REPORT OF STATE LEVEL CONSULTATION

ON

HEALTH PROMOTION THROUGH SCHOOLS

IN
KERALA:

ORGANISED JOINTLY

BY

CHILD TO CHILD TRUST LONDON

AND

CORPORATE EDUCATIONAL AGENCY TRUST MANANTHAVADY

JANUARY 12TH AND 13TH, 1996.

State level consultation on "Health Promotion through schools Kerala.

1. Introduction:

The idea of health Promotion through schools is not a new one. In many part of the country and the World over, successful experiments in this field have been conducted. However, till recently no organised effort has been taken in Kerala to bring together all the agencies who are involved in the field of health promotion through schools and to pool together the fathomless experiences of different agencies which can be a motivating factor for others and will enrich the already existing programmes of agencies already in school health programme. Corporate Educational Agency Trust (CEAT) Mananthavady under its Corporate School health Programme (CSHP) in collaboration with Child to Child Trust, London, organised a "State level consultation on Health Promotion through schools in Kerala, on January 12th and 13th , 1996.

2. Importance of School Health Programme:

India is a developing country. Like many other under developed countries in the world, the health and development scenario in India is far from being satisfactory. The root cause of this situation is the existence of extreme inequality in the case of resource distribution between rich countries and the poor countries, between rich people and the poor people and between urban rural and tribal areas. A comparative analysis of the disease pattern of India with other countries shows its reflection. While cancer and circulatory diseases are the major causes of death in a country like the U.S.A, the diseases of poverty is responsible for most deaths in a country like India. The poverty and ill health in childhood leads to an undergrown mother who can give birth only to an under weighed baby. Thus a vicious circle of ill health is formed. Other problems like pollution, ozone depletion, desertification, extinction of species, green house effects, growing communal violence, social disturbance etc., require our urgent attention. The present health policy of India is not capable of tackling these problems. Therefore, we must initiate community based health action and one such effective measure is health promotion through schools.

A simple analysis of the feasibility of health promotion in schools reveals the efficiency of this approach. Child hood is the state when children develop habits and if we could inculcate good health habits among young generation, its impact will be lasting. Secondly, children can perform well in schools only if they are healthy. Therefore health promotion of children is again very important. The health care of the children, who constitute about 40 per cent of the Indian population is important in community health perspective. Fourthly, children can serve as cost-effective means to disseminate health messages, and lastly, with the expansion of education facilities in Kerala, the percentage of school going children increased considerably. Therefore, school health promotion is easy, and an urgent need in Kerala.

3. Background of the Consultation:

The School Health Programme of the Corporate Educational Agency was launched in November 1993 and the result so far have been very encouraging. The programme became a point of attraction for many agencies both inside and outside Kerala. Many agencies got motivated from this programme and got interested to start school health programme in their own areas.

Another motivating factor behind organising this consultation was the National level workshop at EMMA Madras, organised by The Child to Child Trust London and the Southern Regional Meeting at St. John's National Academy of Medical Science, Bangalore. At the end of the meeting it was decided to convene State level meeting in all the south Indian states. CEAT was entrusted with the responsibility of convening the Kerala Meeting.

4. Objectives of the Consultation:

The consultation had 4 major objectives.

a) to motivate the participating agencies to initiate school health programme in their respective agencies.

b)To help those agencies, who are already implementing school health programme to improve their programmes with child to child approach.

c)To create an awareness among participants on the need for networking,

d) To enable the agencies to work together and share their experiences.

5. Organisation of the Consultation:

In fact, the organisation process of this consultation started in 1995. Initially the programme was planned as a workshop in Calicut in November 1995. It was postponed to January due to the lack of funds. While we were looking around for funds, the Child to Child Trust London came forward with a grant of 200 pounds. The programme was then re-scheduled for early January at Boys Town, Manamthavady.

From mid-November onwards, the organisational machinery was working in full swing. All the Agencies were contacted with letters together with reply card, highlighting the importance of the programme. A second letter, with a resource paper showing 6 steps of Child to Child activity, taken from "Child to Child: A Resource Book" and a frame for sharing of experiences and involvement, was sent to all the participants. Couple of weeks later, a write up on School health (An introduction to School Health) prepared by Mr. Jose Mathew was sent to all the prospective participants for their remote preparation for the consultation.

Side by side Dr. Veda Zachariah and Dr. Indu Balagopal were contacted through letters and over telephone and for their guidance and support. Meticulous attention was given to details of each activity of the consultation.

5. The Consultation:

I. The first Day (12-1-96)

a). Starting the Consultation:

The consultation got started at 10 am with a silent prayer, followed by the welcome speech, by Fr.Thomas Joseph Therakam. In his talk, he briefly narrated the general objectives of the consultation and the participatory methodology of the programme. It was followed by introduction of the participants by using a simple game in which each participant was introduced by another. It was followed by participatory planning where the group shared about their expectations from this consultation.

b). Content and Process of Consultation:

The group had an input session by Dr. Veda Zachariah. Briefly she narrated the concept of health promotion through schools and why it is important today. Health was presented as a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity. The three aspects of school health programme was identified as health education, healthy school environment and health services. She convinced the participants on the need of the programme, with schools becoming agents of health promotion.

It was followed by a short session by Dr. Indu Balagopal who explained what is 'Child to Child' all about. She simplified the concept, by saying that child to child is one child helping another child to lead a full life with all its richness. She again explained about the six steps in child to child programme as 1). Choosing the right health idea 2). Finding more about the topic. 3). Discussing what was found out by the group. 4). Planning an action to tackle it. 5). taking or implementing action. 6). Discussing the results.

Dr. Indu Balagopal facilitated a brain storming session to identify the health needs, where all the participants shared one or two health problems, and they prioritised it. Then a practical question was raised. There are two types of needs. One is felt needs and another is real needs. Only felt needs are projected in such discussion and the group arrived at the conclusion that children are children and they require the guidance of adults, to identify the real needs.

It was followed by a role play showing the six steps of Child to Child programme, taking tooth ache as a problem. It helped the group to get clarity on the child to child approach. The session ended with the statement of children's rights as stated in Article 12, of the International convention on the Rights of the child-1989, which says "Don't hurt us, keep us safe, give us food, health and a home. Protect us. Our bodies are our own. We need to learn and play. Treat us as people, listen to what we say." Children have the right to express their opinions freely and have their opinion taken into account in matters that affect them!.

The next session was on participation of children in health promotion, facilitated by Dr. Veda Zachariah. She conducted this session in small groups where participants identified the levels of students involvement from their real

experience. In the first level, children are supported, consulted and encouraged. this is the most desirable level of participation. The second level is that children are informed and involved. It is graded as desirable level. The undesirable level of participation is that children are being used for the programme, by the agencies implementing the programmes. This exercise served as an introspection for those who are already involved and it was a warning for those who are planning to launch the programme. Child to child approach is for those who believe that children are partners in the health and development activities and not mere "beneficiaries". Again each step of the organisation of child to child session was worked out in a paragraph puzzle where participants in groups, arranged it in order.

