

**CHALLENGES IN IMPLEMENTING A SUCCESSFUL
SCHOOL HEALTH PROGRAM
IN MALDIVES**

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SCHOOL HEALTH PROGRAM
IN MALDIVES**

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**A project submitted in partial fulfillment of the requirements for the Degree of
Bachelors in Primary Health Care**

**Faculty of Health Sciences
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November, 2015

DECLARATION

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I hereby declare that this project is the result of my own work, except for quotation and summaries which have been duly acknowledged.

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ABSTRACT

It is self-evident that school health program in Maldives has not been in line with School Health Policy 2011. Hence, this study was conducted to evaluate the challenges faced by the schools in implementing school health programs successfully as comprehended in School Health Policy. This research paper focuses mainly on 5 areas of challenges, human resource, perception of importance, staff, parent, community and government's support, adequate infrastructure and budget and finance. 28 schools randomly selected from the first 11 atolls except Alifu Dhaalu atoll was accounted in the research. Several challenges in implementing school health programs among these schools were identified, including lack of human resources, inadequate support from parents, staffs and community in implementation, and lack of adequate infrastructure. In addition to addressing these issues, improving awareness of school management on School Health Policy, school health program and its importance would likely improve the success rate of the program.

Key words: School Health Program, Health Promoting School Concept, Challenges, School Health Policy, Health Research, Primary Health Care

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LIST OF ABBREVIATIONS

CFBS	Child Friendly <i>Baraabar</i> School
CSHP	Comprehensive School Health Programs
ESQID	Educational Supervision and Quality Improvement Division
GSHI	Global School Health Initiative
HPS	Health Promoting School
MOE	Ministry of Education
MOH	Ministry of Health
NQIS	National Quality School Initiative
SH	School Health
SHO	School Health Officer
SHP	School Health Policy
SHPM	School Health Program
SHT	School Health Team
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 CHAPTER

INTRODUCTION

1.1 Background to the Study

Ottawa Charter for Health Promotion (1986) was revolutionary worldwide. Since then the direction and scope of health promotion was amplified and health promotion was introduced in schools. That was then the Health Promoting School (HPS) concept proposed by World Health Organization (WHO). Ottawa Charter and Declaration of the Fourth International Conference on Health Promotion (Jakarta 1997), guided the initiative of WHO's general direction of health promotion. With the WHO's Expert Committee Recommendation on Comprehensive School Health Education and Promotion (1995), WHO's Global School Health Initiative (GSHI) launched, seeking to mobilize and strengthen health promotion and education activities at local, national and global level (WHO, 2015; WHO, 2015).

HPS concept aims at developing supportive environments conducive to the promotion of health to achieve healthy lifestyles for the total school population. HPS concept requires commitments to the provision of a safe and health-enhancing social and physical environment thus providing opportunities respectively (Deschesnes, Martin, & Hill, 2003). One of the primary arguments of the Comprehensive School Health Programs (CSHPs) is that a healthy student will be able to perform better academically vice versa,

and therefore improve the productivity and efficiency of the future adult citizens (National Academy of Sciences, 1997).

Within the change brought by the Ottawa Charter (1986), Maldives introduced its first School Health Programs (SHPM) by Ministry of Education in the same year. A School Health Policy (SHP) was formulated by name Health Promoting School Policy in 2004. In March 2010 Ministry of Education in association with United Nations Children’s Fund (UNICEF) launched the National Quality School Initiative – “Child Friendly Baraabar Schools” (CFBS) in which health has been identified as a key domain. In 2011 SHP was revised inclusive of all the changes (MOE & UNICEF, 2010; Ministry of Education, 2004; Ministry of Education, 2011).

National SHP (2011) states that Ministry of Education (MOE) will be responsible in adopting the concepts of the GSH initiative and incorporate them into the national Quality School Initiative; CFBS to ensure institutionalization of the health promoting school concept into the education system. It also designates that Ministry of Health and Family (MOH) to provide technical expertise and resource materials and offer capacity building of the school health & safety section at MOE and school health teams in the schools. Moreover, facilitate technical support and staff capacity building for the program at national and school levels. The policy also states that MOE shall facilitate appointment of School Health Officers (SHO) in all public schools and provide support to build school health teams with administrative facilitation and supervision (Ministry of Education, 2004; Ministry of Education, 2011; MOE & UNICEF, 2010).

1.2 Problem Statement

Even though a comprehensive school health policy has been established for years and certain targets and goals are set, level of its implementation differs from place to place around Maldives. 11 years after the first school health policy in 2004 there are still several islands across Maldives with no SHO and/or a Health Room, and only few schools has a School Health Team (SHT) allocated, which indicates unsuccessfulness of the school health program up to date. Thus the need for identifying the challenges in implementing a successful school health program is certain.

1.3 Objective of the Study

1.3.1 General Objective

Identify the challenges in implementing a successful SHPM in Maldives.

1.3.2 Specific Objectives

1. Identify the human resource challenges in implementing a successful SHPM in schools.
2. Identify the perceived importance of SHPM by school management.
3. Identify whether staff, parent, community and government support is a challenges in implementing a successful SHPM in schools.
4. Identify whether infrastructure is a challenges in implementing a successful SHPM in schools.
5. Identify whether budget and finance is a challenges in implementing a successful SHPM in schools.

1.4 Research Question

1. Is human resource a challenge in implementing a successful SHPM?
2. Do you think school health component is a priority compare to other school components?
3. Do you receive adequate support from staff, parent, community and government in implementing a successful SHPM in schools?
4. Do you have an adequate infrastructure to implement SHPM?
5. Do you receive adequate budget and fund from government to implement SHPM?

1.5 Significance of the Study

CSHPs are seen as a source to reduce not only illness and deaths but also health care expenses by developing a healthy new generation (National Academy of Sciences, 1997). Therefore it is crucial to assess these programs to identify the gaps, and evaluate current programs to find out the limitations and the challenges, and address the issues accordingly. This study is designed to assess the current challenges faced by the school settings to successfully implement a SHPM in Maldives. It will benefit both the government of Maldives and the school managements as it provides more of a menu of possible and existing challenges in the education sectors. The findings of this study will be useful in reshaping the current and existing SHPMs to address the challenges, and to improve and derive positive outcomes for the best interest of government's intervention programmers, school management, parents, students and the overall country.

1.6 Scope of the Study

Although the study is conducted among a limited number of schools (n = 28) – only from 10 atolls from central to north, the randomness of the selected schools and

similarities among all the atolls of Maldives will make this study a good representative to the situation of all the schools of Maldives except Male' City. It is very unlikely that the study results will have any significant changes if applied to a different sample at a different setting. Therefore, the findings of this research can be generalized to all the schools operating in the atolls.

1.7 Definitions of terms

Health Promoting School Concept

Health-Promoting school concept is a concept developed by WHO in 1995 within the Global School Health Initiative. WHO defines Health-Promoting Schools as “schools constantly strengthening its capacity as a healthy setting for living, learning and working (WHO, 2015)”.

Ottawa Charter

The Ottawa Charter for Health Promotion is the name given to an international agreement signed at the First International Conference on Health Promotion, organized by the WHO and held in Ottawa, Canada, in 21st November 1986 (WHO, 2015). This term will be used in this study as it is defined originally in 1986 no change of meaning what so ever is made while using it in this study.

Global School Health Initiative

According to WHO, GSHI launched in 1995, seeks to mobilize and reinforce health promotion and education activities at the local, national, regional and global levels. The Initiative is deliberate to enhance the health of students, school personnel, families and

other community members through schools (WHO, 2015). This term is used in this paper as it is described by WHO.

Comprehensive School Health Program

According to Institute of Medicine 1995, comprehensive school health program is an incorporated set of planned, consecutive, school-based strategies, activities, and services planned to promote the optimal physical, emotional, social, and educational progress of students. The program includes supporting of families and is settled by the local community based on community needs, resources, standards, and requirements. It is accommodated by a multifaceted team and accountable to the community for program quality and effectiveness (Institute of Medicine, 1995). This term is used in the study in its original meaning and form. No change has been made in using this term.

