AN ATTEMPT TOWARDS IMPROVING HEALTH APPRAISAL IN THE ELEMENTARY SCHOOLS OF LEBANON

by

May Wadih Zacca

Submitted in partial fulfillment of the requirements

for the degree of Master of Arts in

the Education Department of the American

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ACKNOWLEDGEMENTS

It is a pleasure to acknowledge my indebtedness to the chairman of my thesis committee, Dr. Frederick Korf, head of the Education Department at the American University of Beirut, and to Dr. Howard Mitchell and Mr. Thomas Gray, who gave me information, help and advice of inestimable value.

I also wish to acknowledge the help that Dr. Levon Melikian, the other member on my thesis committee, and Dr. Habib Kurani gave me through their criticisms. If I have failed to interpret their suggestions correctly the fault is wholly mine.

I also wish to thank Mr. Leslie Leavitt, Principal of International College, and Mr. Ataya, head of the Elementary Section at the International College for their cooperation in facilitating my interviewing of the elementary teachers during the summer session. Many thanks also go to the various general medical practitioners and educators whom I interviewed, for their patience, their encouragement and their willingness to provide all the kinds of information and advice I sought. They are identified at appropriate places in the body of the study.

ABSTRACT

From episodes related by friends and parents of school-age children, the writer sensed a need for the elementary teacher in Lebanon to be more alert in detecting signs of physical disorders in their pupils, and to be more sensitive to the deviations of their pupils from good health standards. The awareness of this need was also strongly supported in interviews with some experienced pediatricians and educators.

Many teachers fail to recognize that the presence of certain mild and easily overlooked physical defects among their students, may be responsible for their failure at school to take full advantage of their educational opportunities. They also fail to realize that mild defects, if overlooked, may lead to serious physical or mental handicaps later.

Here is a quotation of the 1959 law connected with school health in Lebanese private and public schools translated from the Arabic, and obtained from the Ministry of Health in Beirut, Lebanon, during the summer of 1960.

"1. To perform studies connected with the health situation in private and public schools.

2. To lay down rules for raising the health standard in schools.

3. To provide skilled supervision on actions performed

for the care of the school child, and for sanitary establishments and preparations in schools - like heating and cooling systems, water for drinking, latrines or water closets, playgrounds and safe-guards against burns and other emergencies.

4. To take all the procedures legalized by laws and regulations for the care and preservation of the health of the school child."

The writer shall not go into details stating to what extent does the above stated law appear to be followed in Lebanon. However, it might be worth mentioning that the law does not specify or stress anywhere that medical check-ups are required for every entering pupil and should be performed about two or three times during his elementary school years. If we consider that this requirement is included in the law, among the procedures legalized by laws and regulations for the care and preservation of the health of the school child - as the fourth item of the law states -, it would only be fair to say that such a law is not being properly executed in Lebanon, for there are a number of elementary schools known to the investigator who do not perform any medical check-ups on their pupils.

The medical check-ups performed by most of the elementary schools in Lebanon on entering pupils at the beginning of each

year, are often little more than cursory and hurried inspections. Sometimes health defects in serious need of attention are not discovered. Examples of this are given. However, even if these check-ups were very thorough, some defects and diseases might very well make their onset during the course of the year, and, if neglected or overlooked, might lead to serious consequences.

The investigator has interviewed experienced pediatricians in Lebanon and collected case histories of children whose defects and diseases could have been detected easily by their teachers at school, if those teachers had been sensitized so as to be on the alert for them. These interviews have furnished the writer with the conviction that there exists a strong need for health appraisal in the elementary schools of Lebanon.

After establishing this need, the writer attempts to demonstrate that the elementary teacher is, in many ways, the best - qualified person to detect the day-by-day changes which may reveal incipient physical defects and diseases among elementary school children. She has distinct advantages over school physicians, school nurses and parents in this respect.

An oral questionnaire was prepared by the writer and addressed to the elementary teachers at a well known preparatory school in Beirut.[1] The questionnaire aimed at revealing

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[1] The school is the International College.

the standard of health facilities and services that the school enjoys as compared with other schools known to the writer. It also aimed at discovering how much background or training in health matters the teachers have, and the kinds of symptoms that bring a defect or disease in a child to their attention.

Some suggestions for the guidance of teachers in detecting certain signals of ill health are then presented, after which kinds of health problems that teachers can detect in their pupils are discussed. The description of such ailments are not intended to furnish the teacher with grounds for diagnosis; the information given is intended only to familiarize the teacher with the signs of diseases and defects at their onset, in order that, by appropriate reporting and subsequent qualified follow-up, they may be prevented from becoming worse or spreading to other pupils. Some screening tests that the teacher can perform as part of her appraisal have also been described.

The findings of this study can be as the clear identification of three needs:

(1) The need for elementary school teachers in Lebanon to be more sensitive to diseases or defects among their pupils,

(2) the teacher's need for more training in health, and

(3) the need for routine health appraisal activities and for more communication through "Teacher-Parent" and "Teacher-Physician or Nurse" conferences for carrying the job of health

appraisal through to its logical end - the improved health and welfare of all the children.

The present study should not be conceived of as one that proposes to overburden the teacher with a difficult and impractical job; instead, it should be seen as an attempt to sensitize the teacher to the importance of incipient conditions which once identified, may be easily cured, or progression of the condition arrested before serious consequences arise. It is also intended to encourage the teacher in this job, and to stir in her a sense of more responsibility towards the health, and, in turn, towards the lives of her students.

INTRODUCTION

Interviews with educators and pediatricians in Lebanon reveal that the beginnings of the attempts to improve health appraisal in Lebanese schools are hard to trace. Among the earliest recorded attempts are a set of three summer conferences held in 1951, 1952, and 1953 concerning all the public schools of Lebanon. These conferences (two and a half months each), aimed at improving the level of health in the public schools and encouraging the teaching of health as a distinct subject in the school curriculum.[1] Other attempts were undertaken by the Public Health Division at Point Four for the same purpose.[2]

Another effort aiming partly at improving school health in Lebanon was attempted by a voluntary health agency known as the Social Health Center.[3] This agency acts as a demonstra-

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[1] The sponsers were the Ministry of Education and the Point Four. Dr. Robert Karam (a medical practitioner) and Dr. Hanna Ghaleb (a doctor of education) were in charge of these conferences. They invited all elementary public school teachers in the rural and urban areas of Lebanon, and held conferences for three days in each public school. During the first year, sixty teachers were present at the conference; during the second and third years, eighty were present. In these conferences, both Dr. Karam and Dr. Ghaleb tried to make the teachers live and practice the health habits that they wished them to teach to their pupils.

[2] Supplied by Dr. Hanna Ghaleb in an interview, Aug. 3, 1959.

[3] This center started in 1951-2 by Point Four in cooperatinn with the Lebanese Public Health Association. Its support comes from the American University of Beirut, Ministry of Health, Ministry of Social Affair and Municipality. It serves two areas in Beirut: Ain el-Mraisi and Ras-Beirut. Services are free of charge for everyone in those areas.

tion service for maternal and child health. Its service lies in the following fields: Preventive Medicine, Public Health Nursing, School Health, Sanitation and Curative Medicine.

In the field of School Health,[1] this agency began by approaching government schools. It performed a medical examination for the students, checked their height, weight and vision, and vaccinated them. If any student got sick, he was referred to their doctor. During the check-up, they asked the mothers of the pupils to be present in order to have their consent before referring a child to the doctor for treatment. In cases when mothers did not come, they went to visit them at home, urging them to follow up their children's health cases.

However, they did not find enough cooperation from the public schools. "The school administrators were afraid that we might waste the time of the teachers" said Mrs. Akra, "and so we shifted to a private school."[2] At the private school, they used to give classes in first aid once every week for teachers, and twice a week for students. In addition, they gave lectures in hygiene for students and spoke to them about cleanliness and care of teeth and eyes. They also related to the teachers during their lectures some symptoms of eye-trouble. During the physical check-up, they asked parents to be present in order to give them the results and recommendations of the

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[1] Information obtained from Mrs. N. Akra, an active member of the center in an interview July 20, 1960.

[2] Ibid.

check-up. However, they have stopped working in schools this year because of lack of time.