After the tea break, the group assembled again for a sharing session. the sharing was divided into five major areas. The first area was on "impact of school health programme". Mr. C. V. George, a teacher under the Corporate Agency and one among the five Regional co-ordinators facilitated the session. He shared his experience from observations and involvement in C.S.H.P. The second major area was "Involvements of students in health promotion" facilitated by Mr. K. J. Joseph Master, one of the C.S.H.P Regional co-ordinators. He divided the areas of involvement in 4 levels viz.:- Child to Child, Children to Children, Child to family and Child and Children to Community. The sharing on "Importance of Cultural Media on dissemination of health messages" was facilitated by Mr. P. J. Jose who is in charge of the C.S.H.P Cultural Team. He opined from his experience that the retention of what is learned is more if health messages are transmitted through cultural media.

These sharing sessions were followed by cultural programmes on health topics presented by students volunteers of the Cultural Team of Corporate School Health Programme. the programme started with a Corporate School Health Anthem which consist of all the major objectives of Corporate School Health Programme, sung by students from St. Joseph's High School Kallody. It was followed by a puppet show named "Samhara" (Which means total distruction) presented by Cultural Team of St. Sebastian's U. P. School Kommayad. The theme of Samhara was on AIDS and community based rehabilitation of AIDS patients.

The third item was a street drama on care of our body presented by Cultural Team from St. Joseph's High School Kallody. It depicted how a man who lived in this world distroyed his various organs due to his careless life styles. However, in heaven, God did not allow him entry, as he reached there with a [illegible] body. God gave him one more chance to live in a different manner, paying due care to the various organs of his body.

This was followed by few songs sung by Cultural Team from St.Joseph's H. S. Kallody. The major theme was the difference of health habits of old and new generation.

Another programme was "Villupattu"(a traditional art form using a bow and few arrows and with songs and conversations) presented by Cultural Team from St. Mary's U. P. School, Thariode. The main theme of the Villupattu was on the deteriorating ecological balance of the universe.

The next item was a "Kathaprasangam" through which students from St. Joseph's H. S. Kallody presented the issues related to substance abuse in school campus.

It was followed by a street drama on health habits, presented by St. Joseph's H. S. Adackathode.

The last session on the first day's programme was evaluation, facilitated by Fr. Thomas Joseph. The group observed that the content and presentation of various sessions were good, and the consultation is moving in the right direction. The input sessions were found relevant. All the participants appreciated the cultural programme which widened their vision and deepened their understanding of health promotion through schools. Participants also felt that their idea of school health programme is getting clarified and they become more confident about the programme.

SECOND DAY 13-1-96

The second day of the consultation started at 9 am. At the very outset, the group re-scheduled the whole programme of the day. Mr. Jose Mathew, Regional co-ordinator, C.S.H.P. from Manimooly started the session with a sharing on "Organisation of Corporate School health programme". He presented the organisation as well as the process of organising the C.S.H.P. (Details see in Annexure). He also shared on the "Role of teachers and head masters in Corporate school health programme". In this he explained the role of teachers in the class, as teacher health volunteers and as Regional co-ordinators (Details see in Annexure) A lot of discussion generated after each sharing

After the sharing session, Dr. Veda Zachariah facilitated a session on low cost training materials with the use of demonstrations. She explained how to make training materials from, waste as well as low cost things. The session widened the vision of participants and introduced them to the technique of making low cost training materials.

It was followed by an exercise by the group to identify objectives and task chart. The participants in groups developed the objectives of their school health and different tasks of the programme.

In the second exercise on task and resource inventory, the participants in groups identified different resources in terms of human, money and materials for the realisation of the task. These two practical exercises enhanced the clarity of the participants as to how to go about and what to do in order to launch school health programme in their respective areas.

The Mass Media Education Officer from the State health Services, Kerala, gave a lecture on the status of children in Kerala. He pointed out that 70 percent of the children born in Kerala are underweighed. He stressed the importance of early detection of such children through schools.

After the lecture by the MMEO, the group again divided themselves into two , for working out future plans and follow up action. All the Corporate Agencies constituted one group and all the Non Governmental Organisations and

Hospitals formed another group and worked out an action plan to do follow up and to activate the health promotion through schools in Kerala. Both the groups prepared on action plan and presented in the Plenary.(Details see in Annexure). The group requested Mananthavady Corporate Educational Agency to convene the next state level meeting in November 1996.

6. Net working:

The group felt the importance of networking in the field of health promotion through schools. The following methods such as exchange of ideas, concepts, innovative programmes, experiments etc., were identified for effective networking. Periodical meetings, exchange of Newsletters (if any), Training materials and resource persons were also seen as important. Thus the Voluntary agencies participating at the consultation decided to meet on 15th March 1996 at Kerala Voluntary Health Services, Kottayam; and The Corporate Educational Agencies on April 10th and 11th, 1996 at Calicut.

7. Evaluation of the Consultation:

The consultation was evaluated at the end of the programme, jointly by the participants, experts and organisers using workshop method. The important comments of the participants are highlighted below.

a. Content and Presentation:

All the participants except one was satisfied with the content of the consultation. One of the comment was "very good programme. Presentation was very effective. All the essential aspects related to school health programme were covered. It has strengthened me to go forward to conduct school health programme" One participant commented that "the content was relevant and effective, but I didn't like the morning session of the first day."

b. Method:

All the participants commented that the method used were "useful", "interesting", "not boring". To quote one comment "sharing, group discussion, role play, use of overhead projector etc., helped me to grasp more things."

c. Realisation of general objectives of the Consultation:

All the participants except two were of the opinion that "the objectives are met very well". Two participants commented "to a certain extent" because he is "not sure about the training materials."

d. Realisation of the expectations of the participants:

Almost all the participants expressed the view that the consultation gave them "more than what they expected". "The experience sharing by the Regional co-ordinators made me enthusiastic, and I have decided to do my level best towards health promotion of the school children" said one.

e. The session liked most and sessions that could have been avoided:

All the participants unanimously opined that no part of the consultation could have been avoided.

Most of the participants, summed up their comments in the following way: "General sharing by teachers gave more ideas and the stage performance was very good". Two participants commented that " sessions conducted by Indu and Veda "were the sessions they liked most".

f. Impact of the consultation on the participants:

The participants expressed manifold impacts on them. The consultation "enlightened the idea", and inculcated "more courage and optimism" in most of the participants. The members were "encouraged, enthusiastic and empowered to go forward" and "added more knowledge" to the participants. A participant went on saying "Now I feel very confident to enter into this field and know how to proceed." "I am motivated to start school health programme in our Corporate Educational Agency", says another participant.

Food and Accommodation:

All the participants are satisfied with the food and accommodation provided. A comment from one participant went like this, "Food and accommodation were very homely and my special thanks to the organisers for selecting such a nice spot for this programme."

7. Concluding Talk:

Rev. Fr. Thomas Joseph, Corporate Manager made the concluding talk. In that he reminded the participants that this consultation is a small beginning of a big process. He thanked all those who made this programme a grand success. He expected that all the agencies will initiate school health programme sooner than later.

