

School health programmes in Burkina Faso: the Helen Keller International experience

Zeina Sifri is the Regional Coordinator for Africa for Helen Keller International;

Mohamed Ag Bendech is HKI Country Director, Burkina Faso; and

Shawn Kaye Baker is Country Regional Director for Africa, HKI Regional Office, Côte d'Ivoire.

School-age children face health and nutritional problems that may affect their individual physical development, their capacity to attend school and their ability to learn and to take advantage of formal education. Associations between iron deficiency, iodine deficiency and parasitic helminth infection and under-achievement in school have been demonstrated recently. While a better picture of the health and nutritional status of this age group is emerging, the true extent of the burden of ill health and malnutrition is not known (The Partnership for Child Development, 1998).

Why school health?

Delivering health programmes through the educational system that already has an infrastructure in many countries is one of the most cost-effective public health strategies (Maier, 2000). Schools can

affect children's health and well-being through the environment they provide and by developing life skills on health and health-related issues such as hygiene. Water and sanitation facilities are fundamental for hygienic behaviours and children's well-being but, in practice, many schools have extremely limited sanitary conditions. This may contribute to absenteeism and the drop-out rates of girls (UNICEF/IRC, 1998).

The school health strategy relies on the children's eagerness to learn, as well as the teachers' and families' willingness to be involved. New health and hygiene behaviour learned in school can lead to life-long positive habits. Teachers can function as role models for the children and within the community. Schoolchildren can influence the behaviour of family members and thereby positively influence whole communities.

Health promotion in schools involves all the health learning and health action that takes place in the school. According

to The Child-to-Child Trust and the United Nations Children's Fund (Hawes, 1997), this includes:

- school health services;
- school policy and management practice in relation to health;
- nutrition provided to schoolchildren;
- school hygiene and sanitation;
- teaching and learning that takes place in the school;
- actions to spread health from school to the community.

Helen Keller International in Burkina Faso

Helen Keller Worldwide (HKW) is a non-governmental organization (NGO) whose mission is to save the sight and lives of the most vulnerable people in the human

behaviour change communication, operations research, nutritional surveillance to gauge need for intervention and effectiveness of programme implementation, and advocacy of food fortification.

Burkina Faso, a Sahelian nation in West Africa, is one of the poorest countries in the world, ranking 172nd of 174 countries on the Human Development Index.¹ The under-five mortality rate is very high at 197/1 000 live births and the infant mortality rate is 104/1 000 live births (UNICEF, 2002). The nutritional status of children has worsened since 1993, and malnutrition is the underlying cause of over 50 percent of all-cause child mortality.

HKI currently has four ongoing integrated school health projects in Burkina Faso. This article describes two

children under five on their self-reported experience of night blindness during their most recent pregnancy, showed that night blindness is common among pregnant women – with a prevalence reaching 50 percent in some villages and a mean of 16 percent (Tarini, 2001). It was also found that families living in the district of Fada N'Gourma considered the availability of garden produce to be very low, with great seasonal variability. Their diets were monotonous and very poor in micronutrient-rich foods.

School-gardening programmes can introduce new ideas about gardening and become effective channels for reaching the community, especially women and children. It is within this context that UNICEF and HKI initiated and implemented a project entitled

The school health strategy relies on the children's eagerness to learn, as well as the teachers' and families' willingness to be involved.

New health and hygiene behaviour learned in school can lead to life-long positive habits

family. Helen Keller International (HKI) is the international division of HKW that works to establish primary eye-care networks and to combat vitamin A deficiency, trachoma, onchocerciasis (river blindness) and cataract.

It is a technical assistance agency that focuses on developing the capacity of local partners to effect systemic change and advocate for supportive policy at the regional, national and international levels.

HKI is recognized as one of the leading organizations in West Africa for technical assistance in vitamin A programming. HKI nutrition programmes include providing technical assistance and nutrition education in home-gardening, promoting beneficial health and nutrition practices through mass media and

projects: a nutrition and gardening project that targets schools and their communities in the province of Gourma in the eastern part of Burkina Faso and a school health project in the province of Kourwéogo that focuses on providing a minimum package of nutrition interventions.

UNICEF–HKI nutrition and gardening project

The population in Burkina Faso suffers from chronic undernutrition, including micronutrient deficiencies and protein-energy malnutrition. A baseline survey that included questions to mothers of

“Sustainable Improvement of Nutrition and Food Security in Schools and Communities”. The project is funded by UNICEF and implemented by HKI and covers 16 schools and village communities in the province of Fada.