2 CHAPTER

REVIEW OF LITERATURE

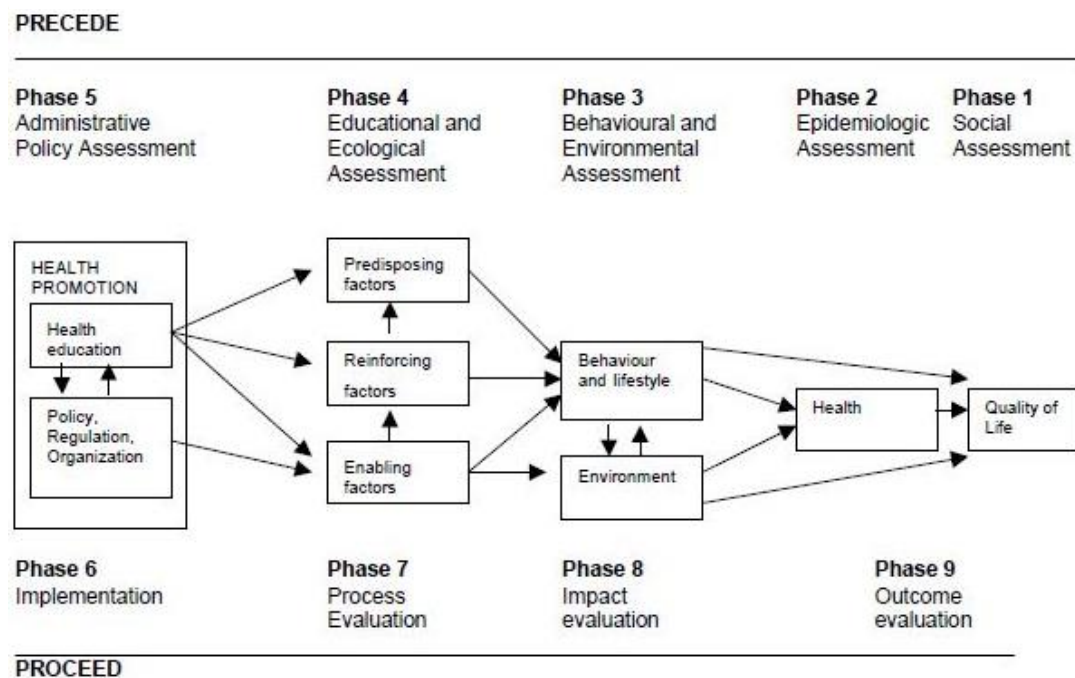
Many researches have been conducted around the world at all the times to assess, evaluate, and to find out the facts and evidences to proof different study subjects. This literature review would demonstrate evidence of understanding current study. The theoretical framework of the study will be highlighted along with the gaps in the literature reviewed for the study. Human resource challenges which might accompany with the SHPMs will be enlightened with literature review. Moreover, challenges faced to the school in participating parents and other community members will be discussed. It will also highlight challenges that can be face to the government to implement such programs.

The Director General of WHO; Hiroshi Nakajima states that “Educating children at school on health should be given the highest priority, not for their health per se, but also from the perspective of education, since if they are to learn they need to be in good health” (UN agencies, 1992). The health status of school-age children and youths are highly dependent on the local environmental condition, and their choice of lifestyle, making it more complex and challenging to direct health education programs (UN agencies, 1992, p. 3. para 4). Developing and strengthening a comprehensive school health education program to address these issues not only needs political commitment and advocacy, but also needs alliances among all sectors of society, including all relevant ministries and agencies, as well as teachers, health workers, parents, youth, media, and others (UN agencies, 1992, pp. pp. 5-6. para 4-10).

2.1 Theoretical Framework

This study is based on L. Green's PRECEDE-PROCEED model. This model is based on 9 phases, in which phase 5 – 9 deals with implementation and evaluation of programs. Thus, the mentioned phases has been taken into formulate the concept of the study. It guides assessment of the changes in predisposing, reinforcing and enabling factors, as well in behavioral and environmental factors, which generally covers the whole subject area. Fig. 2.1 shows a chart to represent all the phases of this

Figure 2. 1: PRECEDE-PROCEED Framework by L. Green



model.

2.2 Human resource

One of the main challenges to implement the SHP was identified, as lack of human resources, and equipment and supplies (Shaibu & Phaladze, 2010). To address such matters, there has been a recent reorientation of staff development in terms of capabilities for presentation of vital public health services (Chauvin, Anderson, & Bowdish, 2001). Management and coordination in each school by an education professional trained to implement the program has been identified as an important measure. While connecting health to other curricular areas can increase relevance for students, infusion courses are taught primarily by teachers not trained in health, and health messages may be buried among other topics. (National Academy of Sciences, 1997)

2.3 Perception of Importance

Any activity or program conducted in any setting is believed to be based on its perceived importance or significance and its ability to make a change in different aspects of the subjects. “Change is brought about by people so their feelings, concerns, perceptions, frustrations all play a critical role in determining the success or failure of an innovation (Dowrich)”. Dowrich also says that implementation of programs in school needs deep changes in staff’s or teacher’s perception. He confirms that perception of teachers towards the program has a huge effect on implementation process. So is the perception of school managers towards school health program.

It is evident that competing priorities has a strong association with not being able to deliver best out come from the program or intervention. Factors reported to effect continuity of implementation within a school system includes program’s acceptability and perceived relative importance to school administrators and teachers, perceived

effectiveness of the intervention, feasibility to implement on an ongoing basis, and flexibility and adaptability (Wang, et al.).

2.4 Support from staffs, parents and government

Although, the approach selected is school or community-based, most of the literature reflecting the HPS or CSHP concepts underlines the significance of good relations between the school, the family and community stakeholders. The design of such a partnership influences the participation of, and potential collaboration between, stakeholders in the schools and those representing other community sectors such as nongovernmental organizations or local government. According to a study sponsored by the US Department of Education, most administrators and teachers see their affiliation with parents as being unrepresentative; in other words, they want parents to support them in their educational role, whereas parents are more interested in carrying on a mutual relationship with teachers (Shartrand, Weiss, Kreider, & Lopez, 1997). From these results, it seems that the involvement of parents and community stakeholders should be a portion of a school – family – community partnership that imitates the dominant features of children’s living atmospheres, so that all the important community players contribute in the decision-making process and work together towards improving self-development, social assimilation and educational accomplishment in children. Among appropriate solutions to be deliberated with a view to establishing a comprehensive, integrated method to child-youth health promotion, an approach based on inter-sectorial input would seem to be one of the alternatives most worthy of recreation. This is exactly the kind of approach that is promoted when responding to a problem situation demanding collective action on various elements (Deschesnes, Martin, & Hill, 2003; WHO, 1997)

2.5 Adequate Infrastructure

It is self-evident that appropriate infrastructure is necessary in conducting any activity or program. Some studies conducted to assess challenges in developing health promoting school's projects shows lack of adequate infrastructure as one of many challenges facing in implementation phase. As the concept requires to meet set standards it is found that the funding allocated for many of the projects was insufficient in refreshing or rebuilding some of the infrastructures in existing schools. It is also seen that the physical space of the school infrastructure is also a huge set back in implementing school health programs effectively in many settings (Fathi, Allahverdipour, Shaghaghi, Kousha, & Jannati, 2014).

Adequate physical infrastructure accounts for successful implementation of many programs, and hence, it is among the top focus with policy makers who develop coordinated models for school health programs. Infrastructure is a critical facility where all the students, teachers and parents work together to maintain wellbeing of children and young adults (Buente, Hashemi, Moujaes, & Samman, 2010).

2.6 Budget and finance

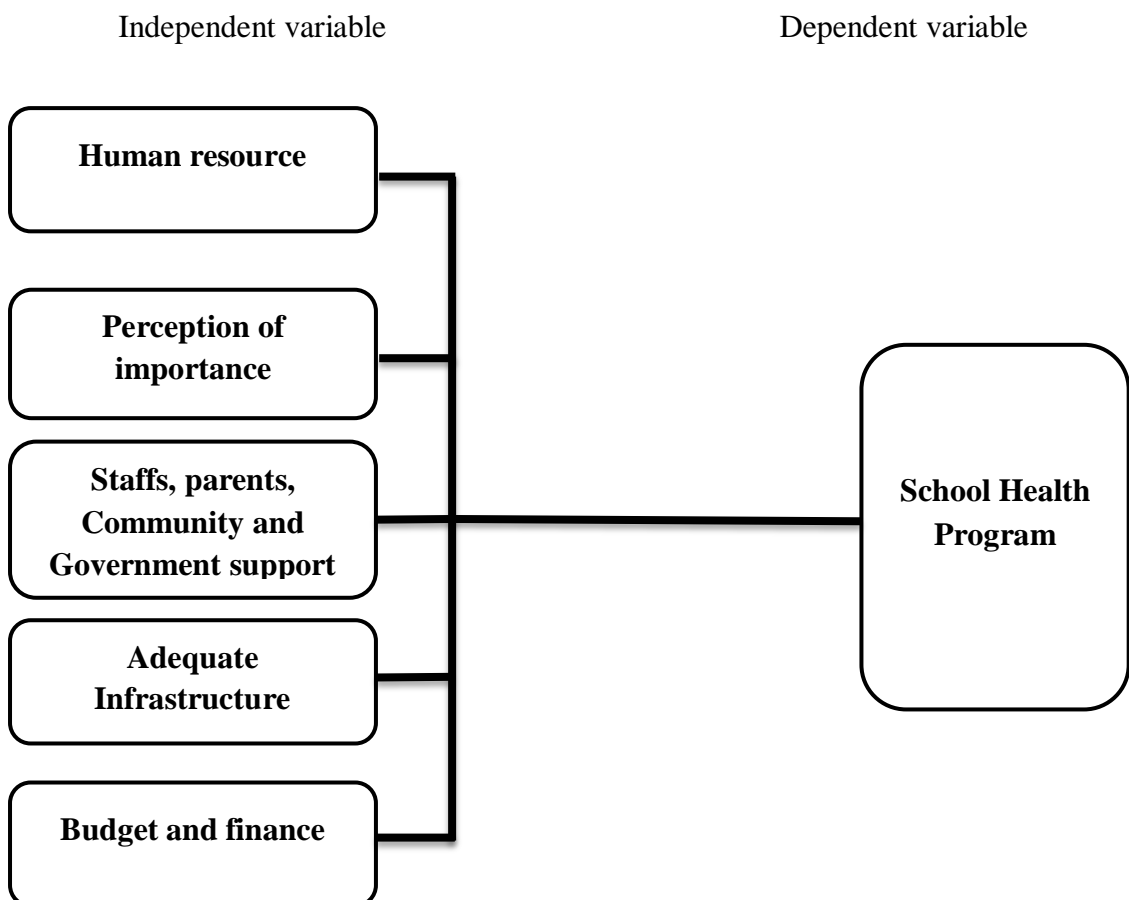
Lack of political and financial support from the sectors involved in these kinds of initiatives sets up a major obstacle to its implementation (Stokes & Mukherjee, 2000). Hence, inadequate resources for training of staffs, lack of coordinative participation of different sectors will be lead to an unsuccessful implementation of these policies and plans. "Because of the lack of support, there is a danger that the interventions will not be intensive enough to produce significant and lasting effects" (Deschesnes, Martin, & Hill, 2003, p. 392 para. 3). Despite the fact the political and financial obligation and assistance of policy makers are believed to be vital for successful health promotion intervention, such pledge is still unenthusiastic in several communities that contribute