From her experiences in the field of school health in Lebanon, Mrs. Akra said that teachers are untrained and almost entirely ignorant about aspects pertaining to health and hygiene. In rural areas she continued, there is really not much work done in the field of school health services. The Social Health Center itself sometimes vaccinates the students of the government schools. It has been understood from some health personnel that neither the Ministry of Education nor the Ministry of Health are doing their jib properly; the Ministry of Health do not even send a doctor to check on the health of the students in schools.

Another attempt related to school health services in Lebanon is made by a private Armenian agency known as the "Howard Karageuzian Child Welfare Center". This Center started in 1942. The school health work is concentrated in the Armenian schools, but their clinic is open to all sects and classes. The area that the clinic serves is Bourj Hammud, which has a population of 100,000, mostly belonging to the middle and lower classes.[1] In that area, they serve the elementary private or community schools. Their connection with the Ministry of Health is only for obtaining Typhoid vaccine.

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[1] Information obtained from Mrs. N. Tavitian, acting head of the Center in July 25, 1960.

It might be interesting to trace the work of the Center in the field of eye infections and their treatment.[1]

In 1941-2, the clinic started Trachoma treatments in two cooperating schools. Out of 785 students examined, 193 needed eye treatment. In some other schools of that area, the per cent of the students needing eye treatment went as high as 33 per cent. In 1948, there were eleven schools under treatment; out of 3195 pupils, 600 (i.e., 19 per cent of the pupils) needed eye treatment. The treatment was given. At the beginning of every year, the clinic performs an eye examination for all children, marking down those pupils needing treatment. Two practical nurses then go around the schools every two days giving the treatments. Later, another examination is performed; and the next year the process is repeated.

Mrs. Tavitian said that the schools involved had neither a doctor nor a nurse. They were primary schools of a very poor state as regards health services and facilities.

The reader might be interested to observe that in 1959-60, there were only 3 per cent of the students in fourteen schools of the area being served who needed Trachoma eye treatment. Then treatment was carried out, reducing this percentage to .07 per cent.

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[1] The infections looked for were Trachoma, Conjunctivitis and Blapharitis.

With the decrease of Trachoma, the clinic turned its attention to doing eye refractions, in order to prescribe glasses. Typhoid vaccinations is another activity started by the œnter in 1941. This year (1960 the clinic has vaccinated all the children in twenty-nine schools and made general physical examinations for three schools.

The investigator has adressed an oral questionnaire to a set of thirteen elementary school administrators in Lebanon.[1] Nine out of the thirteen schools represented (both private and public) had neither a special doctor nor a nurse, in spite of the fact that one might have expected such schools to be more aware of health matters than those less willing to cooperate with outside agencies. Upon asking the administrators of those schools the following question: "Who is responsible for noticing and reporting health problems in your school?", four school administrators replied "no one". Three said the administrator, two replied that they have few teachers responsible for such a job, while two others said that the parents are the ones responsible for noticing health defects. One administrator replied that the doctor who visits the school twice a year is the person responsible; and one said that the nurse is the person fit for such a job. However, when the

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[1] Names of school administrators likely to cooperate were supplied by Miss Mimi Dadis, who had recently undertaken an investigation of school cooperativeness with outside requests.

question "do you feel that the teacher is the proper person to notice and report health problems?" was asked, the four school administrators who had replied "no one" to the first question, said that the teacher is the proper person to notice and report health problems, yet they felt that she is untrained and unfit for such a job and therefore cannot be the proper person for detecting health problems in children. Most of the elementary teachers employed do not hold more than an elementary certificate in training.

Most elementary teachers are still selected exclusively on the basis of their training in certain academic subjects. No knowledge of health matters is required of them. The curriculum of Lebanese schools as such, does not have enough courses in health such as hygiene, first aid, nutrition etc.; the Baccalaureate program itself does not require the taking of such courses. Elementary teachers therefore cannot be much blamed for not having had adequate background information in health appraisal and the rudiments of preventive medicine.

The term Health Appraisal has been used throughout the present study as a term referring to a set of organized procedures conducted by the teacher (with the help and advice of qualified individuals) in order to evaluate the health status of school children. These individuals may include the school physician, the school nurse, school administrator, and others who may wish to share responsibility and concern for the health

of school children.

The study is limited to elementary schools for the following reasons: The elementary school child has little capacity or background for comparing himself with the rest of his schoolmates. His friends are too young to evaluate symptoms of ill health that he may exhibit, and the child himself cannot easily note that he is different from others. It is during the elementary school years that the pupil develops health habits that are very apt to become more or less permanently rooted in his behavior.

CHAPTER I

THE NEED FOR STUDENT HEALTH APPRAISAL IN THE ELEMENTARY SCHOOLS OF LEBANON

When preventive medicine was still in its infancy, few persons were inclined to pay attention to minor deviations from good health. Today, with the rapid progress which has been made in that field, there is little excuse for failure to take note of and to correct minor health defects and diseases that, if overlooked, may lead to handicaps or chronic conditions impossible to cure later. Even today a student who is not making good progress in school, and who has no obvious physical condition to explain this retardation, may be punished at home and in school for his drop in performance when in fact something connected with his health may be the source of his difficulties.

The need for students health appraisal is probably best manifested in the following true accounts of situations which have recently occured in Lebanon:

Case I. The first case is that of a boy who is now eighteen years old, but who is still in the seventh grade. He had a glandular disturbance that remained overlooked until he was seventeen years old (1958).[1]

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[1] The boy is a neighbor of the present investigator, who know him when he was very young, and went to the same school with him. He repeated each class, sometimes remaining in a class for three years.

The boy always acted and responded very slowly and sluggishly. Each of his teachers at school predicted his failure at the end of the term the moment he entered the classroom at the beginning of each year. Since he was the only child of the family, the teachers attributed his fatness and slow behavior to the fact that he was his parents' only pet. Even the doctor who performed the medical check-up at the beginning of the year saw nothing wrong with him except his excessive fatness; at least he never suggested that he should consult a specialist in glands. Only last year (1958), when his parents became truly alarmed at his fatness, did they resolve to take him to a doctor they felt was diet specialist. This man, an endocrinologist, immediately suspected glandular dysfunction. On further medical examination he discovered quite a serious deviation in the boy's glandular pattern. The boy is still under treatment today. He has lost some weight and this year he entered a boarding school. He has gained in vitality, and a new spark of brightness can be seen in his eyes as he answers the questions a person asks him. He responds to questions much more quickly than he did before.

Case II. A very pale elementary school-boy went into

a coma and was brought to a pediatrician[1]. After check-up, it was discovered that the boy had severe anemia. The pediatrician wondered how the school physician who did the medical check-up at the beginning of the year, did not discover or notice that he had a spleen enlargement (Splenomegaly). He wondered how the school nurse or even his teacher did not suspect that the boy must be sick from the symptoms of general weakness, tiredness, dizziness or faintness that he must have exhibited, or from the obvious paleness of his face and hands.

Case III. The following story was related by a friend of the present investigator.[2] She still remembers when she was eight years old, sitting in a classroom at a private secondary girl's school in Beirut. She asked the teacher if she could sit in front. The teacher, thinking that bright children usually like to sit in front, permitted her to do so without suspecting that something might be wrong with her eyesight. The teacher, like many others, believed that a pupil usually likes to sit at the back only to have more chance to talk to others. The girl's poor eyesight was discovered by her

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[1] This case was related by Dr. Firzley (pediatrician at A.U.B. Hospital) May 16, 1959.

[2] This story was related as part of a conversation May 7, 1959.

mother only about eight months later. The girl is now so helpless without her eye glasses that she cannot recognize a friend even when she is only four or five meters away from her.

Case IV. A nine-year old boy from Tripoli came to the doctor complaining of dizziness and of a blurring in his vision. From the boy's answers to the doctor's questions, the following story was revealed.[1]

The boy was a student in a characteristically large Lebanese public school class. When he told the teacher around the beginning of the year that he could not see well from his seat at the back of the room, and asked her if he could sit in front, the teacher replied that since he was a good quiet boy he should remain in his seat at the back because she puts only the troublesome boys in front in order to keep an eye on them. The boy told the doctor that during the whole academic year, he could not see the pictures drawn on the board and therefore had much difficulty in grasping what the teacher explained. When his mother taught him at home, he said, he learnt quickly and well.