The project aims to test a model for improving the production and consumption of garden produce in schools and communities through the creation of school, women's group and home gardens. The project is innovative in its use of female village social workers to promote gardening and in its emphasis on setting up a strategy to ensure project sustainability. Schoolchildren are used as

¹ The Human Development Index (HDI) is a summary composite index that measures a country's average achievements in three basic aspects of human development: longevity, knowledge and a decent standard of living. Longevity is measured by life expectancy at birth; knowledge is measured by a combination of the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio; and standard of living is measured by gross domestic product (GDP) per capita (purchasing power parity [PPP] US\$). Further information on the HDI is available from <http://hdr.undp.org/default.cfm>.

Why invest in school health?

Many bilateral, multilateral and non-governmental organizations as well as national and local governments invest in school-based health and nutrition programmes because these school-health programmes can lead to the following results:

1. **Better learning and better educational outcomes.** In Africa, more than half of the schoolchildren are stunted and anaemic and most suffer from parasitic infections, which impair cognitive ability. Ensuring their good health can boost attendance and educational achievement.
2. **New opportunities, unfulfilled needs.** Initiatives aimed at achieving universal access to basic education mean that more children now have the opportunity to go to school and can be reached by the school system.
3. **Enhanced equity.** Children who begin school with the worst health status have the most to gain from health and nutrition programmes, as well as educationally, because they show the greatest improvement in cognition as a result of health interventions. School health programmes thus particularly benefit the poor and the disadvantaged.
4. **Building on investments in early child development.** Integrated management of childhood illness, early child development, and growth monitoring and promotion programmes all help to ensure that a child enters school fit and ready to learn. But school-age children, especially girls, continue to be at risk of ill health. School health programmes ensure that children remain healthy during the critical years for education.
5. **Promoting youth development.** School-based promotion of healthy behaviours is successful in tackling major problems of adolescence: violence, substance abuse, teenage pregnancy and sexually transmitted diseases, including HIV/AIDS. Achieving positive behaviour change can promote the educational achievement of young people and contribute to social capital.
6. **A cost-effective investment in education (not just health).** School-based health programmes can be among the most cost-effective of public health interventions. They promote learning and reduce repetition and absenteeism, and can be used as leverage for existing investments in schools and teachers. It should be emphasized, however, that these programmes must be well designed.

SOURCE: World Bank/The Partnership for Child Development, 2003.

agents of change to introduce vegetable gardens into the community. Children are considered to be more open than adults to using new approaches and adopting new ideas. The project activities are implemented according to a framework inspired by Cederstrom (2002); its main components and a summary of results are outlined below.

Physical requirements

Each project village currently has at least one well that has been provided through school partners such as UNICEF. In most villages, the water supply from the wells becomes insufficient starting from March–April every year. During these periods schools and communities are

advised to favour plants that need less water, such as green leafy vegetables. The use of organic fertilizer is also recommended.

Knowledge and management requirements

The project strategy consists of providing basic equipment and inputs; setting up a technical provincial committee responsible for orienting the project; creating an experimental site; and training, monitoring and supervision of project activities. Two female representatives are selected from each village to serve as village social workers; the village groups (youth, elders, opinion leaders, traditional leaders, administrative

delegates and women) are united in an assembly to avoid husbands' influence on their selection. Generally, one older and one younger woman are selected. These social workers, as well as the teachers and agriculture extension agents, receive training in gardening and nutrition by Ministry of Education staff and the project coordinator. The social workers are supported by agricultural extension agents and are responsible for supervising community activities. Their duties include the following:

- **Facilitating group dynamics and the functioning of the groups.**
- **Training.** After their own training, they train other women, groups involved in gardening, and the community as a whole on important topics relevant to village life.
- **Monitoring and supervising.** They are in charge of monitoring and supervising village gardening activities, and are provided with bicycles to help them carry out this task.
- **Transfer of technical knowledge.** They transfer their knowledge to women and the community as a whole.
- **Mobilizing and sensitizing.** they conduct information, education and communication (IEC) activities using flip-charts. These activities benefit from the influence of the senior woman, who is considered to be an opinion leader and respected by all.
- **Organizing women to support schoolchildren.** They organize women's groups to help schoolchildren and teachers undertake the watering and maintenance of the school gardens.
- **Participating in the management of school wells.** They sensitize women to encourage them to contribute to maintaining pumps and organizing sanitation activities at the water points. These activities are made possible by revenue generated from the sale of surplus garden vegetables.
- **Contributing to school/community integration.** They serve as a link between communities and schools through village gardening activities

that mobilize young people and other community members.