8. Vote of Thanks:

Mr. Jose Matthew, the Programme Co-Ordinator of C.S.H.P. proposed the vote of thanks. Gratefully he remembered Mrs.Christine Scotchmer of Child to Child Trust London, Dr. Indu Balagopal, Dr. Veda Zachariah, Mr. Jaimon, Fr.Thomas Joseph Therakam, participants of the consultation, Regional co-ordinators members of the cultural team and students, and Wayanad Social Service Society, which arranged for food and accommodation as well as all those who contributed their mite towards the success of the programme.

Conclusion:

India is committed to the cause of Health for all by 2000 A.D. One of the most effective way to achieve this goal is through schools, where we could reach out to maximum number of children who are concentrated in a place. Therefore this consultation for the promotion of school health and Child to Child programme in Kerala is highly urgent.

We have done many crimes to the young generation. The worst crime we did is neglecting the children. It is at this time that their bones are set and brains develop. To them we cannot say "wait". Let us stand together for the cause of the children.

JOSE MATHEW,
PROGRAMME CO-ORDINATOR.

ANNEXURE I

IMPACT OF SCHOOL HEALTH PROGRAMME:

EXPERIENCE OF C.S.H.P, MANANTHAVADY.

Paper presented by **Sri.C.V.George:**
(Regional Co Ordinator, Pulpally)

Impact on Students' Sanitation:

1. Attitudinal changes and behavioural changes among students were observed. Students in all the schools constructed compost pit, soakage pit and placed waste boxes in the class rooms on their own initiative and expense, after the campaign on sanitation.

2. teachers observed the enhanced level of personal cleanliness and sense of hygiene among school children.

3. The students are taking proper care of their health and as a result attendance rate among school children have increased considerably.

4. Students are aware of the fact that earthly resources are not renewable, and they have reduced wastage of water.

5. It was reported that students learned about the correct use of water closets and urinals and maintaining the cleanliness of closets and urinals both at home and in the school.

6. Students from few schools constructed compost pits in tribal colonies to improve the sanitation level of the community.

7. Instances of students conveying the songs and slogans learned in the health awareness sessions to their parents and peers are reported.

First Aid

8. Students are confident to handle accidents occurring at home, in school and in the community.

9. Students developed concern for others and developed eagerness to help other students and even elders.

Ecology.

10. Students developed love towards nature and they have planted trees in the school compounds. They are aware of the need for an eco-harmonious life.

Eye Care

11. When the students learned about the ways by which eye diseases spread, they could control the eye diseases in this summer. The fear of the students towards the disease is reduced considerably.

12. Students are keen to test the vision of the family members with local techniques and encouraged them to go for vision screening. It indicates that the students have become conscious of the importance of eye care.

13. After the slide show on eye care students in one school conducted an exhibition of vegetables containing vitamin A.

Dental Care:

14. A very evident instance of impact was that, prior to the dental campaign, the number of students brushing the teeth before bedtime was below 10 percent. Now more than 90 percent students do it as a matter of routine.

Leadership:

15. Leadership skills among students increased considerably. They are enthusiastic in academic matters and their interest to attend health sessions have increased.

Herbal Medicine:

16. Students' interest to learn more about herbal medicine increased considerably. They are using it for their own minor illnesses.

Substance Abuse:

17. Students are conscious about the bad effects of smoking and they have made representations to the Corporate Manager and State Government requesting them to prohibit smoking in school campus and in public places.

Impact on Teachers:

18. Percentage of teachers smoking in the schools have reduced substantially. A teacher who was a chain smoker for 27 years, and taking alcohol for 25 years stopped both the habits after he got involved in the anti-tobacco campaign.

19. Attitude of the teachers towards the programme changed favourably.

20. It was observed that items containing health messages were prominent in the last science festival organised by the department of education, Government of Kerala. It indicates that health messages have gone deep in the minds of the teachers as well.

Impact on Family and Community:

21. Parent Teacher Associations in the schools became motivated from the knowledge and interest of the students in the programme. We have also observed an attitudinal change in them.

22. Parents are motivated to brush the tooth before going to bed.

23. After the AIDS Seminar for parents many clubs and associations around the school came forward for AIDS Seminar in their localities.

24. When Corporate School health Programme launched a drinking water and sanitation campaign, 8 lakhs of rupees was raised by the local people. It also indicates, the level of increased health awareness among parents and the community.

ANNEXURE II

INVOLVEMENT OF STUDENTS

IN CORPORATE SCHOOL HEALTH PROGRAMME:

Paper presented by **Sri. K. J. Joseph:**
(Regional Co Ordinator, Mananthavady)

Corporate School Health Programme has developed a structure to facilitate the optimum involvement of the students. The major area of involvements are given below.

1. Work as a member, and leader in Corporate School Health Club in the schools.

2. Meet periodically and plan activities to be implemented for the month.

3. Form sub-committees for specific task and implement them, e.g., for the maintenance of Bulletin Board in schools, there are sub-committees functioning in each school. They are collecting, editing and presenting health related paper clippings, cartoons and posters on bulletin board.

4. Collecting signatures against smoking.

5. Placing waste box in each class room and motivating students to use them.

6. Constructing soakage pits in schools.

7. Constructing and maintaining compost pits in schools.

8. Conducting eye screening among students on the basis of vision charts and screening guidelines.

9. Conducting Dental screening among students on the basis of guidelines given.

10. Collecting and reading out health related news from News papers, in the school Assembly.

11. Giving first aid to students who require it.

12. Doing follow up of students who are identified as children who require medical assistance.

13. Disseminate health messages to other children, at home and in the community.

14. Exhibit health related posters, slogans etc.. in class rooms and sing health related songs at leisure.

15. Develop art forms on health topics in schools and present them in different places.

16. Raising funds for school health programmes and sharing it with region.

17. Constructing soakage pits, waste pits etc., at home.

18. Students are keen to make vegetable gardens and kitchen gardens at home.

19. There are instances where students raised their voice against smoking in buses.

20. Students periodically evaluate their activities with the help of teacher health volunteers.

ANNEXURE - III

ROLE OF TEACHERS AND HEAD MASTERS IN C.S.H.P.

Mr. Jose Mathew:
(Regional Co-Ordinator, Manimooly)

Head Masters:

1. to encourage motivate and support teachers and teacher health volunteers to implement the programme.

2. Audit school fund.

3. Monitor school level activities.

4. Plan policies as a member of the Core Team.

Regional Co-Ordinators

1. Co-ordination of school health activities in their regions.

2. Planning, implementing and evaluating regional level activities.

3. Monitoring and evaluating school level activities.

4. Auditing school health fund.

5. Participation in regional level planning.

6. Organising and co-ordinating Regional Resource Team

7. Networking with other NGO's , Government organisations and local groups.

8. Reporting the programmes to Programme Co-Ordinator.

9. Maintaining Regional Accounts and presentation in regional co-ordination committee.

Teacher Health Volunteers:

1. Planning, organising, implementing and evaluating school level activities with other teachers, student leaders and headmasters.