The doctor again said that if the teacher had been

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[1] The case was related by Dr. Robert Karam, Head of the Health Center for Labor Union in Masrah Street, Beirut, in an interview April 20, 1959.

alert enough to consider the possible implications of the boy's request to sit in front, or was wise enough to observe for some signs of shortsightedness that the pupil must have shown all through the year, she could have saved him a lot of trouble in learning what she was explaining, and she could have prevented the boy's eyesight from becoming worse.

Case V. A child from South Lebanon was brought to the doctor by his parents. He had been going to school for about seven months until his uneducated parents discovered his hearing defect. The doctor said that he had acoustic nerve palsy, that is, a paralysis in the hearing nerve of one of his ears. That nerve, he said, was completely deprived of action, and he wondered how his teacher had failed to notice his hearing defect which she could have detected earlier if she had been alert enough to some symptoms that he must have shown.[1]

Case VI. Another case is that of an eleven-year old boy who was one of the leading member of the football team in his school. He had only newly recovered from an attack of grippe when he was

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[1] This case was related by Dr. Zellweger, Head of the Pediatrics Section at the A.U.B. Hospital in an interview May 5, 1959.

asked by his physical education teacher to play with the team against another school. The boy did not yet feel strong, and asked to be excused from playing. The teacher thought that since he had been allowed by the school nurse to attend classes, he must have recovered completely from his illness. Thus he suspected malingering and strongly urged him to play. The boy played on the first day of his recovery, with the result that he developed pneumonia and facial paralysis.[1]

Case VII. In a story related by a pediatrician[2], a boy with quite a serious and contagious skin disease came to see him at the hospital with his parents. The boy was still going to school, said the pediatrician, and it is very likely that he transmitted this disease to others. All the members of his family had the disease.

Case VIII. This case took place in a village in South Lebanon called Juweih. A certain teacher, observing smallpox symptoms in a ten-year old boy,

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[1] This case was again related by Dr. Robert Karam in an interview April 20, 1959. The boy was then his patient.

[2] The story was related by Dr. Zellweger in the May 5, 1959 interview.

thought that he had scabies[1]. The teacher sent for the boy's father and told him that his son was scabby and should be taken to a doctor. The enraged father gave the teacher a good beating before he left.[2]

All the examples related above tend to demonstrate the fact that elementary teachers in Lebanon are not alert enough in detecting certain signs of physical disorders in their pupils or sensitive to the presence of certain mild and easily overlooked physical defects among their pupils - defects which may be responsible for their failure to take full advantage of their educational opportunities. They also lack a full awareness of the fact that if a disease is overlooked in a child, it may not only lead to a serious physical or mental handicap later, but to the infection of the other pupils who are exposed to it.

In addition to the mentioned examples, the four medical practitioners interviewed agreed unanimously that student health appraisal is lacking in most if not all the elementary schools of Lebanon; they strongly supported the idea that it

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1 "Scabies, an infectious disease, results from infection of the skin by small mites". Quoted from The Book of Health, Randolf Clark and Russell Cumley, eds., (Houston, New York, 1953), p. 227.

2 The case was related by Dr. Robert Karam in an interview May 15, 1959.

is seriously needed, for there are some diseases in which children lose some of their faculties and sometimes their lives, if they are not detected and treated at the right time. Each doctor interviewed could remember more than one case that demonstrates the point that student health appraisal is not only greatly needed in the elementary school, but that it is necessary for at least two main purposes: To help the defective or diseased child himself, and to prevent the infection or the defect from spreading to or adversely affecting other children.

Experts in the literature have also come to the same conclusion. "Whether from influences within or outside of the school", says Delbert Oberteuffer, "some 40 per cent of all school children have some handicap in seeing".[1] There is not a classroom teacher who does not in all probability have one or more children in the room in need of some special attention concerning defects of vision.

Eye defects such as nearsightedness, farsightedness, and astigmatism can lead to eyestrain, a condition which may be manifested by pains around or within the eyes, headaches, and blurring or dimness of vision[2]. The student with a

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[1] Delbert Oberteuffer, School Health Education, (New York, 1949), p. 291.

[2] The Book of Health, Op.cit., p. 515.

vision defect, even a mild one, tires easily, for he cannot see the written material well enough. If his eyes do not properly fuse their two separate images untold confusion results. A myopic (nearsighted) child may be very uncomfortable or ill at case reading in front of others. Also, a far-sighted child finds close work difficult. The strain that results from uncorrected eye defects makes children nervous, and often causes lack of interest in study and reading.[1] Astigmatic[2] children often get headaches from reading, and a good number of other more serious disorders of childhood such as emotional unbalance and heart irregularities may be traced to astigmatism.[3] A child's left or right eye may be slightly crossed. He cooks his head to one side, because with his head held in that position, he can use his good eye to the best advantage and suppress the visual images from the crossed eye so as not to see double.[4] If this condition remains uncorrected, vision in the squinting or crossed eye may become impaired because of lack of use. The sooner the tendency to squint is brought to the attention of the eye specialist, the more chance there is for the correction of this defect.[5]

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1 Oberteuffer, Op.cit., p. 292.

2 Astigmatism is a form of defective vision in which there is a distortion of the lens of the eye so that vision at any distance is blurred.

3 Oberteuffer, Loc.cit.

4 Metropolitan Life Insurance Company, What Teachers See. (New York, 1951), p. 9.

5 Ibid.

In the same manner, a pupil with a slight hearing defect which is not corrected misses much of the discussions and explanations and therefore does not profit as fully from his school experiences as the child with normal hearing.

These and other defects should be located and corrected as early as possible, because they not only cause personal distress but academic retardation and social maladjustment, which show up in school work and in general behavior.[1] A child is apt to become mischievous and unruly because his defective vision does not allow him to participate in ordinary pursuits. Being bored and lonely, he tries to win the attention of his fellow students by show-off behavior which reduces the effectiveness of the learning situation.

Loss of hearing is also an underlying cause of undesirable behavior or lack of progress in school. If it is not recognized, a child may be scolded for seeming stupid or indifferent; and as a result of feeling misunderstood at home and in school, he may become emotionally maladjusted - he may feel forced to accept the idea of failure and to seek compensation in undesirable ways.

Deviations in level or pattern of endocrine function also affect the pupil's vitality in class. Endocrine

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[1] Ibid.

malfunctionings sometimes cause either restlessness, over-activity, or sluggishness and slowness in behavior and mental response, as well as disorders in bodily growth. A teacher who is ignorant of the physical conditions that might be affecting a particular pupil, may neglect him or refuse to accept him in her class if he is restless, over-active, and causes disciplinary problems. On the other hand, a child may be unable to enter wholeheartedly into any activity. He may be cooperative and may try hard, but be unable to keep up with his classmates. Such a child might be found to have large adenoids interfering with his breathing and lowering his vitality.[1]

If existing departures from good health are contagious, they are a menace to the whole group. Early indications of communicable disease ought to be detected and treated. If professional assistance is not available, the child should at least be isolated from other pupils. Many children come to school with colds or other extremely contagious diseases such as influenza, measles and chickenpox. An invaluable part in limiting the spread of infection can be played by reporting immediately any child who shows signs and symptoms of such diseases to the proper person in the school-health-service set-up. Colds, for example, constitute statistically the highest frequency of respiratory diseases of childhood.[2]

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[1] Ibid., p. 23.

[2] Information obtained from Dr. Zellweger in an interview May 5, 1959.

They are great sources of contamination for they are airborne diseases, easily transmitted to others through the air of enclosed spaces.[1] If cold symptoms, for example, are known and detected in a pupil, a great service can be done by avoiding the exposure of the rest of the pupils.

From what has been mentioned so far, one can conclude by saying that in any school, and at any time, there are bound to be children who are suffering from specific disabilities.

It would be absurd for any teacher to expect optimum school work from a child who has defective eye-sight or hearing, who is badly fed or insufficiently rested. Some children are normally bright and others are naturally dull, but both the bright and the dull can do finer and more persistent mental work, and derive more benefit from their schooling when put in their best possible working condition as regards physical fitness.[2]

According to the Joint Committee on Health Problems in Education of the NEA and AMA, it would be unfair to other pupils to be held back by the slower progress of children

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[1] George Wheatley and Grace Hallock, Health Observation of School Children, (New York, 1951), p. 221.

[2] Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, Health Appraisal of School Children, (1957), p. 7.

whose bodily condition prevents them from doing better work. It is also a waste of time and money for teachers to work with pupils who cannot profit as much by their efforts as might be the case if they were in their best bodily condition. There is no substitute for day-to-day observation to make sure that good health prevails, or that an acute developing disease or defect is detected before a child becomes a menace to his fellows or completely unfit for work himself.[1]

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[1] Ibid.