- **Serving as intermediaries between women and men.** They regularly update the village on what has been learned and what is expected of them, and involve the men.
- **Involving young people.** Young people are encouraged to become involved in activities such as the maintenance of school gardens.
- **Integrating HKI's programmes in the field.** They integrate trachoma sensitization activities into the gardening awareness sessions.
- **Serving as a link between the agricultural extension service and the village.** The number of agricultural extension agents is limited; thus, the women serve as an important link for promoting garden production and sensitization activities in the villages.

using fruit trees (mango, papaya, néré, guava and morenga trees) as a possible measure to extend the availability of vitamin A-rich products.

Production increases

Two campaigns cover the annual production cycle, one in the dry, cold season, and the other in the wet season. The latter focuses on a more limited range of garden produce (orange-fleshed sweet potatoes, local squash, okra and green leafy vegetables).

Cultural considerations

New foods (orange-fleshed sweet potatoes and carrots, for example) have been readily accepted and consumed in the project area, first by schoolchildren and then by the households, with a minimal IEC component to support this behaviour. Some unexpected results

in locally accessible banks, which ensure the security of the collective funds. Female village social workers are responsible for training and negotiating with the group members – helping them to market the vegetables successfully, and to accept the notion of opening and maintaining a savings account.

Evaluation results

At the end of two years, the project evaluation revealed the following results:

- Gardens were set up in 15 out of 16 schools and in more than 20 groups or structures, three of which are outside the project area (Figure 1).
- Home gardens and new group gardens emerged, set up by young men and women's groups.
- There were significant increases in garden production and the consumption of vegetables and other foods rich

Female village social workers are responsible for training and negotiating with the group members – helping them to market the vegetables successfully, and to accept the notion of opening and maintaining a savings account

Nutritional considerations

Emphasis is placed on producing vitamin A-rich vegetables in schools, such as carrots, orange-fleshed sweet potatoes and green leafy vegetables. Carrots have two production cycles (dry season and wet season) and are consumed on the school premises under the supervision of teachers. In schools with functional canteens, gardening produce is integrated into the schoolchildren's lunch. In response to suggestions by the communities and schools, two or three products destined for resale in the market are also grown (tomato, cabbage, pepper).

A pilot reforestation activity is currently being tested in two schools,

were that several village populations even chose to consume the green leaves of tomato plants, which contain some vitamin A (beta-carotene), when no promotion had been undertaken for this behaviour. In regions that are severely and chronically affected by food insecurity, populations adopt new foods more easily when they are integrated into traditional meal preparation.

Sustainability strategy

The sustainability strategy is based on the sale of surplus. The groups' funds are managed in a combination of individual and group accounts. In total, 14 out of 16 groups (87 percent) have savings accounts

in vitamin A and iron in the project and surrounding (non-project) villages. The vegetables were used in sauces and were often the only fresh produce available in the project area.

- The project contributed annually to the production and consumption of at least 52 tonnes of vegetables during the winter period when availability of fresh garden produce is low.
- Villages where more than 30 percent of households had a home garden were found to have a lower prevalence of night blindness among pregnant women.
- The project contributed to the development of the villages' capacity to organize themselves in general and

to manage their common goods, especially through the opening of bank accounts for profits from the sale of garden produce.

- The project also reinforced the positive links between village communities and their schools and served as a vehicle for other public health interventions such as the introduction of red palm oil and trachoma control activities.
- The planning, IEC, monitoring and evaluation and teaching and survey tools cost the project CFAF 790 000 per village per year (approximately US\$1 215).
- In the first year of the project, the investment in gardening tools and supplies amounted to CFAF 837 500 per village (approximately US\$1 290). This covered one school garden, one women's group garden and ten home gardens. During the second year, the cost was for garden supplies only and was around CFAF 350 000 per village (approximately US\$540), covering the same number of gardens as previously.

Challenges

One of the limitations of the project was the insufficient involvement of health workers in monitoring and supervising the nutrition IEC activities conducted by the social workers. The first year of

implementation in schools and communities highlighted the urgent need for interventions with populations in remote and difficult-to-reach locations. In these areas, fresh garden produce is considered a luxury rather than a basic food.