to these values (O'Neill, Pederson, & Rootman, 2000; Deschesnes, Martin, & Hill, 2003).

Whether a specific program is successful in a particular population may depend on whether adequate contextual work has been done in the population, and whether the population itself is devoted in the implementation of the intervention. However, often schools are unwilling to contribute in external activities that might place even the most negligible affliction on already overburdened teachers and administrators and that might take away from students' class time (Jaycox, et al., 2006).

2.7 Conceptual framework and Measurement of variables

Figure 2. 2: Conceptual framework



3 CHAPTER

METHODOLOGY

3.1 Research Design

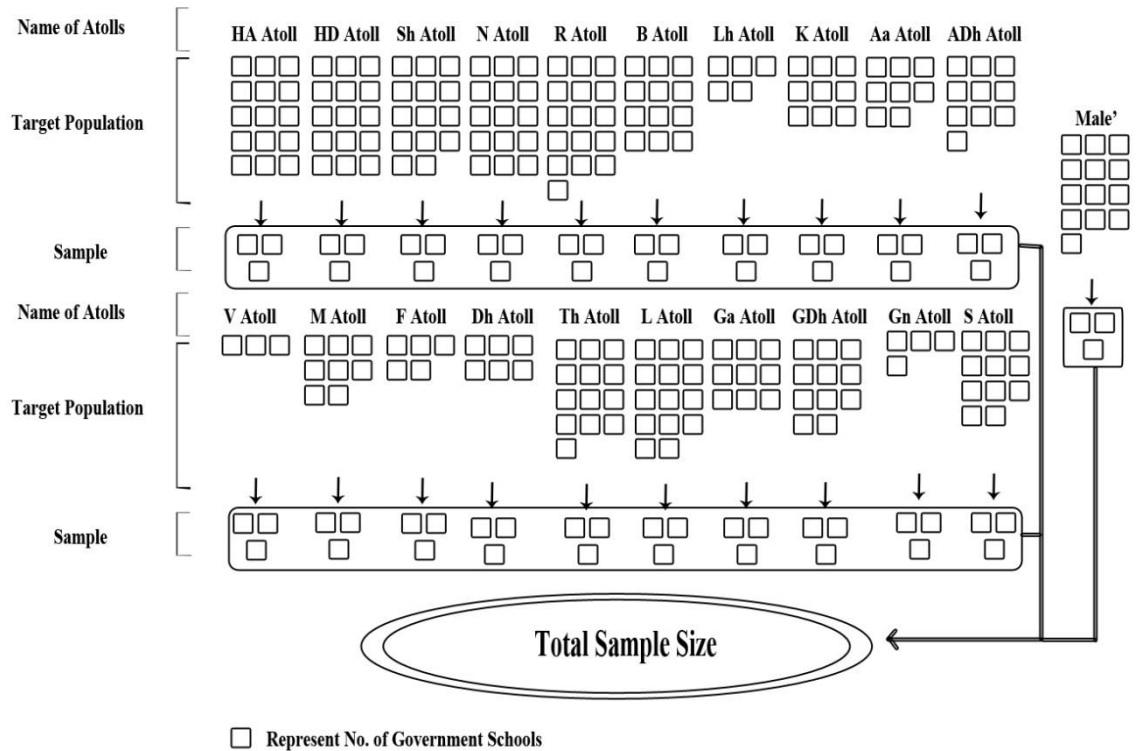
The main purpose of this study is to identify the boundaries and challenges lying in the subject field and to identify the salient factors that might be found in the field that might be relevant for the study. Therefore, an Exploratory Research Design will be used.

3.2 Population and Sample

The target population for this study is all the schools following SHP. There are a Total of 449 formal schools in Maldives, including 212 Government Schools, 123 Private Schools, and 118 Community Schools according to a booklet at MOE's website; www.moe.gov.mv, "School Statistics 2014". This study was conducted only among government schools. Thus, the study population is limited to 212 Schools.

To select samples, sample frame is derived from "School Statistics 2014", which provides a list of all the government schools, in each atoll separately including Male. From the Sampling Frame, through a probability sampling using Microsoft Excel a sample of 3 schools from each atoll and from Male' is selected. However due to time constrain for the research and the respondents, and difficulty in obtaining the information, only 28 schools among the sampled 63 schools were able to participate in this research.

Figure 3. 1: Sampling Technique



3.3 Instrumentation

A self-administered Survey questionnaire is formulated to assess the schools in order to gather required information for the study. A survey questionnaire is chosen as the main instrument, for it is easily build, understood, and time saving for both the parties, as well it is able to extract necessary information if rendered correctly.

First part of the questionnaire will provide questions to assess the extent to which the programs are being implemented. For this part multiple choice, and dichotomous questions will be given to assess how far the programs are being implemented. Each question will reflect the targets and plans indicated in the SHP.

Second part - the last part, will consist of questions to ascertain the challenges that it has been facing to lead the results that are indicated in part 1. This part will focus on

each of the variable systemically. Likert-Type questions will be provided to the best of this section with regards to the variables in different aspects.

3.4 Data Collection Procedures

In the process of data collection, survey questionnaire was made in PDF format and sent through e-mail to be filled and e-mailed back. All the schools who participated were sent the questionnaire through this method. All the 28 schools participated resent the survey questionnaire after it is been filled. No further contact was made regarding any missing answers. All the missing fields were considered as no response.

3.5 Validity and reliability

The whole study focuses on identifying the challenges which are facing in implementation of school health programs in the school level. Thus the whole questionnaire was built to assess the level of implementation in each setting and to identify the challenges faced to the particular settings respective to the implementation.

Questionnaire was tested prior to the data collection. 10 sample questionnaire was distributed to 10 different schools representative of the sample, other than those which are already in the sample, to assess the validity of the questionnaire. The findings revealed some misconceptions in interpreting some questions. Accuracy and its potential to derive targeted information were assessed and necessary changes were made to the questionnaire accordingly. The questionnaire was then reviewed among peers to obtain their idea and to identify potential shortcomings. Changes were made respectively to ensure finest quality for the final survey questionnaire. Questionnaire was pretested as mentioned above to minimize errors and biasness. This will enable the questionnaire to derive specific information of the individual settings which are

reliable, and valid. Hence, the questionnaire will be able to obtain correct information even if administered in a different setting.

3.6 Framework for Data Analysis

Table 3. 1: Framework for data analysis

Objectives	Questions	Source of data	Types of data	Technique of analysis
Identify the human resource challenges in implementing a successful SHPM in schools.	Is human resource a challenge in implementing a successful SHPM?	Survey questionnaire	Primary data	Using SPSS®
Identify the perceived importance of SHPM by school management.	Do you think school health component is a priority compare to other school components?	Survey questionnaire	Primary data	Using SPSS®
Identify whether staff, parent, community and government support is a challenges in implementing a successful SHPM in schools.	Do you receive adequate support from staff, parent, community and government in implementing a successful SHPM in schools?	Survey questionnaire	Primary data	Using SPSS®
Identify whether infrastructure is a challenges in implementing a successful SHPM in schools	Do you have an adequate infrastructure to implement SHPM?	Survey questionnaire	Primary data	Using SPSS®
Identify whether budget and finance is a challenges in implementing a successful SHPM in schools.	Do you receive adequate budget and fund from government to implement SHPM?	Survey questionnaire	Primary data	Using SPSS®

4 CHAPTER

DATA ANALYSIS AND RESULTS

This research was done among government schools of Maldives. It was planned to take random 3 schools from each atoll and from Male' City to achieve a sample of 63 schools. However, due to inevitable circumstances only 28 schools from the derived sample was able to participate in the research. Research questionnaires were sent to the selected 3 schools of the first 11 atolls of Maldives. Among 33 questionnaires sent, a sample of 28 schools (3 school from Ha atoll, 3 from Hdh atoll, 2 from Sh atoll, 3 from N atoll, 3 from R atoll, 3 from B atoll, 3 from Lh atoll, 3 from K atoll, 2 from Aa atoll, 0 from Adh atoll and 2 from V atoll) responded and filled the questionnaires.