CHAPTER II

THE UNIQUE POSITION OF THE TEACHER IN HEALTH APPRAISAL OF SCHOOL CHILDREN

"The teacher has come to be recognized as the 'keystone' of the health examination service, and no matter how adequate the specially trained personnel of that service, she will always continue to hold this unique first line position. She is always present, and the onset of communicable diseases and the development of physical defects do not await the appearance of either nurse or physician. Her importance is increased, however, when as is too often the case, such special workers are absent or their visits infrequent."[1]

In many Lebanese schools today, one can find an awareness of the fact that the teacher can assist in the health observation of pupils and is able to note changes in health and behavior once they occur; while previously, it was thought that only the physician or the nurse of the school could tell if something was wrong with a child. In the International College of Beirut (the Elementary Section) for example, besides the inspections that each classroom teacher is expected to perform the first hour of the day about three

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[1] James Rogers, What Every Teacher should Know about the Physical Condition of her Pupils, (Federal Security Agency, U.S. Office of Education, Pamphlet No. 68, Rev. 1945), p. 2.

times a week, every teacher is encouraged and expected to refer to the school office any pupil she suspects of having something wrong with his health.

At the "Al Makasid Al Ibtidaiah" school in Beirut, two or three teachers sleep with the pupils. They are expected to stay with them and refer, through the administration, every one whom they suspect as having a sickness or disease to one of six or seven doctors working in certain hospitals. The patient himself can choose the physician whom he wishes to consult.

Upon entering the elementary school at five or six, the child is removed for a part of the day from such supervision as may be given by his parents. Instead, the teacher comes in. She spends most of the school day with the child, notices him at the beginning of each day when he arrives at school fresh and rested, and at the end of each school day, tired from play and study, as he leaves for home. Thus the teacher is in an excellent position to be a constant daily observer of the health of her pupils as well as of their immediate and long-term behavior.

According to Wheatley and Hallock, the family physician usually has to depend wholly on the observations of parents in order to know when his child patients need him. At a home or office medical examination, he asks the parent

several questions in order to get a picture of the child as he usually looks and behaves so that he can appraise the importance of what he observes. Even for this, he must depend on the assumption that the parent is fairly constantly with the child.[1] When the child enters school, another eye is focused on him: that of the teacher. Her observations have a great value because, as shall be demonstrated later, they are likely to be more objective than those of the parents. Therefore, the teacher can be of great assistance to the school doctor, not only as Wheatley and Hallock put it, in selecting children who need medical check-ups, but also in giving such health and behavior information about each child as she is in the best strategic position to obtain.[2]

It can be safely said therefore, that the school physician, who sees the child for roughly three to five minutes at the beginning of each school year, and who is bound to compare his findings only with what he knows to be normal for healthy children of approximately that age, is handicapped in a real way if he does not make use of the educated or trained observations of teachers.

The position that the teacher occupies as a daily observer of pupils is potentially quite a favorable one for

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[1] Op.cit., p. 5.

[2] Ibid.

gathering information about each child. Her regular and systematic association with each child leaves a distinct impression on her. By noting his behavior in the classroom and on the playground, she forms an opinion of his learning ability and attitude toward his work and his playmates; and from day to day she is bound to become familiar with his appearance and behavior. The picture that the teacher forms in her mind about each child from the information she gathers, enables her to note when a child is not looking like himself, or if he does not seem to be making the progress he himself has led her to expect of him. If, for example, a child has always been quiet, and one day he becomes restless and noisy, she has reason to suspect that something might be wrong with him either physically or psychologically. The same conclusion may be reached when a sudden decrease in a child's normal energy - level or learning ability is noticed. A doctor cannot know what a particular child's normal, day-to-day behaviors and appearances are; a teacher cannot help but know these things.

However, it should not be concluded that a teacher desires or expects that all of her children will conform to one pattern of growth and behavior. According to the Metropolitan Life Insurance Company booklet, as a child is unique to his parents, he is also unique to the teacher. But unlike parents, the teacher has the opportunity to see indivi-

dual differences of each child, or the changes in his health status as they occur, against a background of many other children.[1] The teacher inevitably learns from the child himself what to expect from him as an individual. At the same time, her expectations are more objective than those of the parents. A child's parents are usually too close to their child to notice the slight changes which mark the slow development of certain physical defects. In addition, parents are more subjective about their children, and therefore may refuse for some time to see a defect because they do not want to see it. Again, according to the Metropolitan Life Insurance Company booklet, a mother may think that what has happened once or twice to her child without disaster is unimportant; a teacher thinks about the same thing from the viewpoint of one who is responsible for a whole classroom full of children.[2]

Children, like anyone else, say Wheatley and Hallock, have personality quirks, and these are often so familiar to parents that they may disuise a developing defect. "Oh he has always been like that - he never pays attention" a mother might say in reply to the suggestion that lack of attentiveness may indicate loss of hearing. A teacher on the other hand sees this condition as a deviation from

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[1] Op.cit., p. 2.

[2] Ibid., p. 3.

the expected norm of behavior or learning ability of her group of children, who are all of approximately the same age.[1] There are also some signs of trouble that parents may neglect or overlook at home because they do not appear to have an immediate effect on the child's general health. Examples of these are poor posture, decayed or crooked teeth, skin eruptions, excessive thinness or fatness, and behavior difficulties like overaggresivness or overtimidity.

The child's friends are too young to evaluate symptoms, although they may feel that these symptoms deviate from normal behavior. The pupil himself cannot easily note that he is different from others. Luella Cole in her book Teaching in the Elementary School, says that the child has little insight and no background for comparing himself with the rest of his schoolmates. For example, he supposes that all pupils are unable to see the blackboard because he cannot; or that all children feel dizzy after running in the yard because he feels so.[2]

In summary then, the teacher is in many ways the best - qualified person to detect the day-by-day changes which may reveal incipient physical defects and diseases among elementary school children. She has distinct advantages over school

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[1] Ibid., p. 4.

[2] (New York, 1947, p. 250.

physicians, school nurses and parents in this respect. Her continuous observation of individual children, each against the background of the class norms, gives her a distinct advantage over all others in noting the unusual behaviors or peculiarities associated with specific defects or handicaps.

CHAPTER III

DAILY OBSERVATIONS: A MAJOR PART OF THE TEACHER'S ROLE IN APPRAISING THE HEALTH STATUS OF HER PUPILS

The need for student health appraisal was best manifested against a background of ignorance and lack of alertness on the teacher's part as demonstrated by the examples given in Chapter I. If any one teacher of the boy with the glandular disturbance had been alert enough to his slow way of behaving and responding, she would have suspected that his abnormal behavior compared to other students must be partly a result of something connected with his physical constitution. The other cases that were mentioned are also typical demonstrations of the teacher's lack of sensitiveness in noting fairly obvious defects.

In the previous chapter, the unique and strategic position that the teacher occupies as a daily observer of her pupils compared to that of parents and other school-health personnel was discussed. As an introduction to the present chapter, a statement appearing in a booklet by the Joint Committee on Health Problems in Education of the NEA and AMA is worth quoting:

> In any school health program, regardless of the degree of its organization or the quantity or quality of its personnel, certain procedures are fundamental to the health appraisal of pupils, These include teacher observations, screening tests and medical and dental examinations.[1]

This Chapter deals with the role that the teacher can play in appraising the health status of her pupils through observations.

The observation method is based on the continued awareness of the student's appearance and behavior. George Wheatley and Grace Hallock in their book,[2] talk of idle and active observations that all of us constantly make. They point out that we are in a habit of noting the general physical traits of others - whether the person is tall or short, stout or weak, whether he is deformed etc. We may even note the color of the hair and eyes. These observations they label under idle ones, in the sense that they cannot be put to work for the benefit of the thing or person observed because they mean nothing to the observer. Then they go on pointing out that it is only when an observer gets to have some interest in a certain person or thing, that he begins to notice specific aspects pertaining to it that convey real meaning and significance for him. It shall also be seen later, that

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[1] Op.cit., p. 12.