The wells, with manual pumps and drainage systems, are important capital. Increasing water needs, limited water availability especially during the hot season (April to June) and significant costs are potential challenges. Possible solutions might be to ensure a maintained coverage of the regular increase in water needs resulting from population growth and the increase in the number of garden sites, and to establish appropriate management systems to cover the high cost of maintaining the water works. In the context of Burkina Faso, this latter issue is being addressed by communities with the support of the government and partners.

HKI-Catholic Relief Services integrated school health programme

This school health programme has a micronutrient deficiency control component and is implemented by Catholic Relief Services (CRS) and HKI in collaboration with the Provincial Directorate for Primary Education in the

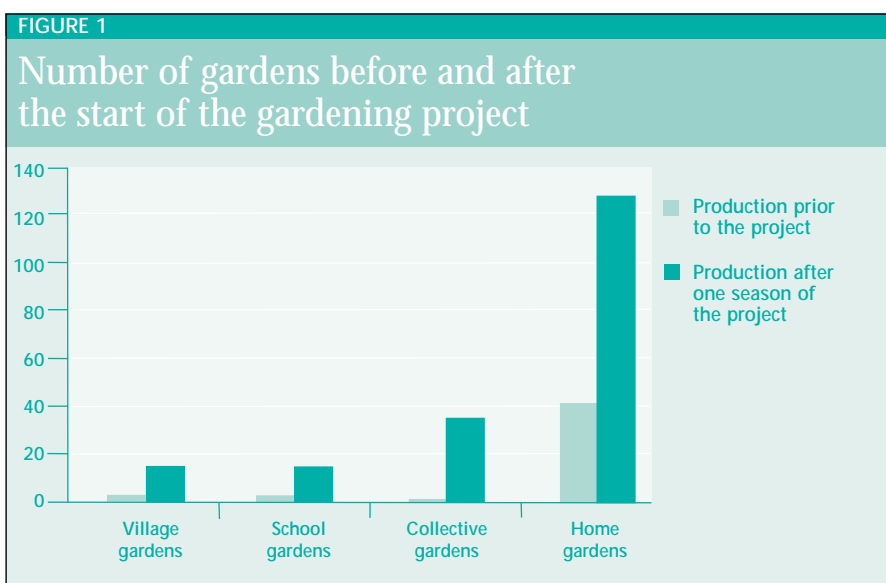
Province of Kourwéogo in Burkina Faso. The project covers 70 primary schools; its goals are to increase attendance rates and decrease obstacles to education through improving schoolchildren's nutritional and health status by improving individual and collective hygiene practices. The project also aims to increase awareness of the importance of nutrition and health in schools. Anaemia decreases school performance and could be one important factor blocking human resource development. In the African context, the causes of anaemia are many (including poor iron intake, intestinal and urinary parasites and malaria); therefore an integrated school health programme is justified. The outline provided here refers to the first phase of the project; the second phase began in 2002.

Main programme intervention strategies

The project offers a package of health and nutrition services, including school canteens, micronutrient supplementation (vitamin A, iron and iodine), the distribution of mebendazole (an antihelminthic drug), the introduction of health and nutrition education in courses, improved hygiene and sanitation, and training and awareness-raising for partners. HKI supplies the micronutrients and CRS provides mebendazole. Teachers are trained in providing the supplements and mebendazole by health and education staff from the provincial and district levels and are responsible for these activities and for completing a monthly tally sheet for schoolchildren receiving iron.

The teachers apply the following protocol for every schoolchild:

- one 200 000 IU vitamin A capsule;
- one iron/folate tablet (60 mg iron and 0.4 mg folic acid) once a week for 16 weeks;
- 600 mg of mebendazole (100 mg tablets) over three days every six months;
- one annual dose of three lipiodol (iodine) capsules (200 mg/capsule).



The project has set up mechanisms at all levels to ensure a participatory approach and promote ownership of activities by local actors. This innovation has ensured the weekly distribution of iron over 16 weeks without interruption by setting up distribution strategies for the school holidays. The project also created tools for data collection. Monitoring has been integrated into the

wider community also participated in the campaign.

- Two nutrition training sessions were organized on the use of a School Health Handbook and on practical aspects of iron supplementation in schools. These were found to be insufficient to enable teachers and parents to become autonomous with regard to their responsibilities.

