schools	Sub-Total
Male			
Female			
Sub-Total			

2. Does your country collect school health and nutrition data from primary schools? (Please mark your response)

   ☐ Yes ☐ No

   If yes, what indicators are being collected and which government agency/agencies collect them? (Please mark all those that apply and mark the corresponding responsible government agency.)

Indicators	Government Agency Responsible for Data Collection		
	Ministry of Education	Ministry of Health	Others (Please identify)
☐ % of malnourished primary pupils	☐	☐	_____
☐ % of underweight primary pupils	☐	☐	_____
☐ % of overweight primary pupils	☐	☐	_____
☐ % of primary pupils with hearing impairment	☐	☐	_____
☐ % of primary pupils with visual impairment	☐	☐	_____
☐ % of malnourished primary pupils	☐	☐	_____
☐ % of primary pupils with intestinal worms	☐	☐	_____
☐ % of primary pupils with dental carries (tooth decay)	☐	☐	_____
☐ % of primary pupils with skin diseases	☐	☐	_____
☐ % of primary pupils with head lice	☐	☐	_____
☐ % of primary schools with adequate potable water supply	☐	☐	_____
☐ % of primary schools with handwashing facilities	☐	☐	_____
☐ % of primary schools with electricity	☐	☐	_____
☐ % of primary schools with separate toilets for boys and girls	☐	☐	_____
☐ % of primary schools with a medical clinic	☐	☐	_____
☐ % of primary schools with a registered nurse	☐	☐	_____
☐ % of primary schools with a guidance counsellor	☐	☐	_____
☐ % of primary schools with a school canteen	☐	☐	_____
☐ % of primary schools with a dental hygiene care program	☐	☐	_____

Indicators	Government Agency Responsible for Data Collection		
	Ministry of Education	Ministry of Health	Others (Please identify)
☐ % of primary schools with a de-worming program	☐	☐	_____
☐ % of primary schools with a skin disease awareness program	☐	☐	_____
☐ % of primary schools with EENT (eyes, ears, nose and throat) health program	☐	☐	_____

3. How often does each of the government agency identified collect data? (Please mark your response.)

Government Agency	Annually	Bi-annually	Quarterly	Others (Please indicate)
Ministry of Education	☐	☐	☐	_____
Ministry of Health	☐	☐	☐	_____
Others:				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

4. What are the top three school health care and nutrition (SHCN) problems observed among primary pupils your country is currently prioritizing to focus on? (Please check three only.)

☐ Underweight
☐ EENT (eyes, ears, nose and throat) problems
☐ Skin diseases
☐ Bullying
☐ Overweight
☐ Water and sanitation related illnesses (e.g. diarrhea, intestinal worms, etc.)
☐ Dental problems

☐ Others, please provide details:

_____

_____

PART III. SCHOOL HEALTH AND NUTRITION POLICIES

1. Does your country have national policies to support the implementation of the following components of a school health and nutrition program in primary schools? (Please see Annex 1, Page 9 for the description of these components.)

Components	Yes	No	If yes, please indicate the issuance number, title of policy, and year of effectivity		
			Issuance Number/ Policy Number	Title	Year of Effectivity
Healthy and Safe School Environment					
Health Education					
Physical Education					
Nutrition Services					
Health Services					
Counseling, Psychological, and Social Services					
Health promotion for Staff					
Family and Community Involvement					
Others (Please indicate):					

2. Please provide a brief description of the national policies identified in Part III, No. 1.

a. Policy on Healthy and Safe School Environment:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

b. Policy on Health Education:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

c. Policy on Physical Education:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

d. Policy on Nutrition Services:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	

Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

e. Policy on Health Services:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

f. Policy on Counselling, Psychological, and Social Services:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

g. Policy on Health Promotion for Staff:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

h. Policy on Family and Community Development:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

i. Policy on other components identified in Part III, No. 1:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

j. Policy on other components identified in Part III, No. 1:

Policy Title:	**Policy Number:**
SHCN Program:	
Goal/Objectives:	
Expected Outcomes	
Implementing Unit (e.g. national government, schools, etc.):	
Implementing Partners (e.g. local government unit, international organization, etc.):	
Funding Source/s:	

3. What factors among the identified SHCN Programs made them successful? (Please mark all that apply.)

☐ Strong policy support
☐ Adequate funding support
☐ Strong community support
☐ Strong leadership support
☐ Adequate human resources
☐ Strong inter—agency collaboration
☐ Strong partnership with different stakeholders
☐ Others, please provide details:

_____

_____

4. Does your country require the establishment of SHCN Councils or Committees in primary schools? (Please mark your response.)

☐ Yes ☐ No

If yes, at what level is this being required (Please mark all that apply.)

☐ National
☐ Division
☐ Sub-National/Regional
☐ District
☐ Others, please provide details:

_____

_____

Annex 1. Possible Components of School Health Care and Nutrition Program*

1. Healthy School Environment: The physical and aesthetic surroundings and the psycho-social climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

2. Health Education: Classroom instruction that addresses the physical, emotional, mental and social aspects of health – designed to help students improve their health, prevent illness, and reduce risky behaviours.

3. Physical Education: A planned sequential K-12 curriculum that promotes lifelong physical activity develops basic movement skills and sports skills. Physical education shall be the environment in which students learn, practice, and are assessed on developmentally appropriate motor skills, social skills, and knowledge.