[2] Health Observation of School Children, Op.cit., p. 1.

interest alone is not enough, it has to be supported with knowledge and backed with training, in order that intelligent observation can be secured.[1]

According to the Joint Committee on Health Problems in Education of the NEA and AMA, health observation should not be perceived as an extra responsibility imposed upon the teacher. Rather, it is a sensitivity to the developmental needs of children. The alert tea her can detect such deviations without interfering with his or her usual classroom responsibilities. With practice, singling out those children who seem to have something wrong with their health becomes automatic.[2] Since the teacher's responsibility in health observation related mainly to the detection of possible deviations from good health and not to the nature of the condition, that is, as Luella Cole puts it, "since she is never concerned with diagnosis, no deep knowledge of medical science is necessary for her to know when a child is not well."[3]

It is appropriate here to clarify what was meant by Wheatley and Hallock when they spoke of "intelligent observation". According to them, the teacher meeting a child for the first time observes only things like his body build

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1 Ibid., pp. 1-2.
2 Health Appraisal of School Children, Op.cit., p. 13.
3 Op.cit., p. 248.

and posture, facial features and expression, the coloring of his skin, hair and eyes, his tone of voice and diction. She gets a first impression according to the child's appearance and manner and their impact upon her own personality.[1] A certain amount of training is necessary for her in order to decide whether the child who is not obviously ill or who has no obvious physical defect, is in fact in need of medical attention. A teacher has to cultivate and acquire the skill of observing what an unmedically trained person can observe. Undoubtedly, it would take her some time before she will be able to practice that active and intelligent observation of which Wheatley and Hallock spoke. According to them, a first step towards that goal of effective observation would be to look just for one thing in the children during a particular day. For example, if one day the teacher looks only for freckles, she will be surprised how quickly she becomes aware of freckles and the pattern of their distribution on the face. Other exercises in observation would be to note the number of children in the class who put on eye-glasses for example, or the number who write left-handed. The next step is to observe unobtrusively individual children for a few minutes each with the object of descriving each child's face, body build and gait afterwards from memory.

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[1] Op.cit., pp. 20-21.

The final step, according to Wheatley and Hallock, would be practice in observation for the purpose of detecting departures from good health; this implies familiarity with normal appearance and behavior. The conception of the term "normal" is based here upon what is strikingly familiar. For example, the ordinary range of height at various ages is quite familiar that we can tell at once whether a person is unusually tall or short for his age. The same is true of weight and body shape. In this manner, according to Wheatley and Hallock, we can depend on what may be called our feeling for normality and tell whether a person is unusually thin or fat, unusually well shaped or misshapen. We also conceive what is unusual in the way of behavior from our experience with the sort of behavior that is conspicuously familiar at various ages.[1]

In observing the child therefore, the teacher can use her familiarity with that particular child's usual appearance and behavior. As Wheatley and Hallock put it, through her daily association with the pupils, the teacher can "treasure her impressions of each child as a picture of health" after careful observation of his appearance and behavior, and that provides her with grounds for comparing him with the picture in which he appears when he returns to school after an illness. For example, how his face looks drawn and tired, how his pink

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[1] Op.cit., pp. 6-7.

cheeks have become pale and clear eyes dull with circles beneath them, and how his happy rested expression has been lost.[1] After a certain amount of training and experience in the art of observation, the teacher can be well depended on to note immediately when something is the matter with a child. Day by day, she can grow in sensitiveness to individual differences that may throw a child far out of line with what one would expect of children of approximately his age in behavior and learning ability.

The two systems of daily observations that elementary schools in Lebanon usually use for appraising the health status of their pupils are the formal and informal inspections[2] the former being the older system that usually takes place at a certain time and a certain place, and which is very likely to develop into a process that is executed with almost military precision. This formal inspection involves looking at hands, appraising grooming, checking for handkerchiefs, and other such factors while at the same time trying to decide whether any youngster is ill. It is usually done in Lebanon by devoting a brief period at the beginning of each day to lining up the pupils either in the courtyard or in the assembly or classroom where they are inspected by the teacher.

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[1] Ibid., p. 7.

[2] Information obtained from the school administrators and educators interviewed.

At the International College in Beirut, the system of inspection is carried on by six classroom[1] teachers during winter. During summer there is no formal inspection, all teachers being expected to be alert to signs of uncleanliness or to symptoms that may indicate diseases. The school has no nurse.[2] Each classroom teacher inspects her class during the first five minutes of the day, and continues throughout the academic year. The inspection is done about twice a week in the courtyard, or in the assembly or classrooms when it is raining. The pupils stand in a line, and they are inspected for general cleanliness. Teachers investigate their nails, handkerchiefs, shoes, hair, face, clothes etc. If they note any sign of uncleanliness or untidiness, they caution the pupil about it if he is old enough to understand, or they give him a note for his parents. On the other hand, if they notice any symptom of an infection or disease such as red or sore eyes, swollen cheeks, coughing or sneezing, they send the pupil immediately to the office. From there he is sent to the infirmary which is attached to the school.[3]

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[1] A classroom teacher is one who teaches the basic subjects like Arithmetic.

[2] Whenever it is felt by the administration that a child needs medical help, he is sent to the A.U.B. infirmary which is attached to I.C.

[3] Information obtained from the elementary teachers at the International College as answers to an oral questionnaire adressed to them on August 22, 1959.

Points of observation that are looked for in formal inspections vary in number from school to school, and sometimes from one teacher to another in the same school. However, in Lebanese elementary schools, these inspections usually include face, neck, ears, hands and fingernails (for cleanliness), shoes and handkerchiefs.

Informal observation of school children on the other hand could take place, according to Wheatley and Hallock, as each child enters the class in the morning and the teacher says "good morning" to him. She can stand with her back to the light and look unintrusively at each child but with a purpose. Just as she notes whether his hair is combed and his face washed, she can make a quick estimate of his facial expression. Is he happy and smiling? or does he look tired or rested? Is his nose "running"? Are his eyes clear and bright or inflamed?[1] A more careful scrutiny indicates those children who may need special observation during the day. However, if she notices signs which in her opinion require the immediate attention of a doctor or nurse, she will either send him to the nurse - if the school has one, or refer him to the office or principal. She will have to follow the method of referral that is standard in that particular school. During the course of the day's activities,

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[1] Op.cit., p. 9.

still according to Wheatley and Hallock, the teacher continues to note things in the appearance or behavior of the children. How is the pupil sitting in his seat? What posture does he assume? How far from his eyes does he hold the book when reading? What does his lunch-box contain? Does he play happily with others or is he always quarrelsome?[1] A few may look sick with pale skin and lusterless eyes or show signs of a cold or even show evidence of pain. Depending upon the problem the teacher will make a mental note of those children who need further observation or immediate referral.

This informal inspection increases the chances that it will become a continuous process throughout the school day, because there is nothing about it to suggest an end of a job done. There are many opportunities during the day when the teacher can practice intelligent observation without its requiring of her extra time and effort. A first grade teacher several times detected children with high fever, simply by touching their hands as she was moving around the class teaching them handwriting.[2]

Although formal inspection has a special advantage in

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[1] Loc.cit.

[2] Information obtained from Miss Muna Khuri, an elementary teacher at the International College, August 21, 1959.

the sense that it gives all children a good opportunity to be observed attentively for about five minutes or so at the start of the day, yet, it is felt that it is not being sufficiently helpful to the pupils in Lebanese elementary schools.

As mentioned earlier in the Introduction, most elementary teachers that are employed in Lebanese schools do not hold more than an elementary certificate in training[1] and have very little knowledge of health matters. That is why a thorough formal inspection - one that requires more than observing nails, handkerchiefs, ears and shoes - would be more helpful and efficient if it were practiced by some trained health officials than by elementary school teachers.

Informal inspection, on the other hand, requires continuous observation from the teacher and constant vigilance concerning the development of suspicious physical symptoms. The fact that the daily health observation or inspection is continuous, and has no end, should be constantly in the mind of every teacher and not only of five or six classroom teachers. When one teacher was asked, in an interview for this study, how often has he detected a developing physical defect in his students during his teaching career at that school, he answered that he never detected anything because the classroom teacher who usually does the inspection twice

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[1] Information obtained from the health officials, educators and school administrators interviewed.

a week, takes the first period of the classes; she detects such things, he said, and there are no defects left for us to look for.