Data on iron supplementation of 9 745 schoolchildren were analysed, and the haemoglobin level of 450 schoolchildren (in 30 schools) was assessed at the beginning and end of one year of interventions using a portable haemoglobinometer (HemoCue™). Coverage results for iron supplementation showed that 94 percent of the 9 745 schoolchildren received the weekly required

The high compliance rate shows the advantage and importance of directly involving teachers in the health and nutrition programmes implemented in schools

existing responsibilities of the supervisors of school canteens and the educational advisers or inspectors.

Other intervention strategies

- Lesson plans, differentiated by level, were developed for use in teaching nutrition and environmental hygiene. These lesson plans were welcomed by teachers, who have limited access to up-to-date health resources.
- An IEC strategy was developed and implemented as a one-month campaign at the end of every school year. The campaign was conducted in schools and included several components such as a knowledge test on nutrition and health, theatre group presentations and hygiene, poetry and art competitions. Parents and the

- CRS in its general school health programme provides schools with first-aid kits that include regular supplies of essential drugs for use by teachers in treating common conditions such as fever.
- Supervision is conducted at various levels (national and provincial) and is appreciated by teachers and other school partners.

Analysis

The project evaluated the micronutrient supplementation and deworming coverage rates among schoolchildren, and the impact of the project on anaemia prevalence. Data from surveys taken before and after the intervention and from iron supplementation weekly tally sheets completed by teachers were used.

dose without interruption (15 to 16 weeks). The children were able to obtain their supplements even during the Easter school holidays. This high compliance rate shows the advantage and importance of directly involving teachers in the health and nutrition programmes implemented in schools (Hall *et al.*, 2002). The study revealed that coverage rates with vitamin A and iodine capsules, and the second dose of mebendazole were 76 percent, 89 percent and 85 percent, respectively (Table 1). Vitamin A coverage was low because of shortages in a few schools.

In a subsample of the schoolchildren in the programme, the total prevalence of anaemia dropped from 50 percent before the intervention to 21 percent after the intervention – more than a 50 percent reduction. As the final survey was carried out five months after the end of the supplementation programme, this suggests that the interruption of the programme at the end of the school year did not hinder the biological impact of the intervention.

Financial analysis

The planning, IEC, monitoring and supervision activities and the production of IEC materials cost CFAF 830 per schoolchild per year (approximately US\$1.3). The project's supplementation

TABLE 1

Coverage of micronutrients and mebendazole distribution (n = 9 745), 2000–2001

SUPPLEMENT	COVERAGE (PERCENT)
Lipiodol	89
Vitamin A	76
Mebendazole 1st distribution	87
Mebendazole 2nd distribution	85
Iron/folate (16 weeks)	89

activities for vitamin A, iron and mebendazole available in Ouagadougou cost CFAF 175 per schoolchild per year (approximately US\$0.3).

Challenges

The absence of water points in some schools makes the practical work difficult. Several obstacles, such as delays in project implementation as a result of late receipt

generated by gardening activities is essential for the success of such a project. It is therefore recommended that gardening projects be linked with water point development activities. Where water is available, schools and women's groups are excellent entry points for home gardens. Investment in the functional and management capacities of the communities to manage the project

In April 2002, HKI organized the first forum for the exchange of experiences in school health in Burkina Faso, with the participation of international organizations and the Ministries of Primary Education and Health (HKI/FDC, 2002). It was concluded that the challenges that still remain include the creation of a link between schools and their communities, the introduction of health and nutrition

Successful school health programmes rely on the full participation of all the players in the school system, particularly teachers, parents and health staff, in order to promote the sustainability of the programmes

of supplements, the limited involvement of health workers and lack of emphasis on the IEC components, were noted. A further limiting factor was the time required to collect the tally sheets for supplementation activities (iron, vitamin A and mebendazole). These factors, as well as the project recommendations, have been taken into account in the second phase of the project.

Lessons learned from HKI programmes

The inclusion of women social workers was an investment that proved to be very successful. Their willingness and courage constitute one of the major assets for the success of projects linking school gardens with community gardening activities. The quality of the services offered by the village social workers was reinforced by their training and close supervision by health and agricultural extension agents. The social workers received recognition for their role in sustaining the project. The network of female village social workers created an opportunity to maximize, through nutrition education, family and individual consumption of all vitamin A-rich foods.