2. Motivating and monitoring activities of student health club executives, student health volunteers and student health committees formed for specific tasks and duties.

3. Helping student health volunteers in giving first aid.

4. Reporting school level activities to the region and to the diocese.

5. Active participation in regional level activities.

7. Maintenance of school health fund.

8. School health fund raising.

9. Networking with local community, No's, Resource persons etc..

10. Identification of local health issues and organising programmes to tackle it.

11. Contacting parents of the students.

12. Organising programmes for parents and community.

Class Teachers:

1. Co-operate with Teacher health volunteers to conduct school level programmes.
2. Implementation of class level activities.
3. Follow up of students requiring special attention.
4. Contacting the parents.

ANNEXURE - IV

ORGANISATION OF CORPORATE SCHOOL HEALTH PROGRAMME:

Paper presented by **Mr. Jose Mathew,**
(Regional C-ordinator, Manimooly.)

Process of Organisation:

1. Problem identification.

2. Contacting different agencies in India and abroad, who are involved with school health programme

3. Project formulation and financing from funding Agency.

4. Staffing: (the programme co-ordinator was appointed.)

5. Pre-evaluation to study the existing programmes in schools and disease pattern of the school children.

6. Consultation with Headmasters, Managers, and teachers.

7. Selection of Teacher Health volunteers by the teachers from each school, and Their Training.

9. Training of the Headmasters.

10. Creating appropriate organisation structure.

11. Prioritising students' needs.

12. Preparation of action plan and work plan for one year, for Diocesan level, Regional level, school level and class level.

13. Resource mobilisation and organisation.

14. Student Health Volunteers Training.

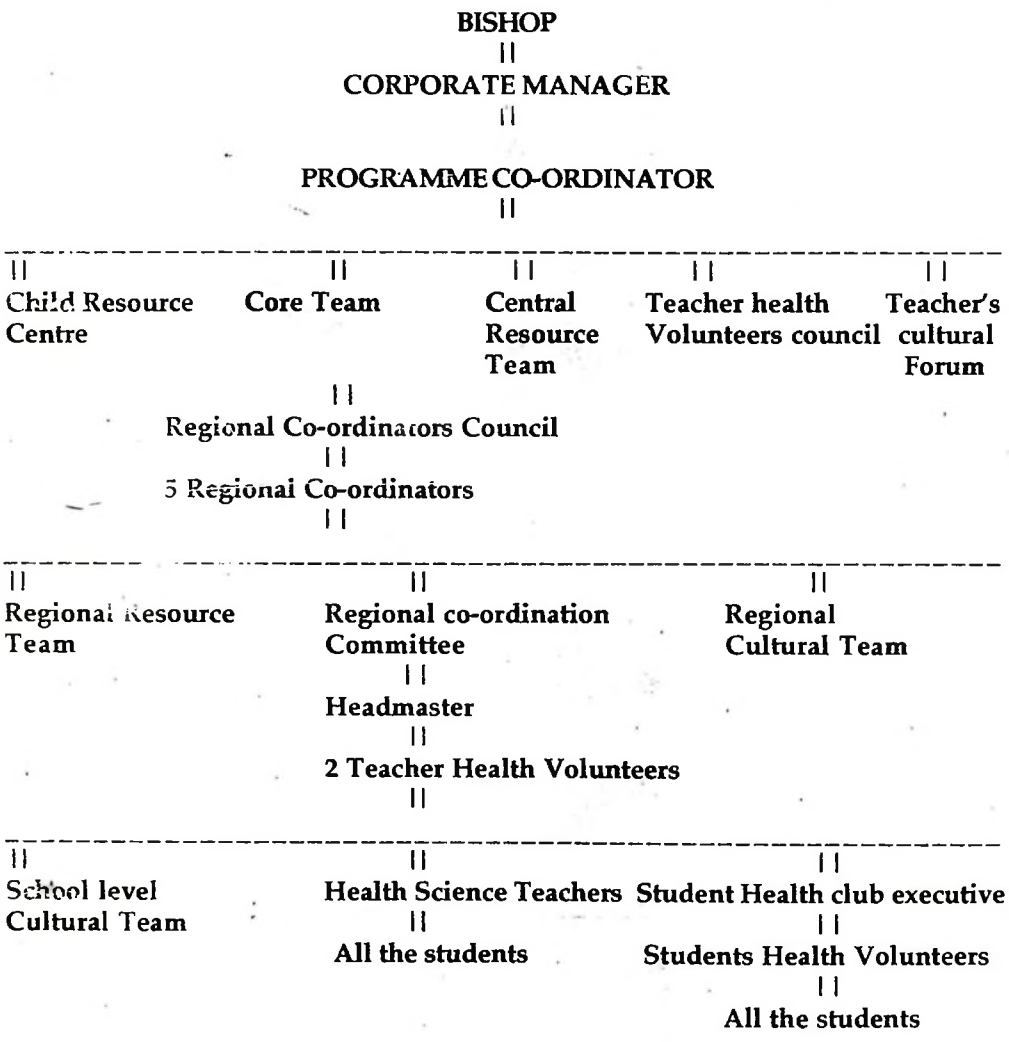
15. Student Health club executive members training.

16. Students training, Seminars etc..

17. Health promotion sessions in each class.
18. Half yearly and annual evaluations.

ORGANISATION STRUCTURE OF CORPORATE SCHOOL HEALTHPROGRAMME:

In the project, very limited organisation structures were visualised. However, when we implemented the project many more structures got evolved for the implementation of C.S.H.P. The present organisation structure is given below.



Description of the Structure:

1. **Bishop:-** Bishop is the legal holder of the project. He is incharge of all the programmes and mission activities under the Diocese.

2. **Corporate Manager:-** Bishop has delegated the Corporate Manager to implement the education mission of the diocese. He is the manager of 34 Schools in the Diocese. He sets the policies of Corporate Educational Agency including school health programme.

3. **Programme Co-ordinator:-** He is the staff appointed by the Corporate Manager to implement Corporate School Health Programme. He prepares plans, implements and evaluates the programmes as per the policies of the diocese and the Corporate Educational Agency.

4. **Child Resource Centre:-** It consist of books training materials like slides, video cassettes, T.V and V.C.R Set, slide projector, Overhead projector etc. which are used for implementing the programme.

5. **Core Team:-**Core Team consist of representatives of Headmasters from Primary, Upper primary and High schools, from all the regions, the Regional Co-ordinators, the programme co-ordinator and the Corporate Manager. Core Team set the policies for C.S.H.P.

6. **Central Resource Team:-** Central Resource Team consist of trainers who are Doctors and experts , who train teachers and Regional Resource Team members.

7. **Teacher Health Volunteers Council:-**It consist of all the teacher health volunteers of C.S.H.P.

8. **Teachers Cultural Forum:-** It is a team of Teachers who have the talent to develop art forms appropriate for students with appropriate health messages. The chairman of the forum is the programme co-ordinator and a Teacher selected by the Forum is the Convenor.