4. Nutrition Services: Integration of nutritious, affordable and appealing meals; nutrition education, and an environment that promotes healthy eating.

5. Health Services: Preventive services, education, emergency care, referrals, and management of acute and chronic health problems – designed to prevent health problems and injuries and ensure care for students. It can include school nursing as well as dental services and school based/school linked health centers.

6. Mental and Social: Services that include individual and group assessments, interventions, and referrals – designed to prevent problems early and enhance healthy development.

7. Health Promotion for Staff: Opportunities that encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modelling. Health promotion activities have improves productivity, decreased absenteeism, and reduced health insurance costs.

8. Family and Community Involvement: An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts.

* Source: Adapted from Centers for Disease Control Prevention. *School Health Index: A Self-Assessment and Planning Guide. Elementary school version*. Atlanta, Georgia: 2012. http://www.cdc.gov/HealthyYouth/SHI/

Thank you for your time in answering this survey.

Appendix B. Canteen Monitoring and Evaluation Form Developed by Philippine DepEd Division of Makati

Region: SY
School: Principal:
Enrollment:
School managed: Cooperative managed:

AREAS OF CONCERN	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	Date	*Date*	*Date*	*Date*
Sanitary Permit (Valid/Renewed)				
Health certificates of canteen personnel (Valid/Renewed)				
Wearing of clean and proper attire (apron, hairnets, close shoes) of canteen personnel				
Provision of adequate hand-washing facilities				
Provision of potable water supply (with certificate of potability)				
Dining area is clean, well-lighted and well-ventilated				
Kitchen area is clean, orderly and provided with exhaust fan				
Canteen is generally pest-free, odor-free, with screened windows and doors				
Daily sterilization of feeding paraphernalia (spoons, forks, cups, and glasses)				
Proper storage of foods, kitchen utensils				
Proper labelling of condiments				
Provision of covered garbage cans/ practice waste segregation				
Accomplished Record of Daily Food Inspection (RDFI)				
Supplementary feeding program (35% share from canteen funds)				
Variety of nutritious cooked foods sold				

AREAS OF CONCERN	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	Date	*Date*	*Date*	*Date*
Fruits in season and fresh fruit drinks sold				
No junk foods and limited sweets sold				
No carbonated drinks and synthetic juices sold				
Provision of first aid kit and fire extinguisher				
MONITORED BY:				
DATE OF VISIT:				
CANTEEN MANAGER:				

-

Appendix C. Evaluation Form for the Division Search for Outstanding Supplementary Feeding Program Implementer (CY 2013) Developed by Philippine DepEd Division of Makati

CRITERIA	4 pts.	3 pts.	2 pts.	1 pt.
The beneficiaries of the feeding are all the identified severely wasted and wasted pupils. At least 50% of the target beneficiaries are fed regularly.				
The feeding fund can accommodate to feed indigent pupils aside from the regular beneficiaries as recommended by the advisers.				
The prevalence of malnutrition is reduced by at least 50% at the end of 120 feeding days.				
Encouraged pupils to increase intake of foods rich in calories, proteins, vitamins, and minerals.				
Promote scientific knowledge and develop wholesome attitudes and desirable habits and values related to health, nutrition, and other learnings (table manners, prayer, handwashing and toothbrushing)				
Established/strengthened the intra and inter-agency linkages that resulted to supporting the feeding beneficiaries.				
Developed self-reliance among the beneficiaries.				
All recipients have undergone deworming with parental consent.				
Permission slip/feeding program contract accomplished and signed by the parents/guardians.				
Nutritional and physical assessment done periodically (baseline, midline, and endline).				
Production of vegetable garden and fruit bearing trees and utilize the harvested crops for feeding.				
Adheres to the food safety standards are practice religiously.				
Self-sufficiency measures and income generating projects instituted to sustain supplementary feeding.				
Supplementary Feeding Program beneficiaries are fed daily (Monday-Friday) for 120 feeding days during the school year.				

CRITERIA	4 pts.	3 pts.	2 pts.	1 pt.
Feeding program is sustained by mobilizing support from parents and other concerned organizations.				
Treatment form of beneficiaries properly recorded and kept in the clinic for reference purposes.				
The feeding center is well-lighted and properly ventilated with complete feeding paraphernalias and kitchen utensils.				
The teaching load of the Feeding and Agriculture teachers should be at least 40 minutes but not more than 120 minutes a day and time spent for supplementary feeding and food production should be 120 minutes.				
Nutritious foods are served with standardized recipes developed utilizing the available indigenous foods.				
Financial statement is accurate and readily available for audit by authorized officials.				
The 35% allocated for the Supplementary Feeding Program is utilized properly.				
The supplementary feeding as a laboratory for nutrition education has involved the intermediate pupils in the food preparation, cooking, and serving on rotation basis. Their performance is evaluated by the food service teacher and credited in HELE.				
The academic performance of the recipients have improved and manifested in their quarterly grades and NAT results.				
Nutritional Status, Daily Attendance, Monthly Expenses, Cycle Menu, Documentation and other related reports are properly accomplished and posted at the feeding center for monitoring.				
The school has record of success stories related to supplementary feeding program.				
TOTAL				

_____ Conforme: _____

Evaluator

Publication Feedback Form

Thank you for taking the time to read our publication.

We would be grateful if you could provide feedback on how our work has been helpful and how we can further improve our succeeding knowledge and research outputs.

Please scan the QR code on the left to proceed to the online feedback form.

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