The availability of water points to cover the increasing water needs

and acquire the necessary knowledge and practices is essential to the success of such projects. Gardening projects, because their results are both rapid and visible, are very motivating for communities and help improve participation in other development and public health initiatives. Seeds, small equipment, knowledge and technical expertise are all prerequisites that need to be ensured before school-gardening projects start their activities. School health projects with a service delivery component need to ensure that permanent mechanisms are established for supplying schools with essential drugs and micronutrients to avoid the possibility of stock-outs or wastage.

Successful school health programmes rely on the full participation of all the players in the school system, particularly teachers, parents and health staff, in order to promote the sustainability of the programmes. Negotiating the sustainability strategy with the communities at the onset of the programme also contributes significantly to its success. A well thought-out expansion strategy that can be implemented as soon as programmatically possible is also important. Teachers and schoolchildren have an essential role in the success of these school health programmes.

education into the existing curricula and ensuring the sustainability of actions in Burkina Faso. Partners agreed to define a clear institutional framework for school health, to coordinate their activities, to create tools for collaboration between the primary education and health sectors, and to revise the school curricula.

The HKI experiences highlight the value of building partnerships with the government, communities, United Nations agencies, NGOs and with other donors. Such initiatives can contribute to the success of school health projects in the future. The sharing of experiences and resources with any interested parties is already happening through multipartner initiatives such as the Web site (www.schoolsandhealth.org) and should be further encouraged.

bibliography

Cederstrom, T. 2002. Learning to grow: how school gardens can provide food for education. *Food Forum*. 3rd Quarter, Issue 61.

Hall, A., Roschnik, N., Ouattara, F., Touré, I., Maiga, F. Sacko, M., Moestue, H. & Bendech. M.A. 1997. *Health promotion in our schools*. London, Child-to-Child Trust in association with UNICEF.

Hawes, H. 2002. A randomised trial in Mali of the effectiveness of weekly iron supplements given by teachers on the haemoglobin concentrations of schoolchildren. *Public Health Nutrition*, 5(3): 413–418.

HKI/FDC. 2002. *Rapport de synthèse de la rencontre de partage d'expériences en santé scolaire au Burkina Faso*. Ouagadougou.

Maier, C. 2000. *School-based health and nutrition programmes: findings from a survey of donor and agency support*. Oxford, United Kingdom, Partnership for Child Development.

Tarini, A. 2001. Rapport de l'enquête de base du projet jardinage scolaire et communautaire. Burkina Faso.

The Partnership for Child Development. 1998. The anthropometric status of school children in five countries in the Partnership for Child Development. *Proceedings of the Nutrition Society*. 57, 149–158.

UNICEF. 2002. *The State of the World's Children 2003*. New York.

UNICEF/IRC (International Water and Sanitation Center) 1998. *Towards better programming: a manual on school sanitation and hygiene*. Water, Environment and Sanitation Technical Guidelines Series No. 5. New York.

World Bank/The Partnership for Child Development. 2003. *School health: why invest in school-based health and nutrition programmes?* (available at www.schoolsandhealth.org).

School health programmes in Burkina Faso: the Helen Keller International experience

School health programmes can comprise a variety of health and educational interventions that need to be tailored to the priorities and perceived needs of the target groups. They have the potential to be one of the most cost-effective public-health activities, if they are well designed and implemented. This article describes two school health projects in Burkina Faso carried out by Helen Keller International (HKI), one of the leading non-governmental organizations in West Africa providing technical assistance in preventing vitamin A deficiency and eye diseases.

A nutrition and gardening project targeting schools and their communities in the province of Gourma is discussed, as well as nutrition interventions in a school health project in the province of Kourwéogo. Both projects are being implemented in collaboration with local government and international partners and use a variety of integrated approaches, combining behaviour modification with service delivery, to promote health and nutrition in schools and their communities. The approaches include training teachers and women's groups on health and nutrition components of the project interventions, assisting teachers to develop teaching tools on health topics, and providing inputs and continued technical assistance to schools and communities through local community workers.

Lessons learned from the project point to the key elements contributing to the success and sustainability of school health programmes. These include the full participation of teachers, schoolchildren, their parents and the community as a whole in the interventions, and investment in the functional and management capacities of communities to manage project activities. Reinforcing the involvement of women social workers with training and close supervision enhanced recognition of their role in sustaining the project, which also contributed to the success of the project.

Many advances are being made in school health around the world; the sharing of experiences and knowledge will contribute to the success of school health programmes in the future.