9. **Regional Co-ordinators Council:-** The council consist of 5 Regional Co-ordinators and the Programme Co-ordinator. They draw workplan for regional level and diocesan level activities and take decisions regarding urgent matters subject to the policies.

10. **Regional Co-ordinators:-** Regional Co-ordinators are Teacher Health Volunteers elected by the Regional Co-ordination Committee, They are in charge of Regional level activities.

11. **Regional Resource Team:-** It consist of selected Teachers and eminent persons even from outside Corporate schools, committed to the cause of children and their health. The Team is trained by Central Resource Team of C.S.H.P.

12. **Regional Co-ordination Committee:-** It consists of all the Teacher health volunteers of a Region. A region consist of a group of schools in an area.

13. **Regional Cultural Team:-** Regional cultural team consists of students who are trained in some cultural media and will present the programme in other schools in the region.

14. **Headmasters:-** Head master is the administrator of the CSHP in the school.

15. **Teacher Health Volunteers:-** Teacher health volunteers are the teachers selected from among the teachers by the teachers themselves. There will be a male and a female Teacher Health Volunteer in a school

16. **School Level Cultural Team:-** Consists of Students trained in some art form related to health.

3. Initiate school health programme in their agencies and improve the quality of the work using child to child approach.

4. To elicit the support of health and education department of government of Kerala for conducting school health programme.

5. Development and establishment of training programme for all categories of people involving social workers, head masters, school health leaders, health club members etc.

6. Exchange of ideas through News letters, visits, exchange of training materials, informations, problems etc..

7. In order to evaluate the progress, it was decided to convene a meeting of voluntary organisations and hospitals on 15th of March 1996 at Kottayam. Kerala Voluntary Health Services will convene this meeting.

ANNEXURE - VI

SHARING BY PARTICIPATING AGENCIES

1. JANASAUKHYA - INTEGRATED SCHOOL AND COMMUNITY HEALTH PROGRAMME

Sri . Baby Vadakel
(Project Co-Ordinator.)

Year of starting the programme: 1985.

Programmes and activities Implemented:

1. Training Programme:

Janasaukhya has five levels of training to address five major categories
a. Training of resource team.
b. Students.
c. teacher health guides
d. Mothers
Cultural troops.

2. Exposure programmes for students & teachers.
3. Formation and promotion of health clubs.
4. Cultural Programmes.
5. Audio-visual programmes.
6. Vegetable and herbal home garden.
7. Health day celebrations.
8. Vinjan pareeksha (health general knowledge contests)
9. Quiz competition for high school students.
10. Distribution of herbal first aid kit.
11. Publications.
12. Essay competition for teachers.
13. Survey of school drop-outs.
14. Health bulletin board in schools.

17. Health Science Teachers:- All the teachers in a school under the Corporate Educational Agency takes health sessions in their respective classes.

18. Student Health Club Executive:- In a school, there is a health club constituted by student health volunteers. A President, Secretary, Vice President and Joint Secretary are elected from among the students. The strength of executive members vary according to the strength of the school.

19. Student Health Volunteers:-A girl and a boy from each class is elected by the students as student health volunteers.

20. All the Students:-

ANNEXURE - V

FUTURE PLANS

CORPORATE EDUCATIONAL AGENCIES:

1. To extend school health programme in many more schools in Thamarasserry and Trivandrum Corporate Educational Agencies.

2. Thalasserry and Kothamangalam Corporate Educational Agencies will initiate school health programme by the next academic year. However, the preliminary work will be done in the coming months.

3. It was decided to mobilise sufficient funds for the programme by each Agency.

Man: To identify resource persons in their own agencies at different levels.

Money: a) To workout project and submit it to funding agencies.
b) To raise local funds using different means such as coupon collection, approaching local sources etc..

Materials:-a) Create low cost training materials.
b) Mobilise Government resources.
c) Exchange of materials between different Corporate Agencies.

Follow Up: A follow up meeting of Corporate Educational Agencies to be convened on 10th and 11th April 1996 at Calicut. **Rev. Fr. Mathew Mattakottil** From Thamaraserry has agreed to convene the meeting.

VOLUNTARY AGENCIES:

1. Members who represented Hospitals, decided to involve nursing students in their activities.

2. Voluntary Organisations and Hospitals decided to develop and use cultural media and audio visual media for school health programme.

15. Health check up camps.
16. Net-working with Government and other like minded organisations.
17. Health exhibition.
18. Eye camps and blood detection camps.
19. Organised workshops and seminars on STDs; HIV / AIDS, alternative lifestyles and life style diseases etc..
20 Campaign against alcoholism , drugs and smoking.

2. Number of staff Employed: 6

3. Students' involvement in the programme

Health clubs consist of students' representatives of schools. Each section (L.P., U.P., H.S) has health clubs. These health clubs, organise and conduct programmes and activities in the schools.

4. Number of students covered by the programme.

32,811 students from 67 selected schools of Wayanad District.

5. Number of teachers involved in the programme: 101

6. Impact of the programme:

1. the H.P. of Janasaukhya has influenced the educational policy of the government of Kerala.

2. Seeing the success of our programme, the Corporate Educational Agency of Mananthavady, introduced school health programme in their schools.

3. The Director of Public Instruction, Government of Kerala, directed the Deputy Director of Education. Wayanad., to co-operate with the programme of Janasaukhya.

4. Our herbal First Aid Kit is widely accepted and is in great demand.

5. The contribution of Janasaukhya through its various programmes helped in improving the health status of the people.

6. The programme when introduced had a lot of resistance and reluctance from various sectors, namely teachers unions, political parties and vested interest groups but it melted down gradually.

7. The teachers are of opinion that Janasaukhya programme helped to effect changes in various sectors. Some of them are:

1. Improvement in the attendance of students.
2. Improvement in personal hygiene and environmental sanitation.
3. Students have developed certain values and positive attitudes and concern for the fellow beings, respect for the teachers, authorities and elders.
4. Better discipline.

8. First Aid Kit and the basic knowledge of health and medicine was a great boon to the teachers to manage the simple ailments and accidents of students at the school itself.

7. Problems Faced.

1. the vastness of the area.

2. Lack of support and co-operation of the school authorities and inaction from the government.

3. Transfer of teachers/incharges, often cause discontinuity of the programme.

4. Opposition from the teachers' unions.

5. The cold war between the health department and education department causes difficulty.

6. The teachers are on pressure due to the vast syllabus and schedule of extra-curricular activities.

7. The image of Janasaukhya as an agency who receives foreign contribution, make the school authorities to demand financial contributions and material benefits.

8. The staff strength of Janasaukhya is limited.

Lack of transport facilities and training accommodation.

10. There is a lot of demand to have the S.H.P. in each school of Wayanad district.

11. Floating population as beneficiaries.

12. Suspicious attitude of the political parties.

13. Lack of basic facilities in schools.

8. Future:

Steps are initiated to make the programme sustainable and accordingly colloquiums, consultations, programmes are being planned.