In order to keep her memory fresh on certain points during her continuous observation, the teacher can confer with members of the school - health personnel, i.e. nurse - if the school has one - or the doctor who visits the school and performs the medical check-ups, in order to agree on a method which she can utilize for keeping a record of the general appearance, behavior, learning ability of her pupils, and other characteristics that may prove to be of great help for herself, the physician or nurse, and parents later. According to Wheatley and Hallock, the recorded observations of teachers can be of the greatest help to physicians in making decisions such as, for example, when there is doubt as to the advisability of removing tonsils and adenoids. A history of recurrent colds, earache or ear discharge, frequent sore throats, or swollen glands have direct bearing on the problem. The child's manner and appearance are also important. Persistent mouth breathing, mannerisms suggesting hearing loss, easy fatigability, slowness in gaining weight, and listlessness are among the signs that the medical practitioner will wish to consider in interpreting his findings.[1]

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[1] Op.cit., p. 176.

The content and use of these records vary. However, they would be more valuable if they were designed jointly by representatives of the persons who will be using them - in this case, by the doctor or nurse and the teacher. An example of this is suggested in Chapter VI for Lebanese elementary teachers to use.

In an interview with Dr. Howard Mitchell[1], he mentioned that the details of this "Record" method should be worked out by both teacher and medical practitioner, because the observations recorded by the teacher are wasted unless the physician has them available in conjuction with his own findings, and in a form and degree of comprehensiveness which he considers appropriate. At the same time, when certain policies and practices have been agreed upon by the teacher and nurse or doctor and are well recognized by the teacher, the health observations done by the teacher will be carried out more efficiently.

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[1] Head of the School of Public Health at A.U.B., the interview was in November 25, 1959.

CHAPTER IV

KINDS OF HEALTH PROBLEMS THAT THE TEACHER CAN DETECT IN HER PUPILS

"What symptoms bring a child's illness to your attention?" was an oral question adressed to the seven elementary teachers of the International College, Beirut, in the summer of 1959.

In answer to it, the following symptoms were cited: Red eyes, rash, bad cold, coughing, sore throat, sluggishness, excessive obesity, bad cuts, skin diseases, swelling in the neck, headache, toothache, stomachache, drowsiness, swollen cheeks, vomiting, red spots on the skin, a child who cannot carry his head up and has to put it on the desk, a child who sits in the court without playing, a child who does not pay attention in class but sits quietly, and a child who squeezes his eyes as he looks at the board, or copies numbers incorrectly from his seat.

Each of the seven teachers gave a different set of symptoms that made her suspicious of a condition of ill health in a pupil, Only two symptoms, namely red eyes and coughing, were mentioned by five teachers out of seven. Shortsightedness was mentioned by three.

The school chosen to be asked that question can be said

to enjoy a higher standard of general health than many other private and public Lebanese schools known to and interviewed by the investigator. The A.U.B. Infirmary is just beside the school and is administratively connected to it for health service to its pupils and staff. The general physical examination that is performed at the beginning of each year plus innoculations at times of epidemics - both practices can be said to function in varying degrees in almost all schools of Lebanon. In addition to these, the school asks a dentist to check on the teeth of the pupils and talk about the importance of brusing teeth and keeping them clean.[1] Teachers are also asked to look for symptoms of epidemic diseases. It has been found that every teacher interviewed had had courses in Biology and Hygiene or General Science during high school or during the years of teacher training.

Despite these obvious health advantages in the school, it is still felt that a more extensive acquaintance of teachers with the kinds of health problems of elementary school children is needed.

A child, for example, may have some chronic difficulty that has been existing for some time, but which has gone

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[1] Information obtained from Mr. Najib Hubayka, an elementary teacher at the International College, in an interview, August 18, 1959.

unnoticed or unremedied. An untrained person cannot notice it, or he may think it is a mere personal idiosyncrasy. If the teacher also fails to note the condition, the child may go on for years handicapped by the condition.

Sometimes a child in the classroom makes grimaces and involuntary jerky movements involving the muscles of his limbs and face. The teacher may think that the pupil is making fun of her, but these movements may in fact be symptoms of an acute rheumatic infection called Sydenham's Chorea - "a convulsive nervous disease, especially common in girls and is in many cases either a forerunner of a follower of acute rheumatic infection."[1]

Because of the strategic position that the teacher occupies in health observation of school children and the role that she can play in appraising their health status if able to recognize the signs of illness at their onset, it follows that every teacher should have some knowledge of symptoms of slowly developing defects, and of the commoner communicable diseases and their characteristic features.

Kinds of health problems that the teacher can detect in her day-by-day contact with her pupils - either by direct

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[1] Wheatley and Hallock, Op.cit., p. 162.

observation or by questioning - shall be exposed now. It will be worthwhile to mention here that the reader cannot escape some of the similarities that are found among symptoms of slowly developing children's diseases - a fact that makes the job of the teacher in remembering and recognizing symptoms somewhat easier.

Among the conditions which the teacher may note as she observes her pupils are the following:-

Carriage: All of us can recognize a condition where there is much deviation from normal carriage or posture, especially in the "drooping of the head, rounding of the shoulders or projecting forward at the hips."[1] Posture can be observed consciously or unconsciously by the teacher while the pupils are sitting, standing in line for lunch, during the physical education class, or in the way a pupil wears down his shoes. According to the Metropolitan Life Insurance Company booklet, when not due to inheritance or to some bony deformity, such posture is to be taken either as a sign of fatigue and general weakness or malnutrition. Fatigue and general weakness can be recognized by the teacher when the child has frequent complaints of pains in his legs, or feels tired and seems reluctant to join with other children in activities that

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[1] Rogers, Op.cit., p. 3.

require walking or running.

Malnutrition can be noticed by the teacher as she observes the pupil's general appearance, is he excessively thin or fat? Does he often exhibit signs like a sallow face, dull hair, eyes ringed with shadows, persistent cracking and slight redness at the corner of the mouth? Do his muscles look very thin? Is there no fat between his skin and bones?[1]

Skin, hair and scalp: Parasites may attack a clean skin, causing skin disorders. A teacher should always be alert for the condition of slightly raised reddish scaly spots on the skin of a child, spots which spread later into circular reddish rings of different sizes with a smoother, paler center.[2] Another condition is marked by groups of small or large brownish or yellowish, (usually thick) crusts upon the face, hands or behind the ear.[3] This should be reported immediately by the teacher once detected, since the moist discharges of the crusty sores are infectitious; towels, toilet seats and fingers help to spread this infection to other parts of the body as well as to other persons.[4] Scratching of the skin by a child is a warning signal to which the teacher should also be alert. All conditions like those

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1 Ibid., pp. 20-21.
2 Ibid.
3 Ibid.
4 Metropolitan Life Insurance Company, Op.cit., p. 18.

mentioned may easily be contagious skin diseases.

It should always be kept in mind by the teacher that any skin erruption - a rash, an inflamed skin area, a persistent sore of the skin, habitual scratching and excessive redness of the skin - is abnormal;[1] a medical or nursing authority should be consulted immediately.

Frequent scratching of the scalp by the child should also lead the teacher to suspect that there must be something wrong and that an investigation is needed. Lice, a very communicable insect infection, may be found residing on the head, and their nits or eggs can be seen as oval, gray bodies clinging to the hair, especially behind the ear and on the back of the head. If there happens to be an infected pupil in the classroom, about one third or half of the rest will soon be attached, possibly including the teacher herself.[2] The teacher should also suspect the presence of Ringworm of the scalp, another communicable infection difficult to get rid of, as soon as she finds small or large, nearly bald patches with stubby hair or crusts.[3]

Eyes: "The vision of the school child is of the utmost importance, and the stating of such a truism should seem unnecessary. Nevertheless, this importance is constantly

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[1] Rogers, Op.cit., p. 17.
[2] Ibid., p. 4.
[3] Ibid.

overlooked.[1]

This fact is well demonstrated in cases III and IV of Chapter One of the present investigation. If the teacher had had a good knowledge of the symptoms that a shortsighted pupil may show, she would have been more suspicious and keener in her observations of the pupil's eyesight, and more sensitive to the signs of trouble.

Any of the following observations should make her suspicious of something wrong connected with a pupil's eye or eyesight, and should lead her to take a quick step or action regarding it:

If the pupil

1. Holds reading material very close to or far away from his eyes.
2. Rubs his eyes as if to wipe away a blur.
3. Reads poorly and makes mistakes in letters and figures.
4. Is inattentive during the reading period or while looking at the board.
5. Blinks excessively.
6. Frowns at the book or blackboard and makes errors in reading such work.
7. Leans forward when viewing a work at a distance.
8. Fails to keep up with his classmates in their school activities - both in the classroom and on the playground.