Table 1 shows the frequency and percentage of schools who have met the achievement indicators and who do not. Out of 28 schools 26 schools (92.9%) doesn't have a health team established while only 2 schools (7.1%) have. Only 3 schools (10.7%) have a comprehensive school health policy for the school community while 25 schools (89.3%) have not developed a policy. 11 schools (39.3%) conduct health awareness sessions to students for the issues identified as national health concerns while 15 schools (53.6%) does not and 2 respondents (7.1%) left the question unanswered. All 28 schools (100%) give Vitamin A capsules and Albendazole tablets to all the primary grade students every semester. Except one school (3.6%) all other schools (96.4) check height and weight of students every semester. Among them 22 schools (78.6%) compare this with standard growth chart and report to parents while 6

schools (21.4%) did not. 19 schools (67.9%) identifies students who comes to school without having breakfast, lunch or snacks and take appropriate action while other 9 schools (32.1%) doesn't identify those children. 6 schools (21.4%) says they provide only healthy food at school / from school canteen while 2 schools (7.1%) says no. Other 20 schools (71.4%) say they do not provide food at school / do not have a canteen. Among all 28 respondents, only 3 (10.7%) school says their school health program is up to the standards stated in school health policy while 23 schools (82.1%) says not and the other 2 schools (7.1%) left unanswered.

Table 4. 1: Achievements

Indicators	Frequency	%
Have established a health team		
Yes	2	7.1
No	26	92.9
Have a comprehensive school health policy for school community		
Yes	3	10.7
No	25	89.3
Conduct health awareness sessions to students for the issues identified as national health concerns		
Yes	11	39.3
No	15	53.6
*no response n=2		
Vitamin A capsules and Albendazole tablet given to all primary grade students each semester		
Yes	28	100
No	0	0
Height and weight of students checked every semester		
Yes	27	96.4
No	1	3.6

Height and weight of students compared with standard growth chart and reported to parents accordingly		
Yes	22	78.6
No	6	21.4
Identify students who comes to school without breakfast, lunch or snacks		
Yes	19	67.9
No	9	32.1
School/School canteen provides only healthy foods		
Yes	6	75.0
No	2	25.0
*no canteen in school n=20		
Our school health program is up to the standards stated in school health policy		
Yes	3	11.5
No	23	88.5
*no response n=2		

Table 4.2 displays the frequency and percentage of the schools conducted the mentioned activities in the past year. Among 28 schools participated in this research 22 schools (78.6%) haven't conducted first aid program to their staffs in the past year while 4 schools (14.3%) conducted in the last year and 2 schools (7.1%) conducted in the past 6 months. 2 schools (7.1%) only conducted a first aid program to parents or students in the past 6 months while 3 schools (10.7%) conducted in the past year and 23 schools (82.1%) did not conduct a first aid program to its parents or students in the past year. Among the participated schools 2 schools (7.1%) say that they conduct health education sessions to their students in every month, 7 schools (25%) says they conduct every semester, 11 schools (39.3%) says they conduct every year and the rest of 8 schools (28.6) say that they did not conduct a health education session in the past

year. 25 of 28 schools (89.3%) conducts health screening to the students every year while the remaining 3 schools (10.7%) conducts every semester. Among the 28 schools, 27 schools (96.4%) includes physical health in their screening while 26 schools (92.9%) includes dental health and vision along with physical health in their screening while only 19 schools (67.9%) includes mental health along with physical and dental health and vision in their screening.

Table 4. 2: frequency and percentage of activities conducted in the past year

Statement	Frequency	%
Have conducted a first aid program to staffs in the past		
Year	4	14.3
6 months	2	7.1
Not conducted in the past year	22	78.6
Have conducted a first aid program to parents / students in the past		
Year	3	10.7
6 months	2	7.1
Not conducted in the past year	23	82.1
Conducted health education sessions to students in every		
Month	2	7.1
Semester	7	25
Year	11	39.3
Not conducted in the past year	8	28.6

Conducted health screening for students in every		
Year	25	89.3
Semester	3	10.7
Health screening includes:		
Physical health	26	96.3
Yes	1	3.7
No		
*no response n=1		
Mental health		
Yes	19	70.4
No	8	29.6
*no response n=1		
Dental health		
Yes	26	96.3
No	1	3.7
*no response n=1		
Vision		
Yes	26	96.3
No	1	3.7
*no response n=1		

Table 4.3 illustrates frequency and percentage of schools who has the indicated technical capacity. Only one school (3.6%) says 2 orientation/advocacy sessions

conducted for school heads on Health Promoting School Concept and health and safety dimensions of Child Friendly Baraabaru School Initiative in the past year and 4 schools (14.3%) says 1 session was conducted while the other 23 schools (82.1%) says no advocacy / orientation sessions were conducted. 4 out of 28 schools say (14.3%) above 80% of their staffs knows to administer basic first aid, 7 schools (25%) says it is 50%, 12 schools (42.9%) says less than 50% knows while 5 schools (17.9%) says none of their staff knows to administer basic first aid. 1 school out of 28 (3.6%) says they have more than 5 teachers trained in skill based health education to deliver Health and Wellbeing syllabus, 4 schools (14.3%) says 2 teachers received training, 5 schools (17.9%) says 1 teacher while 18 schools (64.3%) says none of their teachers were trained. Among 28 schools only 5 schools (17.9%) has a trained health officer or health assistant in their school while 23 schools (82.1%) says they do not have. 1 out of 28 school (3.6%) has a trained counselor in their school while the rest of schools (96.4%) doesn't have a trained counselor. Same frequency and percentage of schools had a health room too – 3.6% yes and 96.4% No. from the 28 participated schools 3 schools (10.7%) said that their school health program is up to the standards stated in school health policy, 23 schools says no they are not, and the remaining 2 schools did not respond.

Table 4. 3: Technical capacity of the schools

Indicators	Frequency	%
No. of orientation/advocacy sessions conducted for school heads on Health Promoting School Concept and health and safety dimensions of <i>Child Friendly Baraabaru School Initiative</i> in the past year		
1 session	4	14.3
2 sessions	1	3.6
No sessions conducted		

	23	82.1
% of staffs who knows to administer basic first aid		
Above 80%	4	14.3
50%	7	25
Less than 50%	12	42.9
0%	5	17.9
No. of teachers trained in skill based health education to deliver Health and Wellbeing syllabus		
More than 5	1	3.6
2	4	14.3
1	5	17.9
0	18	64.3
Have trained health officer / health assistant		
Yes	5	17.9
No	23	82.1
Have a trained counselor		
Yes	1	3.6
No	27	96.4
Have a health room		
Yes	1	3.6
No	27	96.4
Our school health program is up to the standards stated in school health policy		
Yes	3	11.5
No	23	88.5
*no response n=2		

Table 4.4 demonstrates respondents' view on the priority of school health component compared with other school components. No respondents say it is not a priority or a

low priority. However, 3.6% school said it is somewhat a priority, 3.6% school say neutral – it is in the same priority level as other components. 21.4% schools say it is a moderate priority, 28.6% schools says high priority and 42.9% schools say school health component is an essential priority. Mean = 6.04, Standard Deviation = 1.071.

Table 4. 4: Priority of school health component compare with other components of school

Statement	7	6	5	4	3	2	1	Mean	SD
n = 28	%	%	%	%	%	%	%		
School health component is	42.9	28.6	21.4	3.6	3.6	0	0	6.04	1.071

Average Mean Score for Priority: Mean = 6.04 SD = 1.071 Min = 1 Max = 7

Score: 7 = Essential Priority, 6 = High Priority, 5 = Moderate Priority, 4 = Neutral, 3 = Somewhat a Priority, 2 = Low Priority, 1 = Not a Priority

Table 4.5 shows the rating of support respondent schools has received from parents, community and from the school staffs from poor to excellent in percentages. 9 schools (32.1%) say support received from parents is excellent, 6 schools (21.4%) say very good, 10 schools (35.7%) say good 2 schools (7.1%) say fair and 1 school (3.6%) say they received poor support from parents in implementing school health programs. 4 among 28 schools (14.3%) say they received excellent support from community, 3 schools (10.7%) say very good support, 11 schools (39.3%) says they received good support from community while 9 schools (32.1%) says fair support and 1 school says that they receive poor support from community to implement school health program. 10 schools (35.7%) says they receive excellent support from staffs to conduct school health programs, 8 Schools (28.6%) say they receive very good support, 7 schools (25%) say they receive good support while 3 schools (10.7%) say support is fair. No school said that they receive poor support from staffs to implement school health program.