II. CORPORATE EDUCATIONAL AGENCY, DIOCESE OF MANANTHAVADY

1. Name of the Agency : Corporate Educational Agency Trust (CEAT)

2. Name of the Programme: Corporate School Health Programme (CSHP)

3. Major programmes of Corporate School Health Programme, Ma. anthavady

I. Physical Health
a. Care of eyes
b. Campaign on Care of ears
c. Care of Teeth
d. Campaign on substance Abuse
e. Campaign on promotion Herbal Medicine
f. Herbal First Aid and fi t aid training

II Mental Health
a. Sex Education
b. AIDS and STD awa ness

III Social Health
a. Campaign on Ecology
b. Sanitation training and construction of sanitation facilities
c. Campaign Communal harmony

IV. Mental & Spiritual Health
a. Value Education

V. Beneficiaries:
25,000 students studying in 34 schools are the direct beneficiaries. 731 teachers 34 headmasters and commu ity around the school receives indirect benefit.

VI. Number of Staff:- One

4. Methods used

1. Slide show for students and parents
2. Video programmes
3. 16 mm film show
4. One day seminars for all the students and parents.
5. Training camp for teachers, resource team, student leaders , parents and other agencies.
6. Bulletin Board.
7. Cultural Programmes.
8. Exhibitions
9. Observation visit for teachers and students.
10. Child to child sessions.
11. Workshops and Work camps
12. Health club.
13. Competitions
14. Leaflets and publications
15. Bulletin Boards

5. Year of starting the Programme: **16.11.1993.**

Number of teachers involved: Regional Co-ordinators - 5
Teacher Health Volunteers - 68
Teachers - 731

III. SCHOOL HEALTH PROGRAMME OF KERALA V.H.S.

SHAJI ZACHARIAH
PROGRAMME OFFICER

1. Name of the Agency: **Kerala Voluntary Health Services**

2. No. of schools : 100

3. Programmes
1. Health Education
2. Environment education.
3. Career guidance
4. Counselling
5. Health quizzes.
6. Leadership quality development camps.
7. Tackling of Behavioural problems.
8. Scholastic performances and training of teachers.

SCHOOL HEALTH PROGRAMME OF MEDICAL TRUST HOSPITAL -MUNDAKAYAM:

SR. GRACY KALLOKULANGARA M.M.S.

1. Name of the Agency: **Medical Trust Hospital**

2. Name of the Programme: School Health Programme

3. Year of starting: 1991

4. Number of students involved: 14 schools and 50-100 students as health club members

5. Students involvement: In every school, there is a health club consisting of 2 - 3 members from each class. They initiate the messages to their friends in the class.

6. Programmes.

- Notice Board for health messages
- Provision of drinking water facility in each school
- Waste basket in every class
- Waste pit in every school
- Classes for mothers
- Herbal Nursery in some schools
- Study tour for health club members.
- Bala Mela
- Cultural programmes
- Health education
- Teachers' training

7. Problems faced: Problem due to floating population.

IV. NATIONAL INSTITUTE OF HOLISTIC HEALTH AND RESEARCH

Dr. T Abraham Vaidhyan.

They have been planning for a school based health programme for students, with the aim to promote general hygiene, structural improvement in motivation and all round achievement, through strengthening the self-esteem, fostering courtesy, good manners, community health and cleanliness and AIDS and drug awareness for the last two years for the back bench students.

ANNEXURE - VII

Resource Papers:

THE CHILD - TO - CHILD WORKSHOP:

WHAT? STEP 1 - CHOOSING THE TOPIC

Teacher and children

"Do the children fall ill often?
What are the common illnesses they have?
Are any of them more prevalent than the others?
Shall we classify them?
Which is the most urgent problem?

List the illnesses
Classify them
Identify the most pressing problem.

WHEN? STEP 2 - FINDING OUT MORE

Children.

Then teacher and children.

What happened?
How many fell ill?
Were they treated? How?
Is it spreading?
Are there any traditional beliefs or practices that they observe regarding the illness?"

Children should report to the teacher or other adult
Record and tabulate the findings.

WHY? STEP 3 - DISCUSSION

Resource Person: Teacher and children.

"What causes the illness?
How does it spread?
Can it be prevented?
Is there immunisation for it?
Are the traditional practices sensible?
Where can children intervene?"

Get your facts right.
Discuss prevention - personal and environmental.
Discuss treatment.

HOW? STEP 4 - PLANNING ACTION

Teacher or other adult and children.

"How can children tackle the problem?
What methods of communication can they use?
What materials can they prepare?
Can they use the c-to-c activity sheets"?

Identify the target group.
Materials and methods should be interesting.
Activities should be age-appropriate
Messages should be specific to the situation and culture.
Many activities make it more interesting and sustainable.

WHO? STEP 5 - TAKING ACTION.

Children

Which are the children taking action?
Whom will they address? Other children or their families?
Will the community accept them?
When and how will they convey the messages?
Individually or in groups?

They may need adult guidance.
Their action should be acceptable.
Action should benefit the target group
Impact should be sustainable.
Children should be non-competitive.
The time needed for conveying the message and for reinforcing it should be planned.
Children should be trained to be non-aggressive and compassionate.

Taking Action

In the classroom:

Preventive:	1. Personal Hygiene 2. environmental sanitation 3. Immunisation
Promotive	1. Good habits - including behaviour 2. Nutrition
Curative	1. ORS 2. Caring for the sick child 3. Giving medicines

In the community :
Same as above.

Individual or group activity

Activities

In the classroom	- Games, Action Songs, Puppets, Storytelling, role-plays, riddles etc.
In the family	- Talking about it, acting, demonstrating (e.g.. ORS) doing (clearing yard) recording findings etc..

Children should have applied knowledge. They have to experiment and experience the learning. They have to internalise their learning.

Multi sensory inputs are very effective - **seeing, hearing, doing, saying.**

WHERE? STEP 6 - DISCUSSING RESULTS.

Children and teacher, resource person and community.

"What happened? Were the message understood?
What action was taken?
Where? In the classroom, family or community?
What was the result of the action?
What further action should be taken?
Will it be sustained? How can it be reinforced?"

Get the feedback on action taken from family and community.
Find out if there were problems.
Record impact of action- Improved health status .
Children trusted and respected.
Discuss if message has to be repeated.
Discuss time frame for long-term impact.

Feedback and Follow up-

Children: What was the impact of their action?
Did the younger children learn anything?
Did their family and community accept them?
Which messages were well received?
Were there any concepts they did not understand?
Were there any questions they could not answer?
Were any of the activities confusing?
Did they have nay problem while taking action?
Were the materials useful?
Do they have to change or expand any message?
What did they expect to come out of the exercise ? In how much of time?

Family and community -

What was their reaction?
Has it made any difference?
What is the next step in dealing with the problem?
How shall we sustain the impact?