Programmes de santé scolaire au Burkina Faso: l'expérience de Helen Keller International

Dans le domaine de la santé et de l'éducation, les programmes de santé scolaire peuvent prévoir différentes interventions, qui doivent être adaptées aux priorités et aux besoins des groupes cibles. S'ils sont bien conçus et mis en œuvre judicieusement, ces programmes peuvent se révéler l'une des actions de santé publique les plus rentables. Le présent article fait état de deux projets de santé scolaire menés au Burkina Faso par Helen Keller International (HKI), l'une des principales organisations non gouvernementales actives en Afrique de l'Ouest, qui offre une assistance technique pour prévenir les carences en vitamine A et les maladies des yeux.

L'article présente un projet axé sur la nutrition et sur les jardins potagers réalisé dans des écoles de la province de Gourma et les communautés dont elles dépendent, ainsi que des interventions sur la nutrition relevant d'un projet de santé scolaire dans la province de Kourwéogo. Mis en œuvre en collaboration avec les autorités locales et des partenaires internationaux, ces deux projets s'appuient sur différentes approches intégrées alliant le changement de comportement à la fourniture de services, dans le but de promouvoir la santé et la nutrition dans les écoles et dans les communautés dont elles dépendent. Ces approches incluent la formation d'enseignants et de groupes de femmes aux aspects santé et nutrition des interventions réalisées dans le cadre du projet, une aide aux enseignants pour la mise au point d'outils didactiques sur les questions liées à la santé et la fourniture d'intrants, et une assistance technique permanente aux écoles et aux communautés, grâce à des agents communautaires locaux.

Ces projets ont permis de déterminer les conditions nécessaires à la réussite et à la durabilité des programmes de santé scolaire, à savoir la participation active des enseignants, des élèves, des parents et de la communauté dans son ensemble, et l'investissement dans les capacités opérationnelles des

communautés et leur formation à la gestion des activités des projets. Du fait que les travailleuses sociales impliquées ont été formées et supervisées, leur rôle pivot a été reconnu, ce qui a également contribué à la réussite du projet.

La santé scolaire progresse dans le monde entier. La confrontation des expériences et le partage des connaissances contribueront au succès des programmes de santé scolaire à venir.

Programas de salud escolar en Burkina Faso: la experiencia de Helen Keller International

Los programas de salud escolar pueden abarcar diversas intervenciones en materia de salud y educación que han de ajustarse a las prioridades y necesidades percibidas de los grupos a los que se dirigen. Si se formulan y ejecutan adecuadamente, pueden constituir una de las actividades de salud pública más eficaces en función de los costos. En este artículo se describen dos proyectos de salud escolar en Burkina Faso ejecutados por Helen Keller Internacional (HKI), una de las organizaciones no gubernamentales más importantes en África occidental, que proporciona asistencia técnica para prevenir la carencia de vitamina A y las enfermedades oculares.

Se examina un proyecto de nutrición y horticultura destinado a las escuelas y a sus comunidades en la provincia de Gourma, así como las intervenciones en materia de nutrición de un proyecto de salud escolar en la provincia de Kourwéogo. Ambos proyectos se están ejecutando en colaboración con la administración local y con asociados internacionales y aplican diversos métodos integrados, combinado el cambio de hábitos y la prestación de servicios, con objeto de fomentar la sanidad y la nutrición en las escuelas y sus comunidades. Dichos métodos incluyen la capacitación de docentes y de grupos de mujeres sobre los componentes sanitarios y nutricionales de las intervenciones del proyecto, la asistencia a los profesores para elaborar materiales de enseñanza sobre temas de sanidad, y el suministro de insumos y asistencia técnica continua a las escuelas y las comunidades por conducto de agentes de la comunidad local.

Las enseñanzas extraídas del proyecto ponen de relieve los elementos fundamentales que contribuyen al éxito y a la sostenibilidad de los programas de salud escolar. Estos contemplan la plena participación en las actividades de los docentes, los alumnos, sus padres y la comunidad en su conjunto, así como la inversión en las capacidades funcionales y de gestión de las comunidades para administrar las actividades del proyecto. Fomentando la participación de las trabajadoras sociales mediante su capacitación y seguimiento continuo se logró un mayor reconocimiento de su importancia en el mantenimiento del proyecto, lo que a su vez contribuyó a la ejecución satisfactoria del mismo.

En todo el mundo se están realizando muchos progresos en la esfera de la salud escolar; compartir experiencias y conocimientos contribuirá a la eficacia de los programas de sanidad escolar en el futuro.