Table 4. 5: Support as a challenge

Statement	5	4	3	2	1	Mean	SD
n = 28	%	%	%	%	%		
Support received from parents are	9	6	10	2	1	3.71	1.117
Support received from community is	4	3	11	9	1	3.00	1.089
Support received from staffs are	10	8	7	3	0	3.89	1.031

Average Mean Score for Support: Mean = 3.53 SD = 1.079 Min = 1 Max = 5

Score: 5 = Excellent, 4 = Very Good, 3 = Good, 2 = Fair, 1 = Poor

Table 4.6 illustrates the level of agreement to the perceived internal challenges in implementing school health programs, rated by the respondent schools. 2 internal challenges has been focused, infrastructure and trained staffs. Out of 28 schools, 78.6% strongly agree that lack of adequate infrastructure is a challenge, 10.7% schools agrees to it, and 10.7% school somewhat agree, neither agree nor disagree and somewhat disagree respectively. Among 28 schools, 75% schools strongly agrees that lack of adequate trained staff is a challenge to them, 14.3% schools agrees with it, 3.6% school somewhat disagrees, and 3.6% school strongly disagree that it is a challenge.

Table 4. 6: level of agreement on internal challenges

Statement	7	6	5	4	3	2	1	Mean	SD
n = 28	%	%	%	%	%	%	%		
Lack of adequate infrastructure is a challenge	78.6	10.7	3.6	3.6	3.6	0	0	6.57	0.997
Lack of adequate trained staff is a challenge	77.8	14.8	0.0	0.0	3.7	0.0	3.7	6.48	1.369

*no response n=1

Average Mean Score for Challenge: Mean = 6.525 SD = 1.183 Min = 1 Max = 7

Score: 7 = Strongly Agree, 6 = Agree, 5 = Somewhat Agree, 4 = Neither Agree Nor Disagree, 3 = Somewhat Disagree, 2 = Disagree, 1 = Strongly Disagree

Table 4.7 illustrates the level of agreement to the perceived external challenges in implementing school health programs, rated by the respondent schools. 2 external challenges has been focused, government’s support and assistance, and funding from the government. 10.7% schools strongly agree that they receive adequate support and assistance from government for implementing SH Programs, 46.4% schools agrees to the statement, 17.9% schools somewhat agrees, 7.1% schools neither agrees nor disagrees, 10.7% schools somewhat disagrees, 3.6% school disagrees and 3.6% school strongly disagree to this statement. To the statement “we receive adequate fund or financial assistance from government for implementing SH Programs” no schools strongly agrees to it, 25% school agrees, 32.1% school somewhat agrees, 7.1% school neither agrees nor disagrees, 3.6% school somewhat disagrees, 21.4% schools disagrees to the statement while 10.7% school strongly disagree.

Table 4. 7: level of agreement on external challenges

Statement	7	6	5	4	3	2	1	Mean	SD
n = 28	%	%	%	%	%	%	%		
Receiving adequate support and assistance from government	10.7	46.4	17.9	7.1	10.7	3.6	3.6	5.14	1.533
Receiving adequate fund or financial assistance from government	0.0	25	32.1	7.1	3.6	21.4	10.7	4.04	1.815

Average Mean Score for Challenge: Mean = 4.59 SD = 1.674 Min = 1 Max = 7

Score: 7 = Strongly Agree, 6 = Agree, 5 = Somewhat Agree, 4 = Neither Agree Nor Disagree, 3 = Somewhat Disagree, 2 = Disagree, 1 = Strongly Disagree

Following are the other challenges and barriers mentioned by respondents to the question

“What are the other barriers / challenges faced in implementing school health program?”

- Adequate training to school health officers
- Information provided about the school health program is limited
- Inadequate amount of equipment to conduct health programs / first aid
- Lack of internal support
- Lack of support from the government
- Staffs are not paid for overtime work
- Time

Following are the changes mentioned by respondents to the question

“What changes should be made to successfully implement school health programs?”

- Provide adequate space / infrastructure
- Training workshops on implementing school health programs effectively
- Providing information regarding the importance of school health program to parents, staffs and students
- Providing adequate technical assistance from government
- Provide adequate financial assistance from government
- Corporation from other sectors of the government
- Providing required technical staffs to the schools including small island schools

- Attractive salary to health personals
- Proper monitoring and evaluation from Ministry of Education
- Strengthen reporting system

DISCUSSION AND CONCLUSION

5.1 Summary of main findings

This exploratory research was conducted among 28 participant schools randomly selected from Haa Alifu atoll to Vaavu atoll except Alif Dhaalu atoll. Main 5 areas has been focused in the research to identify the challenges. Following is the summary of main findings of these areas.

5.1.1 Human resource

It was noticed that 82.1% of the schools from this sample had no HA or SHO while 96.4% schools had no counselor. 64.3% schools had no teachers trained in skill based health education to deliver Health and Wellbeing syllabus, while 82.1% of these schools had no orientation/advocacy sessions conducted for school heads on Health Promoting School Concept and health and safety dimensions of *Child Friendly Baraabaru School Initiative* in the past year.

5.1.2 Perception of importance

It was seen that 3.6% school thinks schools health component is somewhat a priority compare to other school components, 3.6% school say neutral – it is in the same priority level as other components, 21.4% schools say it is a moderate priority, 28.6% schools says a high priority and 42.9% schools say school health component is an essential priority. Mean score of priority stays at 6.04, Standard Deviation = 1.071.

5.1.3 Staff, parents, community and government support

It is observed that school health program had support from parents (mean = 3.71), staffs (mean = 3.0) and community (mean = 3.89) at an acceptable level. Most of the

schools agree that they receive adequate support and assistance from government to implement School Health Programs (mean = 5.14).

5.1.4 Adequate Infrastructure

This research has identified that only one school among 28 participants had a health room – 3.6%, and all the other schools – 96.4% had no health room in their school. To the last question of the questionnaire “What changes should be made to successfully implement school health programs?” many of them has stated that adequate space or infrastructure should be provided in order to implement school health program successfully.

5.1.5 Budget and finance

Although best of the schools agree that they receive adequate financial assistance and funding from government to implement school health programs (mean = 4.04), no schools strongly agrees to it, 25% school agrees, 32.1% school somewhat agrees, 7.1% school neither agrees nor disagrees, 3.6% school somewhat disagrees, 21.4% schools disagrees to the statement while 10.7% school strongly disagree.

5.2 Discussion

5.2.1 Human resource

Although it is mentioned in School Health Policy 2011 that “Ministry of Education shall facilitate appointment of school health officers in all public schools and provide support to build school health teams with administrative facilitation and supervision (Ministry of Education & Ministry of Health and Family, 2011), and stated that by the end on 2015, 80% of schools will have SHOs and counselors with refresher training, it is observed that 82.1% of the participant schools does not have a school health officer, while 96.4% of schools did not

have a counselor in the school. This indicates that there have not been sufficient efforts put in place by the liable government authorities – Ministry of education, Ministry of Health and Family and the Schools to take this policy into effect by the end of the planned 5 years term (Ministry of Education & Ministry of Health and Family, 2011).

By the end of the year 2015 it was planned in school health policy that No. of primary school teachers in service provided with training and resource materials for skilled based health and wellbeing education will be up to 80%. However, it is observed that 64.3% of schools had no teachers trained in the mentioned area. This indicates a huge set back in implementation of the policy. Although 35.7% of schools have 1 or more teachers trained in skilled bases health and wellbeing education, it is far from achieving the set target in 2010. Refer to Table 4. 3.

In School Health Policy 2011 it indicates that “No. of orientation/advocacy sessions conducted for school heads, school senior management on HPS concept and the Health and safety dimension of CFBSI” will be 4 in the year 2014 and 2015. Conversely, it is observed that 82.1% of these schools had no orientation or advocacy sessions conducted at all for school heads on Health Promoting School Concept and health and safety dimensions of Child Friendly Baraabaruru School Initiative in the past year. This shows that the top management staffs of the schools would not have updated knowledge and capacity on the components of HPS Concept and the indicators set in CFBSI. Due to all these facts it can be said that most of the schools still lacks technical capacity or human resource capacity to implement school health program (Average mean = 0.19). Refer to Table 4.3. Mean level of agreement that lack of human resource is a challenge to implement SH Program rated by participants is = 6.48.

Similarly, research conducted to evaluate the implementation of School Health Policy in Botswana schools shows similar findings. Among the challenges identified to implement School Health Policy includes lack of human resource (Shaibu & Phaladze, 2010).

5.2.2 Perception of importance

In SHP 2011 it is indicated that by the end of 2015 percentage of the school community (school management, teachers, other staff, parents and students) that believes health and wellbeing as an important aspect of school education will be at 70%. Rated perception of school health component's priority among respondent schools when divided from mean to see what percent of schools agree that it is a priority compared with other school health components is sadly 42.9% (mean = 0.43). Refer to table 4.4. This indicates that there is a huge gap between what is planned and what have achieved within the past 5 years.