9. Has complaints of headaches, eheache, blurred vision or fatigue of eyes, dizziness.
10. Has red or watery eyes, protruding eyes very sensitive to light.
11. Shows red and crusted lids.
12. Has persistent redness and swelling of the eyeled.
13. Has eye-margins accompanied by the appearance of scaly yellow crusts around the eyelashes.
14. Has complaints of twitching lids.
15. Squints or is "cross-eyed".[1]

In the "cross-eyed" condition, the vision of one eye may be excellent but that of the other is usually bad, and will grow worse unless it is brought into use with the better one. For this reason cross-eyedness should be treated as early as possible.[2] To be sure of the presence of this condition, the teacher can hold an object - a pencil for example, asking the pupil to look at it. If only one eye is focussed upon the object and follows it as it is moved from side to side, while the weaker eye looks in another direction, then the pupil is cross-eyed.[3]

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[1] Information obtained from readings done in Oberteuffer, p. 292, Rogers, p. 8, Metropolitan Life Insurance Company booklet, p. 8.

[2] Rogers, Op.cit., p. 5.

[3] Ibid.

Ears: The teacher may suspect hearing difficulty when any one or more of the following signs or conditions are noted:

If the pupil

1. Asks to have words or phrases repeated.
2. Cocks an ear toward the speaker when addressed.
3. Answers questions incorrectly.
4. Seems to be stupid in understanding instructions or makes many mistakes in carrying them out.
5. Appears to be inattentive to conversation going on about him.
6. Fails to respond when called or questioned and fails to locate the source ofa sound as shown by going in the wrong direction when responding to a call.
7. Watches others before beginning to workd or copies from other pupils.
8. Has a bewildered facial expression that shows he is not fully aware of what is going on about him.
9. Has a look of "watchful waiting".
10. Has a voice that is unnaturally pitched - too high, too low, too loud, or monotonous.
11. Makes poor progress in school and repeats grades, (repetition of grades is on the average directly proportional to the hearing loss).
12. Complaints of earached, buzzing or ringing in the ears, and a hearing of noises in the head.

13. Has ear discharge or has got cotton in the ears.[1]

Dr. Zellweger[2] was quite astonished, and wondered how the teacher had failed to notice that her pupil (case V in Chapter I) had defective hearing, when the pupil, Dr. Zellweger added, must have exhibited some obvious signs that should have made his teacher suspicious of something wrong with the pupil's hearing.

Nose and Throat: The teacher should always note the condition when a pupil has recurrent, long continued cold and persistent or chronic nasal discharge. A pupil may have a running nose and may remain in this condition for a long time. A pupil's running nose may be due to a chronic condition such as sinusitis, or another respiratory infection that demands the quick consultation of a physician.[3]

Other conditions such as frequent nose bleeding, nasal speech, and persistent mouth breating - which the teacher can note while walking among the students in class or standing beside them near the blackboard - are also of importance. Thick speech, frequent sore throat and tonsillitis, also suggest that the troat should be examined by a physician.

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[1] Copied with very slight changes from Wheatley and Hallock, Health Observation of School Children, pp.383-4.

[2] Please refer to case V of Chapter I.

[3] Metropolitan Life Insurance Company, Op.cit., p. 13.

Mouth and Teeth: The teacher should be on the lookout for decayed and carious teeth, uncleanliness of teeth, irregularities or deformities of teeth or jaws, inflamed bleeding or ulcerated gums, sores in the mouth, cracking of the lips and the corners of the mouth. If the teacher finds that a pupil normally has a breath of foul odor, she should ask the nurse or doctor to take a look at him. The source of cause of that odor should be discovered in a tactful way, whether it be the mouth, nose, or alimentary organs.[1]

The Neck: Enlarged lymph glands constitute the most frequent abnormality in the region of the neck. The enlargement happens often because of decayed teeth and diseased tonsils. These glands may get enlarged and appear as lumps on the side of the neck; and a child with such glands should receive a thorough medical examination. Another gland which may become abnormally large is the thyroid gland - a gland consisting of two lobes lying at the base of the neck; the enlargement of either or both lobes is known as a goiter and it demands immediate attention and medical examination.[2] Sometimes enlarged glands of the neck are a sign of Tuberculosis or even mark the start of Hodgkin's disease[3]- a malady of the lymph nodes of the neck.

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1 Information taken from readings in Rogers, pp. 5-6, and Metropolitan Life Insurance Company, p. 31.

2 Rogers, Op.cit., pp. 5-6.

3 Information obtained from Dr. Firzley in an interview, May 16, 1959.

The Chest: A teacher cannot be expected to examine the lungs of a student, but she can note the presence of a chronic cough, or whether a child's breath is abnormally fast, especially after slight exertion as when playing or walking upstairs. The child may be weak because of recent recovery from an illness, but otherwise, there may be something wrong with the organs of respiration or of circulation.[1] The teacher should be alert to report such signs as, breathlessness accompanied by bluish lips and fingernails and excessive pallor.

There are some conditions which teachers often tend to neglect or overlook, for example cold hands, which may indicate poor circulations or poor nutrition, as well as poor interior classroom heating; and frequent requests of the child to go to the bathroom, which may indicate a glandular disturbance[2] or some other abnormal condition - including psychological.

Epileptic children should also be recognized by the teacher and helped, after consultation with a medical practitioner. A pupil who suddenly drops his head in class and then supports himself may very well be sick with the "petit mal" - a kind of epilepay.[3]

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[1] Rogers, Loc.cit.

[2] Information obtained from Dr. Zellweger in an interview, May 5, 1959.

[3] Information obtained from Dr. Firzly in the May 16, 1959 interview.

There are also other distrubances which the interested teacher can hardly escape noticing such as nail biting, involuntary movements, speech defects and tantrums; however, they are often passed over as something for which there is no remedy. General restlessness is not a normal state though its cause may not be known or evident to the teacher. Frequent requests to leave the room should make the teacher suspicious of some abnormal condition.[1] Each of such cases should be studied or referred to someone who may know more on the subject.

Communicable Diseases

The common communicable diseases are most readily transmitted in the earlier days of their onset.[2] It should not be difficult for the teacher to recognize their onset after having become familiar with the physical appearance and behavior of her students and after knowing the general symptoms of these diseases. Some of these infectious diseases like measles, scarlet fever, mumps and smallpox most often affect vision; measles, scarlet fever and smallpox are also causes of deafness.[3]

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[1] Rogers, Op.cit., p. 11.

[2] Ibid.

[3] Encyclopedia of Educational Research, Op.cit., pp. 843-4

According to Rogers[1], besides the signs of listlessness, weakness, drowsiness, a flushed or swollen face, frequent sneezing, a running nose, red and watery eyes, coughing or vomiting, that generally characterize communicable diseases at their onset, there may be complaints of headache or of chilliness, and an eruption may appear on the face, neck or arms. However, it is easier for the teacher to recognize a specific disease, especially at the time of an epidemic, if she is familiar with the notable symptoms of that disease.

Measles: Cold in the head, sneezing, running nose, red and watering eyes, cough, fever.

Scarlet Fever: Vomiting, sore throat, fever, a fine scarlet rash appearing within 24 hours on the neck, chest, arms and to some extent on the face.[2]

Diphtheria: There may be vomiting or a chill or even only a state of complete exhaustion. The throat may be complained of. There is fever though it is not usually high; and sometimes there is a watery nasal discharge irritating the upper lip[3].

Tonsillitis: Sore throat, high fever usually with chilly

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1 Op.cit., p. 15.
2 Ibid.
3 Ibid., p. 16.

sensations, complete exhaustion, very inflamed throat and yellowish spots may be present on the tonsils.[1]

Smallpox: Chill, fever, backache and usually nausea and vomiting. The eruption appears on the second or third day. Symptoms of the disease may be very mild and not easy to diagnose.[2]

Mumps: There is a swelling of the gland in front of and below the ear, or a gland below the jaw on one or both sides; there is pain in this region particularly on swallowing, and general signs of illness.[3]

Chickenpox: An eruption of separate, red and raised spots appearing usually first on the forehead. There may be a slight raise in temperature, backache, headache, but other symptoms are slight.[4]

German Measles: In about fifty per cent of cases there is no fever. The first symptom of the disease is the eruption of separate spots of a deep pink color appearing first on the face.[5]

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1 Ibid.
2 Ibid.
3 Ibid.
4 Ibid.
5 Ibid.