WORKSHOP AND CHILD - TO - CHILD METHODOLOGY

WHAT	1. CHOOSING THE TOPIC	
	II	Teacher + Children 1 hour
WHEN?	2. FINDING OUT MORE	
	II	Teacher + Children 1 week
WHY?	3. DISCUSSION	
	II	Teacher + Children + Resource person 1 - 2 hours
HOW?	4, PLANNING ACTION	
		Teacher + Children 1 - 2 hours
WHO?	5. TAKING ACTION	
		Children 1 - 2 weeks.

WHERE? 6. DISCUSSING RESULTS

Children + Teacher
Resource Person +
Community
2 - 3 hours.

THE CHILD - TO - CHILD PROGRAMME

A Concept Paper

Dr. Indu Balagopal

The Philosophy:

The idea of using children's ability to learn, and spread their knowledge, has been applied through many programmes and projects in primary and secondary schools from time immemorial. The child-to-child programme also uses this principle, but with the major difference that the education process is child-centred. The Children are encouraged to participate at every stage of the programme, thus enabling them to apply their knowledge in everyday activities, so that good health practices and enquiry based learning become a way of life. The holistic approach to learning makes it an exercise that produces useful and responsible students who can contribute to social change.

The emphasis is, of course, on making it a fun-filled experience. Happiness is every child's natural inclination. Therefore to make it a sustainable programme, experiential learning has to be linked with the joys of childhood. Any activity that is planned has to provide the children the opportunity and the environment for pursuing happiness. Happiness is described as a state of mind that one enjoys. The children may enjoy singing, dancing, playing games, teaching others, or even being mother-substitute. And any experience that is pleasurable makes it long remembered and sustained.

The rational:

The c-to-c strategy of giving children health education through activity-based materials, and a creative approach to education is now common knowledge. Equipping and consequently empowering children to control their own health as well as training them to channelise their energies into influencing the members in their families and in the larger community is a rewarding experience. The "learning through enquiry and experiment" environment provided by this approach helps to inculcate confidence, resourcefulness and creativity, resilience patience, understanding and tolerance, courage and sociability in children. They then act as change agents in the community. Their knowledge and understanding become translated into decisions and positive action. Their applied skills and attitudes help to narrow the gap between the home and school.

The c-to-c approach has become more relevant in the present context because children have the potential to contribute to the stability and reassurance of their younger siblings, a function they perform as baby-sitters while their mothers

work. In addition, they look after their physical health and nutrition, their safety, and provide the mental stimulation so necessary for young children. While interacting with their siblings, the children provide the scarce resource of love and nurture sadly lacking in many families due to constraints of time and energy.

Old social orders are giving way to newer demands of the harsh reality of a fast-changing world. Due to changing patterns of society, life in the rural areas which provided safe environments that encouraged the fun and fantasy of childhood, is being eroded. Migration to cities exposes the children to the impersonal consumer society, with a few technological interventions replacing human interactions.

Family constellations and interpretations are also changing. Extended families with many generations under one roof, that lent tremendous support to child development, are changing in character due to geographical dispersion. Nuclear families are getting smaller while one-parent families are also increasing in number.

Therefore using children to play a responsible role in society is being increasingly recognised. Empowered with knowledge that is practical, the children spread messages that can make an impact on the community while giving them a sense of belonging . Their self-esteem gets a boost which in turn affects their responses and attitudes. They begin to look at practices at home through fresh eyes, and understand and appreciate the need for proper growth and development of their younger siblings. They also serve as researchers collecting information about their own families.

These roles can be performed in or out of school. The important component is that knowledge has to be linked to action. The children themselves plan and execute activities that will solve problems that they have identified. The benefits of this approach are many-

HEALTH EDUCATION: Children can be given the basic knowledge necessary for sensible promotion of good health through practice of hygiene, nutrition and care in sickness. Most of the minor ailments of childhood occur because of poor hygiene, and ignorance of how diseases spread. The common upper respiratory illnesses, diarrhoea and skin infections can easily be prevented if the children understood the process of the disease and knew how to deal with it. If they could also be taught to look after other children who were sick, it would help in reducing the "morbidity".

2. REALITY EDUCATION: The present schooling system does not encourage application of knowledge to real life situations. The scientific approach to providing information has unfortunately de linked it from practical application. For example, the child may learn all about dietetics, calorie requirements and measurements of food in ounces or grams, but may be unable to plan a sensible meal! In every sphere of education, the scientific and the technical rather than the behavioural aspect is given priority. In the c-to-c approach, value -based education is in-built, and helps in personal improvement of moral codes of the children. They can then become useful citizens of society.

COMMUNICATION SKILLS - SHARING AND CARING: By enabling children to be in control of their own lives in terms of hygiene and health, and experiencing the benefit of their knowledge, we equip them with the ability and confidence to share this knowledge with the others in their lives. And the methodology adopted in the c-to-c programme provides them the opportunities and skills necessary for effective communication. It can be viewed as a process of empowerment and preparation for life. This makes them more useful as contributors to their families, society and the country.

4. LEADERSHIP QUALITIES: Decision making and problem solving: As mentioned above, the programme provides the necessary skills for an active enquiry into life situations, and the ability to deal with them. It helps the children to apply their knowledge by analysing the reasons for a problem and to think of ways of solving the problem.

They also learn to deal with unpredictability and chaos in their lives in a mature manner.

5. LINKS WITH OTHER PROJECTS: The approach is applicable with all other programmes ,like primary education, non-formal circumstances and school drop-outs. The programme is not only child-centred, but it is also fun-filled and makes learning an enjoyable experience. It enables children to learn while they play, and sensible behaviour and practice become a way of life. The idea of learning for the pleasure of it or going to school for learning becomes an exciting prospect.

With the flexibility and adaptability that the programme allows it is applicable to all school situations. It can be applied even to children outside the formal school system and helps in the concept of 'Education for All'.

A desirable outcome is that the teachers, parents and the community understand children better. Consequently, the drop -out rate from school reduces.

6. WORKING TOGETHER, TEAMWORK, AND ROLE DIVISION: The c-to-c approach essentially involves all children, thereby encouraging equal participation and a non-competitive milieu for learning. Since the methodology involves thinking and discussing together, team work and role division become automatic.

7. TIME AND BUDGET ALLOCATION SKILLS: This is a natural outcome of planning and team work.

IN CONDITIONS OF CRISIS: Like war deprivation, children can express themselves well, continue their child-like habit of learning while playing, and even experience to a limited extent normalcy of childhood.

STRATEGY:

The children are used as educators in the classrooms or in the community whereby they become active participants in the construction of their own knowledge.

[illegible] work in collaboration with their own peers and teachers rather than in passive submission to instructors. The focus is on the children's participation in every aspect of the c-to-c programme, identifying the problem through observations and discussions, planning the strategy for solving the problem, implementing the programme , and monitoring and reviewing the action taken.

The children learn to use their direct experiences as the basis for learning and immediately apply their knowledge towards the needs of the family and the community. The built-in methods of monitoring and evaluating their action help to develop reflective, honest, concerned and participating children who will grow up to be responsible citizens.