It was noticed that among the schools who said school health component is an essential priority ($n=12$), 3 of them did not conduct a health education session in the past year. Thus, technical capability of these 3 schools was analyzed. Data shows that 3 of these schools had no health officer, no counselor, no teachers trained in skill based health education to deliver Health and Wellbeing syllabus, and no orientation or advocacy sessions was conducted for school heads on HPSC and health and safety dimensions of *Child Friendly Barabaru School Initiative* in the past year. So the absence of HE session is believed to be attributed to lack of technical capability.

Therefore, It was evaluated weather the number of schools who said that school health component is a priority ($n = 12$ (calculated from average mean of the answer. Refer to table 4.4)) and number of schools who conducted health education sessions in the past year ($n = 9$ (calculated from average mean of the answer. Refer to table 4.2)) had any association. Data was analyzed in SPSS[®] using *Chi* square goodness of fit test, $\chi^2(1) = 6.604, p \leq 0.010$. Results show that there is a significant association between perceptions of SH Component's priority and No. of HE sessions conducted among schools.

So it is essential that the liable authorities of government to educate or train the school head or management on the importance of school health component and to make it an essential priority among all schools. Moreover, it is also vital to train required amount of teachers from all schools with skill based health education to deliver Health and Wellbeing syllabus and to conduct appropriate amount of orientation or advocacy sessions for school heads on HPSC and health and safety dimensions of *Child Friendly Barabaru School Initiative*.

Similarly, a review of school health promotion in 10 states of India conducted by Dr. G Balasubramaniam says that lack of priority for health promotion was identified in practical application and absence of time given for and interest in health promotion among reviewed Indian schools was observed as well (Nazar, 2011).

5.2.3 Support from staffs, parents and government

In this study it was seen that half of the schools participated had no support from parents while other half of the schools had received support from parents (mean = 0.5). The case for support to the school management from teachers had the same pattern. 50% of the schools say that they receive support from teachers to implement school health programs while the other 50% received no support. However, contrarily it was seen that the support received from the community for the implementation of this program was quite low compare to the support received from parents and staffs. It was calculated that 75% of the schools disagree that they receive support from community (mean = 0.25) while only 25% schools agrees to it. (*calculated from the mean score for each variable. Refer to Table 4.5*).

This indicates that the unsuccessfulness of the school health programs can be attributed to the limited support from some of its main stakeholders – staffs, parents, and community. However, further studies must be conducted to see the support from other stakeholders such as other government sectors and NGOs in the island.

One of the main challenges of school health program implementation has identified in many settings as constructing an actual connection between students, parents, and the community with the school system. It was identified that teachers had limited knowledge on how to involve community in the school health programs (Kusumawardani, 2011)

Surprisingly, it was seen that the agreement on the government support and assistance to implement school health program is high among the participant schools. 57.1% of the schools agree that they receive support and assistance from government while 42.9% disagrees. The reason why this is rather a surprise to see is justified in the following.

To get a clear picture of the situation among the schools who agrees that they receive adequate support and assistance from the government to implement school health program 57.1% who agreed (n = 16) was isolated and these results were generated. It shows that 13 among 16 schools (81.3%) had no health officer, 15 of 16 schools (93.8%) had no trained counselor, and 15 schools (93.8%) had no health room. 50% of these schools (n = 8) had no teachers trained in skill based health education to deliver Health and Wellbeing syllabus and 87.5% of schools (n = 14) had no orientation/advocacy sessions conducted for school heads on Health Promoting School Concept and health and safety dimensions of Child Friendly Barabaru School Initiative in the past year. Some of the schools has also mentioned in the open ended

question asked to mention what other challenges or barriers they face in the successful implementation of the school health programs that, lack of support from government as one of the main challenge.

Due to this evidence, it is strongly positive that the statement of agreement on government support is independent on any of the achievements or technical capacity of the schools, and there is no base to the statement what so ever related to the actual support from the government.

5.2.4 Adequate infrastructure

Although it is stated in SHP 2011 that “school will have designated space, “Health Room”, to provide basic first aid, counseling and to conduct clinical observations of students and staff requiring immediate attention (Ministry of Education & Ministry of Health and Family, 2011)”, in their monitoring and evaluating tool provided in the document with outcome indicators there is no indicator provided that shows how many Health Rooms they have planned to build in schools within the 5 years period. This can be interpreted as lack of commitment by liable government authorities to provide with infrastructure necessary for successful implementation of school health programs. Although, there might be budget constraints that cannot be resolved to provide it even in a long 5 year period.

Hence, this may be represented by the amount of health rooms present among the participant schools of this study. Only 1 school out of 28 schools (3.6%) had a health room or any infrastructure designated for conducting health related activities mentioned in SHP 2011.

Level of agreement among the participants on lack of infrastructure as a challenge shows that 78.6% of the schools agrees that lack of infrastructure is a significant

challenge to implement school health program in those school. However the rest of the schools (21.4%) disagrees to it.

Certain activities made mandatory in the SHP 2011 requires designated space to conduct it. Some of these includes providing counseling needed to promote psychosocial health in school settings, providing first aid to the injured, conducting consultations and clinical observations of students and staffs who needs instant care. Moreover, it is self-evident that availability of a designated infrastructure for school health related activities will provide space to keep health related tools and equipment necessary in one place and to organize health promotion activities in a more efficient manner (Missouri Department of Elementary & Secondary Education, 2014).

5.2.5 Budget and finance

“Effective implementation of the school health policy requires adequate financial resources, (Ministry of Education & Ministry of Health and Family, 2011)” stated In the SHP 2011. It also delegates the responsibility of ensuring the allocation of adequate financial resources for delivering the program interventions to school health & safety section of Ministry of Education ESQID. It is also evident in different studies conducted in different settings that many of the intervention programs conducted in school settings fails due to inadequate funding and lack of financial resources (Shaibu & Phaladze, 2010; UNICEF, 2008).

5 years after the baseline was established and new strategies were developed through SHP 2011 to achieve targeted goals by the end of 2015, it is seen that the implementation of many of the components stated in SHP has been rather unsuccessful. Assessing the level of acceptability to the statement “we receive adequate fund or financial assistance from government for implementing SH

Programs” it is seen a similar response as the level of acceptance towards government support. Refer to 5.2.3. 57.1% says that they accept that they receive adequate fund or financial assistance from government while 42.9% disagree to it. As mentioned in 5.2.3 among the schools who said they receive adequate financial support from government, the level of implementation of the SHP and technical support provided to them says a different story. However, it cannot be said that the government did not provide necessary funding and assistance to implement school health program based on this finding alone, as there might be other associated factors that lead to unsuccessfulness of the program.

5.2.6 Other important findings

Some of the other challenges or barriers to successful implementation of school health program highlighted by the schools in response to the open ended question address other important factors that influence the successful implementation of the program. These include statements from some schools saying that information provided to the school management regarding the school health program and school health policy is limited. This indicated that proper orientation was not done to familiarize the school managements with the SHP 2011 and school health programs in the past 5 years.

Other challenges faced by the schools in conducting activities outside the scope of education includes time, teachers and staffs tight schedule and unavailability of overtime allowance to them. This they say plays a huge role as a bottleneck in conducting certain activities. Time being other factor that all the teachers and other staffs in schools has already being burdened with their own tasks allocated that is crucial for day to day teaching and running of activities that they do not find extra time being involve in other activities which is outside the scope of education.

This indicates lack of training and orientation programs conducted by the responsible government authorities to the school management and teachers to disseminate adequate information regarding HPS concept and of the components of SHP 2011. The belief of health component not being an integral part of education has to be changed through seminar workshops and capacity building trainings to convince that health is in the scope of education and it is integral part of it.

5.3 Limitations

This study was planned to conduct among randomly selected 63 schools; 3 public school from each atoll and 3 public schools from Male' City. Nevertheless, due to very limited time allocated for data collection and in the meantime difficulty in collecting data from schools as the schools were conducting O'level exams and some were preparing for prize day activities those days, only 28 schools, from the first 11 atolls of Maldives; from Haa Alifu atoll to Vaavu atoll, except one school from Shaviyani atoll, 3 schools from Alifu Dhaalu atoll and one school from Vaavu atoll was able to participate in the study.

It was noticed that the level of importance and corporation received from the schools for this study differ among the schools with expatriate principals and local principals. In schools where expatriate principals are in charge, hesitance for participating or some level of fear was noticed in participating. However, all three schools from Alifu Dhaal atoll despite having local principal or in charges, did not respond to this study even after assuring their participation. Due to this, huge amount of time was taken to receive the research questionnaires from the schools except very few.

Limited literature in the subject area in recent years has been another limitation. The subject of existing challenges in the different models of SHPMs has been long back

addressed frequently in 1980s and 1990s. However, there has not been prominent amount of studies done in the recent years, at least to the extent of the literature review, to represent current status and evolved challenges in the subject field.

5.4 Conclusion

It can be concluded that the bottleneck of school health activities in the schools has significant association with the perception of importance of school health component by the school management. Moreover, lack of adequate human resource and adequate infrastructure is a huge challenge faced to the schools in implementing school health programs successfully following parent, staff, and community's support.

5.5 Direction for future Researches and Recommendations

To ensure what went wrong in the 5 years period that lead SHP to be unsuccessful, a more in-depth and intensive research needs to be done focusing on a broader dimensions of possibilities; more than just parent, staff, community, government and financial support as majority of the participants agree on government support and financial assistance from government. Areas that can be included can be level of school management's knowledge on school health program and its importance, willingness of school management to implement school health policy successfully, support received from other sectors of the government and NGOs to implement the program, availability of human resource needed for the program from the islands etc.

Following are some recommendations to consider:

- More research should be done in school health programs to improve the efficiency of the interventions.

- Achievements of school health program activities can be valued and an award can be given to the school which has achieved highest level of implementation of the components of school health policy.
- Strong monitoring and evaluating and reporting mechanism for the school health program to evaluate equipment and funding allocated for the designated activities has been utilized appropriately and effectively.
- Building capacity to campaign for improved school health programs
- Advocating of further stakeholder involvement in the school health program implementation.
- Providing capacity building workshops to school staffs on the importance of school health components and how to involve parents and community in the school health program.
- Seek collaboration and funds from NGOs and other parties in implementing school health program activities.
- More involvement of stakeholder in the planning and implementing school health program activities.

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APPENDICES

Appendix A

Goals and Objectives of SHP 2011

- To ensure health and wellbeing is mainstreamed in the education system of the country
- To ensure that provision of skills and competencies for health and wellbeing is an integral part of the national curriculum.
- To achieve a common understanding by all members of the school community, on the central nature of health and wellbeing for achieving educational targets
- To empower students with skills and competencies that enable them to make healthy choices to prevent health problems, maintain and improve their health, and adopt healthy behaviors.
- To provide a safe and healthy physical and psycho-social environment that prevents ill health, disease spread and promotes inclusive participation of all students and school community.
- To promote the practice of physical activity, fitness and sports that all students enjoy and can pursue every day of their lives.
- To ensure all students have access to preventive health services and basic medical and psychosocial first aid in schools.

Appendix B

Outcome Indicators of SHP

OUTCOME INDICATORS (for evaluation)	BASELINE (2009/2010)	TARGETS				
		2013		2015		
Percentage of the school community (school management, teachers, other staff, parents and students) that believes health and wellbeing as an important aspect of school education	NA	50%		70%		
Percentage of schools implementing Health and Safety dimension of CFBS	Nil	25%		50%		
Percentage of students 13-15yrs who eat breakfast most of the time or always	47%	55%		65%		
Percentage of students who wash their hands at school, who never or rarely used soap to wash their hands	46%	30%		10%		
Percentage of students 13-15yrs who were physically active for a total of at least 60 minutes per day on five or more days during the week	27%	35%		45%		
Percentage of students 13-15yrs who ever seriously considered attempting suicide	17%	15%		10%		
Percentage of students 13-15yrs who smoked cigarettes	9%	7%		5%		
Percentage of students who used drugs one or more times	5%	3%		1%		
Percentage of students who drank at least one drink containing alcohol	5%	3%		1%		
Percentage of students who were bullied on one or more days	37%	35%		30%		
Percentage of students who were physically forced to have sexual intercourse when they did not want to	17%	15%		10%		
Percentage of students taught in any of their classes during this school year, how to avoid HIV infections or AIDS	31%	50%		70%		
OUTPUT INDICATORS (for monitoring)	BASELINE (2009/2010)	TARGETS				
		2011	2012	2013	2014	2015
Health and well being recognized as an integral part of education system in the country	Explicit in education policies of SAP			Explicit in education policy & law	-	Law & its regulations enforced
Health and wellbeing is made as an integral part of the national curriculum in K-10	Policy decision made at MoE			curriculum with H&W component Piloted		H&W taught in K-10
Percentage of secondary schools with teachers trained in skill based health education deliver health and wellbeing syllabus	Nil	Nil	5%	10%	15%	20%
No. of meetings of the SHCC held annually	Nil	4	4	4	4	4
No. of staff with public health training appointed at School Health & Safety Unit of MoE	1	2	4	4	4	4
Percentage. of 'school health officers' and 'counsellors' provided with refresher training	Nil	10%	25%	50%	65%	80%
Development of Health and Wellbeing subject syllabus	planned	Syllabus developed	Syllabus piloted	Syllabus implemented	Syllabus implemented	Syllabus implemented
No. of primary school teachers in service provided with training and resource materials for skill based health and wellbeing education	Nil	10%	25%	50%	65%	80%
No. of teachers trained to deliver Health and Wellbeing subject	Nil	Nil	Nil	20	40	60
No. of orientation/advocacy sessions conducted for school heads, school senior management on HPS concept and the Health and safety dimension of CFBSI	1	4	4	4	4	4
proportion of monitoring and supervision reports providing feedback on implementation of the Health and Safety dimension of CFBS	Nil	all	all	all	all	all
No. of national public health protection services implemented through school health programme (supplementation, immunization etc)	2	3	4	4	6	6
Proportion of schools implementing health awareness programmes on issues identified as national public health concerns by MOHF	NA	30%	40%	50%	60%	70%
No. of schools at 'Emerging' level for each Standard of Health and Safety dimension of CFBS	Nil	5	7	10	15	20
No. of schools at 'Progressing' level for each Standard of Health and Safety dimension of CFBS	Nil	1	2	3	4	5
No. of schools at 'Achieving' level for each Standard of Health and Safety dimension of CFBS	Nil	Nil	Nil	1	1	2
No. of schools at 'Achieved' level for each Standard of Health and Safety dimension of CFBS	Nil	Nil	Nil	Nil	Nil	1

For indicators at school level, refer to "HEALTH AND SAFETY, Quality Indicators, Child Friendly *Barabaru* Schools, Maldives" published by Ministry of Education, 2010

Source: School Health Policy 2011

Appendix C

Measurement indicators in NQSI; CFBS

Standard 3.1: Health Personnel and Facilities

The school has qualified health personnel, a School Health Team (SHT) and essential facilities to provide health services, promote school health, formulate and implement policies (as per MoH and MoE policies and guidelines) to improve and support health and well-being of all students and staff.

Emerging	Progressing	Achieving	Achieved
<p>School has appointed trained health personnel based on the recommended ratio of at least one health officer and one counselor for every 750 students.</p> <p>First aid /Health room is available for children who need medical assistance.</p> <p>School Health Team (SHT) is responsible for health promotion at the school, and is comprised of a minimum of ten members including principal, leading teachers, teachers, students, parents, health personnel and at least two representatives from the community.</p> <p>SHT creates policies and procedures with school community input, as per MoE and MoH guidelines.</p> <p>School has a program on first aid for staff, students and parents conducted at least once every year.</p>	<p>Evidence of all of <u>Emerging plus the following:</u></p> <p>School health personnel promote health & safety of students and their families by addressing health issues.</p> <p>School publicly posts referral procedure for treating all serious health and related cases beyond the school's capacity which includes child abuse, neglect and drug abuse. Referral procedures adhered to in all such cases.</p> <p>SHT meets at least every other month, develops and implements initiatives in response to at least 5 school health policies, takes action and documents meetings.</p> <p>SHT, in collaboration with health sector workers, provides health intervention training for health personnel, teachers, student health pioneers and parents.</p> <p>All school staff know how to administer basic first aid upon hire, have a manual and take a yearly refresher course.</p> <p>40% of students above grade 4 can practice basic first aid.</p>	<p>Evidence of all of <u>Progressing plus the following:</u></p> <p>School annually evaluates their health activities and use findings to develop next steps/goals. All members of the school community are informed of evaluation findings and use them in the planning process.</p> <p>Health promotion projects are continuously monitored, evaluated, disseminated and results are used to effectively implement new initiatives/projects.</p> <p>School health officer, counselor and SHT have effective working relationships with support agencies; local and regional health service providers, including NGOs, to meet the specific needs of their school based on annual evaluation findings.</p> <p>SHT conducts community awareness campaigns using health intervention teams formed by teachers, student health pioneers and parents.</p>	<p>Evidence of all of <u>Achieving plus the following:</u></p> <p>School health officer, counselor and SHT are models of effective working relationships with support agencies; local and regional health service providers, including NGOs, and help other schools to meet their health needs/objectives and/or hold awareness sessions locally or internationally.</p> <p>SHT is a model for others in enhancing the well-being of students and staff.</p>
<p>School has a comprehensive Health Policy(s) for the school community which covers at least 5 of the following areas:</p> <ol style="list-style-type: none"> 1. Health education curricula and requirements. 2. Health promotion for staff. 3. Physical school environment including indoor/outdoor air quality, safety hazards, emergency preparedness and response. 4. Control and prevention of tobacco, drugs, alcohol, and other addictive substances. 5. Physical education curriculum, requirements and physical activity programs including fitness education, recreational sport, and recess. 6. Child protection and safety; from bullying, violence, and misuse of internet and related ICT. 7. Behavior management. 8. Mental health promotion and surveillance. 9. Food and catering services <p>Members of the school community are provided with information about policies and services of the school in a language and format they understand.</p>	<p>Evidence of all of <u>Emerging plus the following:</u></p> <p>School has comprehensive policy which covers all 10 health areas.</p> <p>All members of the school community are actively involved in roles and responsibilities accorded to them through the developed policy(s).</p> <p>School health policies are reflected in daily school practices and valued as a community wide tool for promoting whole school health. (i.e. displays in the school and community, lessons, student initiatives, and in conversation)</p> <p>School communicates health and safety policy(s) on an ongoing basis to the school community and others (i.e. MoH, community members)</p>	<p>Evidence of all of <u>Progressing plus the following:</u></p> <p>School proactively develops additional policy(s) for arising/emerging issues confronting the society, school, and student health/safety.</p> <p>Policy components are always followed.</p> <p>Annual evaluation involves the school community views in determining policy effectiveness.</p> <p>School principal and SHT conduct annual evaluation of all policy(s), procedures and practices, make revisions, and update school community on needed improvements.</p>	<p>Evidence of all of <u>Achieving plus the following:</u></p> <p>School is a model in effective design and use of health policy(s), and shares their best practices and ideas with other schools</p>