METHODOLOGY:

Since children are used as change agents, it can be implemented in the class, in the school or outside the school. They participate in varying degrees of involvement.

1. As passive messengers of health practices.
2. In acquiring knowledge that they apply to themselves.
3. By taking part in identifying the problem and planning action.
4. By developing activities that will sustain the programme.
5. By acting as change agents in the family and society.

Initially it is important to have adults guiding and supporting the children. They have to be the resource persons who will ensure that the information the children have is correct. They will also ensure that the messages are simple and practical. These adults could be teachers, doctors or social workers.

When the children implement the programme, the adults have to get the feedback from the children themselves, from the younger recipients, from the families and the community. The implementing children are then trained to review their action objectively and make the necessary alterations or additions to make the impact more effective.

IMPACT:

With the introduction of the c-to-c approach into existing programmes for children, it was observed that there was renewed energy and enthusiasm in the classroom. The dull bare walls and sleepy indifferent teachers gave way to activity-filled happy classrooms where children were eager to try out experiments and think for themselves.

The new health knowledge which the children were able to apply in the community gave them respect and recognition in their own families. Working in teams gave them courage and conviction to change or alter some health or hygiene practices followed by their elders. Good preventive health measures and promotive actions prevented the medicalisation of health care. Dependence on doctors was reduced because of informed and confident children who could be in control of their own health.

The psycho-social needs of the younger children in families were automatically met, with the stimulation, play, attachment and the sense of security that develops during the conscious and sensible interaction between the children.

Difficulties:

1. The new, innovative, creative approach to teaching meets with resistance from the teachers who have themselves gone through early rigid formal systems of education. The c-to-c programme offers a great challenge to the teachers who are used to a teacher-centred instructional form of education.

2. Teachers worry about completing the allotted lessons and preparing the children for exams. Enquiry-based education, where the children take an active role in learning, is time-consuming.

3. Teachers feel that they are assessed on the academic performance of the children. A high percentage of achievers in the class indicates success. Any system or education that is non competitive but significant in terms of life skills is not valued.

4. Children are used to being passive in classrooms and learn by note. They feel unable to cope when confronted with having to take an active part in the learning process.

5. Families, authorities and formal schools resist any change in the methodology of teaching as there are no assessment norms except for academic achievements. Practical application of knowledge and its impact on the quality of life are intangible parameters that cannot be measured.

6. Good health is measured only in technological terms and medical parameters - the "medicalisation of health". Maintenance of good health and a sense of well-being are not recognised as personal achievements.

7. Increased confidence and rational thinking by the children may threaten the authority of the adults. Interpersonal relationships in families may become vulnerable and erode traditional expectations. The children have to be consciously trained to develop insights into their own behaviour.

8. Children feel helpless when they are faced with problems beyond their control. For example , abuse of civic systems, or lack of civic amenities are beyond the purview of children.

9. Parents and other adults in the children's lives may refuse to respect their knowledge, or at best ignore them.

10. Traditional gender roles may prove detrimental to implementation of certain plans of action.

Points to note:

1. Children can be given necessary skills and motivation to help and educate each other.

2. Health messages have to be clear and correct. They have to be practically applicable and sustainable.
3. Fun-Filled activities like songs, skits, games and riddles should be used to impart messages.
4. songs have to be simple, rhythmic and repetitive. Songs learnt in childhood are long remembered. Very familiar tunes may sometimes become counter productive as the words will tend to get ignored.
5. Puppets are a very good medium for conveying messages effectively. They don't have to be realistic but what they represent should be clear. For example a stick puppet in the shape of a tooth with its roots may not be recognised by a child who has not seen or studied about a tooth.
6. The c-to-c programme is a partnership between child and community, between health and education, between human beings and nature.

ANNEXURE - VIII

Address List of Participants:

1. Shaji Zachariah
   Kerala V.H.S
   Mullenkuzhy
   Collectorate P.O
   Kottayam.

2. M.T.Joseph
   Corporate Educational Agency
   Bishop's House
   Kothamangalam - 686 691.

3. Santhosh Kumar P.A.
   C.H.C.R.E.
   Rajagiri College of Social Sciences
   Rajagiri P.O.
   Kalamasserry.

4. Varghese Paul
   C.H.C.R.E.
   Rajagiri College of Social Sciences
   Rajagiri P.O
   Kalamaserry

5. Sr. Gracy. K
   M.M.T.Hospital
   Community Health Department
   Mundakayam P.O.
   Idukki - 68 65 13.

6. Sr. Lilly theresa SABS
   Corporate Educational Agency
   Sandesa Bhavan
   Thalassery - 670 101.

7. Sr. Susa MSMI
Corporate Educational Agency,
Thamarassery - 673 573

8. Jose Mathew
Corporate School Health Programme
Corporate Educational Agency
Bishop's House,
Mananthavady - 670 645.

9. Jaimon V. J
Community health Cell
367, Srinivasa Nilayam
Jakkasandra
I main, I Block
Koramangala, BANGALORE.

10. Dr. Indu Balagopal
14, Third Seaward Road.
Valmikinagar
MADRAS - 600 041.

11. Dr.Veda Zachariah, Director
Deena Seva Sangha
School Health Programme
5th Main, Srirampuram
Bangalore - 560 021.

12. Wencestane Lowrence
Corporate Management of R.C.Schools
Diocese of Thiruvananthapuram
Vellayambalam
Thiruvananthapuram.

13. Fr.Thomas Joseph Therakam
Corporate Manager
Bishop's House
Mananthavady - 670 645

14. Dr. T. Abraham Vaidyan
National Institute of Holistic
Health and Research,
Sithara Junction
Kottayam - 691 571

15. Fr.Joseph Memana
Jana Saukhya
Nallurnadu P.O
Mananthavady - 670 645.

16. Sr.Agnes Fernandez,
Health and Anti-alchoholism Commission

Trivandrum Social Service Society
Vellayambam
Bishop's House
Thiruvananthapuram 695 003

17. Fr.Joseph Chittoor
Sangameswerpet.
Chickmagalore District
Karnataka - 577 136.

18. Fr.Mathew Mattakatil
Corporate Manager
Diocese of Thamarasserry
Alphonsa Bhavan
Thamarasserry - 673 573.

19. Fr.Joseph Valiyakandam
Corporate Manager
Diocese of Thalasserry
Sandesa Bhavan
Thalasserry - 670 101.

20. Sr.Lizzy
Nirmala Hospital
Marikunnu P.O.
Calicut -12.

21. Baby Vadakel
Jana Soukhya
Nallurnad P.O.
Mananthavady - 670 645.

22. Mr. Jose Mathew
C.K.H.S.Manimooly
Manimooly P.O.
Malappuram Dt.

23. C. V. George
St. Sebastians U.P.School
Padichira P.O.
Pulpally, Wayanad.

24. Mr. K. J. Joseph
St.Catherines High School
Payyampally P.O.
Kartikulam Via
Wayand.

25. Mr. P. J. Jose
St. Joseph's High School
Kallody, Edavaka P. O.
Mananthavady - 670 64