Source: Health and Safety 2010 (CFBS)

Standard 3.3: Health and Nutrition Services

School health personnel, together with **health partners** (government/NGO) provide a range of health related services to all students and teachers to enhance student learning and achievement.

Emerging	Progressing	Achieving	Achieved
<p>All pertinent medical information about students are systematically collected at school entry and communicated in writing to all appropriate school staff, included and updated in School Management Information System (SMIS)</p> <p>Health screening is carried out of all children for physical, vision, dental and mental health.</p> <p>Students of grade 5 and above self-monitor their health using self health monitoring booklet and inform the health personnel.</p> <p>All students of primary age group receive micronutrient supplementation /de-worming treatment and the records are well maintained.</p> <p>Height and weight are assessed once every semester, compared to standard growth chart and appropriately reported to parents.</p> <p>School identifies students who attend school without breakfast/lunch/ snack and takes action.</p> <p>Nutrition guidelines are displayed and nutrition awareness provided for students, parents and all school staff</p> <p>Children, with guidance from teachers and parents, develop a system for monitoring and improving their personal nutritional needs.</p> <p>Only nutritious food and drink are allowed at school.</p>	<p>Evidence of all of <u>Emerging</u> plus the following:</p> <p>School has established strong links with community sources and identified referral providers; for example, programs for smoking cessation, counseling for health problems etc...</p> <p>Systematic, well-organized medical screening carried out for all students annually in collaboration with school and other health services.</p> <p>Student referrals for health problems are directed to health professionals/specialists and appropriate follow-up is made and recorded. Actions are taken based on screening and results are given to all parents.</p> <p>School community including Parent Teacher Association (PTA) provide assistance for all students with nutritional deficiencies.</p> <p>Students demonstrate knowledge in choosing in nutritious and safe food, and bring healthy food to school daily.</p> <p>Staff are trained to respond quickly & effectively to following types of emergencies: choking, medical emergencies (severe food allergy reactions, diabetic reaction).</p>	<p>Evidence of all of <u>Progressing</u> plus the following:</p> <p>Health checks for all staff are provided.</p> <p>An evaluation of school wide health record is carried out and follow up is made annually to analyze and identify the areas for improvement.</p> <p>School involves students and the entire school community in the planning and sanitary preparation of nutritious foods.</p> <p>All members of the school community plan and evaluate healthy food services.</p> <p>Students take initiatives and demonstrate leadership to make others aware of balanced diet.</p>	<p>Evidence of all of <u>Achieving</u> plus the following:</p> <p>School health services are systematic, and a model for other schools. School health personnel provide leadership in the community and/or nationally.</p> <p>Student health records over a multi-year period show improvement in overall health, health awareness and response to referrals.</p> <p>School is a model in food preparation and conducting nutrition programs for the local and international community.</p> <p>Students and/or others in the school initiate nutrition education programs locally or nationally.</p>

Source: Health and Safety 2010 (CFBS)

Appendix D
Consent and Survey questionnaire

All the information that you provide for this study will be highly confidential, and these information will only be used for research purpose. Your name or representative schools' name will not be included in the survey questionnaire to ensure that the questionnaire is not be identifiable.

By participating in this study, you will not be liable for any illegal offence, and no harm will be caused, for this is only a study conducted in partial fulfillment of subject 'Research for Health' in Faculty of Health Sciences; Maldives National University.

You must participate in this study willingly, without any pressure. Even after participating, if u want to withdraw from the study, you can do so anytime.

This study will identify the challenges faced in implementing a successful school health program in Maldives. Thus it will be beneficial for the government of Maldives, and to the school managements to reshape the current programs to tackle the challenges. Hence, it will be beneficial to you.

I understand the above statement and I am willingly participating in this study. All the information given will be true up to my knowledge.

Name: _____ Sign: _____ Date: _____

Section A

Tick where appropriate

1. There is a trained health personnel appointed in this school
Yes No
2. There is a trained Councelor appointed in this school
Yes No
3. There is a School Health Team established in this school
Yes No
4. There is a Health Room / First Aid Room in this school
Yes No
5. First Aid program was conducted to the staffs in the past
 6 Months
 Year
 Not conducted in the past year
6. First Aid program was conducted to the parents/students in the past
 6 Months
 Year
 Not conducted in the past year
7. This school has a Comprehensive Health Policy for the school community
Yes No
8. Health education session was conducted to the students in every
 Month
 Semester
 Year
 Not in the last year
8. Health education session was conducted to the parents in every
 Month
 Semester
 Year
 Not in the last year
9. School staff will knows how to administer basic first aid
 100% less than 50%
 above 80% Nill
 50%

10. Conduct health awareness programs for students on issues identified as national public health concerns

Yes No

10. Health screening of students are being done

every month

every semester

every year

not in the last year

11. Health Screening is carried out of all students for

Physical Health

Vision

Dental Health

Mental Health

All of the above

12. All the students of primary grades receives deworming and Vitamin A supplementations

Yes No

13. Height and weight are assessed once every semester compared to standard growth chart and appropriately reported to the parents.

Yes No

14. No. of teachers trained in skill based health education to deliver health and wellbeing syllabus

No teacher

1

2

3

4

5 or more

15. Identify students who attend to school without breakfast/ lunch/snack and take action

Yes No

16. Only nutritious food and drink are allowed at school/school canteen

Yes No

17. No. of orientation/advocacy sessions conducted for school heads on Health Promotion School concept and Health and safety dimensions of Child Friendly Baraabaruru School Initiative on the past year

1 session

3 sessions

None

2 sessions

4 sessions

2

Section B

Tick where appropriate

1. School Health Program is implemented successfully upto the standards of School Health Policy

Strongly disagree	Disagree	Somewhat agree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

2. School Health component is

Not a priority	Low priority	somewhat priority	Neutral	Moderate priority	High Priority	Essential Priority
1	2	3	4	5	6	7

3. Support received from parents to implement school health program is

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

4. Support received from community to implement school health program is

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

5. Support received from staffs to implement school health program is

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

6. lack of adequate infrastructure in this school is a challenge to implement school health programs

Strongly disagree	Disagree	Somewhat agree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

7. we are receiving adequate support and assistance from government for implementing school health programs

Strongly disagree	Disagree	Somewhat agree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

8. lack of adequate trained staffs in this school is a challenge in implementing school health programs

Strongly disagree	Disagree	Somewh at agree	Neither agree nor disagree	Somewh at agree	Agree	Strongly agree
1	2	3	4	5	6	7

9. we are receiving adequate fund or financial assistance from government for implementing school health programs

Strongly disagree	Disagree	Somewh at agree	Neither agree nor disagree	Somewh at agree	Agree	Strongly agree
1	2	3	4	5	6	7

10. Any other challenges or barriers you have came across in implementing school health programs (please specify)

11. In your opinion what changes should be made to implement school health program successfully

Thank You for participating in the survey !

Appendix E

Time frame for research

Oct-15																	
Task	Week 1				Week 2				Week 3				Week 4				Assigned to
Pre testing questionnaire	■	■	■	■													ALI GUDHURATHULLA AHMED
Sending Information Sheet and consent to schools					■	■	■	■	■	■	■	■	■	■	■	■	
Sending Survey questionnaires					■	■	■	■	■	■	■	■	■	■	■	■	
Data entering																	
Data analyzing																	
Writing research proposal																	

Nov-15															
Task	Week 1				Week 2				Assigned to						
Pre testing questionnaire									ALI GUDHURATHULLA AHMED						
Sending Information Sheet and consent to schools															
Sending Survey questionnaires															
Data entering	■	■	■	■											
Data analyzing	■	■	■	■											
Writing research proposal					■	■	■	■							