Colds: Some early symptoms of the contagious diseases are much the same as those of the common cold which is also highly communicable. What seems to be the beginning of "only a cold" is often the onset of something more dangerous to the child and other pupils. That is why the coughing and sneezing child is likely to be better off at home until he recovers.[1]

Whooping Cough: Begins with an ordinary cold and a dry, hacking cough gradually increasing in severity. Inflamation occurs in or near the windpipe and causes violent and strangling attacks of coughing ending up in a loud, harsh vibrating "Whoop". It is an acute contagious disease.[2]

The communicable diseases which have been mentioned are most contagious in their earliest stages, before the eruption appears, and chiefly through the discharges from the nose and mouth - though they may be transmitted through some intermediate object which the sick child handles.[3] Hence any child with the above symptoms or complaints ought to be kept away from others in order not to spray them by talking, coughing or sneezing until a nurse or physician sees him. If neither nurse nor physician is available, then the teacher

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[1] Ibid., p. 17
[2] The Book of Health, Op.cit., pp. 66-7.
[3] Rogers, Op.cit., p. 16.

should take the responsibility of seeing that the child is sent home accompanied by a teacher. A child who seems sick has no business at all in the school, especially if he shows any indication of fever such as pallor, chilliness and shivering, or flushed skin and lauguor, drowsiness or restlessness.[1] Such signs and symptoms may or may not be accompanied by others like vomiting, nausea, headache, earache, or aching in the limbs and back, running nose, sore throat, sneezing, red watery eyes, or tight dry cough.

The look that we have taken at the health problems that have been listed according to medical and educational authorities as the most common in childhood is by no means a complete review of all the ills to which the teacher should be sensitized. Nevertheless, knowing from knowledge and experience what can be expected of healthy children in a certain age group in the way of appearance and behavior, it is hoped that the teacher will be guided by the remarks and points of observation that have been mentioned in order to be more alert to deviations from the average or normal.

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[1] Wheatley and Hallock, Op.cit., p. 112.

CHAPTER V

SOME SCREENING TESTS THAT THE TEACHER CAN PERFORM AS PART OF HER APPRAISAL

"Screening tests as part of health appraisal are preliminary evaluations of the state of various body organs and their growth function, most often of vision and hearing, performed by teachers, nurses or technicians in order to screen out those children needing further examination and diagnosis by specialized health service personnel."[1]

Screening tests are highly desirable for the following reasons:

A. Moderate hearing impairment in both ears and severe impairment in one ear may exist without the child, parents, or teacher (despite her observation) suspecting that a problem exists.[2]

B. Not all children who need the help of an eye specialist will show obvious signs of visual difficulty, especially those pupils whose visual impairment is still in its first stages, or beginning in one eye only. For this reason, it is

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1 Joint Committee on Health Problems in Education of the NEA and AMA, Op.cit., p. 16.

2 Joint Committee on Health Problems in Education of the NEA and AMA, School Health Services, (the Association: Washington, D.C. and Chicago, Ill., 1953) quoted in Health Appraisal of School Children, Op.cit., p. 22.

necessary to test the vision of all children and to check whether the glasses are worn always, whether the frames are adjusted properly and the lenses kept clean.[1]

C. Body measurements are useful for checking up on a child's nutritional status and rate of growth in height and weight. It is quite impossible for the teacher to find out whether a child fails to gain weight over a period of three months during his growing years without measuring his height and weight. Failure to gain in weight can be a serious sign. It is also necessary to detect those pupils who are much "overweight" or "underweight", both signs indicating that something may be wrong with their health.[2]

D. Following the tests, not only can the teachers have a certain amount of understanding of a child's visual problem for example, but she would be better able to participate actively in the follow-up program, that is, the counselling program as it relates to helping children obtain needed treatment and corrections.[3]

Chapter III of this investigation has discussed a major

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1 Metropolitan Life Insurance Company, Op.cit., p. 8.

2 State Superintendent of Public Instruction, Teacher Screening and Observation Manuel, (Raleigh, North Carolina, 1954), p. 16.

3 Joint Committee on Health Problems in Education, School Health Service, quoted in Health Appraisal of School Children, Loc, cit.

part of the teacher's role in appraising the health status of her pupils played through daily observations and inspections. But no matter how skilled such observations are, screening tests serve to complement them. Through their utilization, one can approximate a high degree of screening out or identifying those pupils who need medical attention and corrective treatment.

In schools that do not have a nurse or health counselor, it is very appropriate for the elementary teacher to assume the responsibility of performing some simple screening tests for her pupils.[1] However, for the successful accomplishment of this job, two conditions must preside: the first condition requires that the teacher and school doctor meet and agree regarding health observations which the teacher is competent to make and to keep records of. They should also agree about such screening tests for the purpose of children's health appraisal as the teacher can best make. Chapter III has touched upon the fact that in order to secure more efficient observations, and for the purpose of an appropriate follow-up later, there should be an agreement between the teacher and the school medical practitioner on certain aspects of health observation so that the doctor or health counselor will be ready and willing to accept from the teacher her observations and such other remarks as she may make regarding the health

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[1] Ibid., p. 19.

of her pupils.

In the same manner, screening tests are only successful if the teacher, and school administrator agree on certain screening procedures and the manner of recording them. A teacher may screen out many students with eye trouble for example, or find many pupils who in fact do not need medical help. If there has been no previous talk and agreement between teacher and doctor, the latter may refuse to accept her screenings.

The second condition demands that ample extra time be given to the teacher once she is asked to perform those screening tests. A teacher who has a heavy and overburdened program cannot be expected to perform these tests efficiently and thoroughly or to give them due attention and consideration. It might be found by the school health personnel and the administration that the most suitable time for the performance of these tests would be between the school terms. However, any other time could be chosen, provided the teacher who has to do these tests will have enough time to perform them, record their results and confer with the responsible member of the school's health personnel.

The screening tests that shall be discussed in this Chapter are those designed to identify children with impairments of vision and hearing and those which measure the child's

growth in terms of height and weight. They are chosen because they have been rated and discussed in books by educational and health authorities as the most frequently used screening tests. They are both important and practicable; and do not consume a great deal of the teacher's time if she has enough training in them.

Vision Screening

Vision screening tests are not intended to diagnose the nature of eye defects or disclose all vision problems. The screening device that shall be discussed now in general, the "Snellen 'E' Chart" test, does not test for farsightedness or those who have difficulty seeing close up.[1] It only determines whether a child can see a standard size symbol at a distance of twenty feet (6.1 metres).

According to an article written by Blum et al on "Design and Evaluation of a vision Screening Program for Elementary School children"[2], a three-year study of the vision status of approximately 1,000 elementary school children in America was completed, and different screening procedures including the Snellen "B" chart test, were compared with one another and against clinical examinations. The results were compared with

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[1] State Superintendent of Public Instruction, Op.cit., p. 15.

[2] American Journal of Public Health, 49:12, December 1959, p. 1670.

professional opinions obtained on a nation-wide questionnaire.

It was found that the Modified Clinical Technique, refined at the University of California School of Optometry, and which includes visual acuity is the most efficient econo-mical procedure for testing vision; and has the fewest over - or underreferrals. The Snellen E test was found to miss approximately three-fourths of the correct referrals, but this figure includes errors made on "the safe side", and is therefore not as damaging to the Snellen Test as many appear at first glance.

Thus the Snellen "E" chart test is suggested for utili-zation by the teacher in Lebanon. The Modified Clinical Technique procedure cannot be practiced nowadays here due to the lack of necessary equipment and trained personnel. The Snellen "E" chart test is recommended in its place since it is cheap, easy to operate, easy to administer, and does not take more than an average of about one minute per child.[1] One teacher in every school can be trained how to use it if the school has no nurse.

It has also been found after interviews made with Dr. Murphy and Miss Prager at the UNRWA section[2] and Dr. Bshir

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[1] Joint Committee on Health Problems in Education of the NEA and AMA, Op.cit., p. 46.

[2] Interview was made in February 17, 1960.

a well-known Lebanese optician, that the Snellen "E" chart test is the most widely - used and popular device utilized in Lebanon for testing vision. Dr. Bshir[1] said that, if accurately employed, the "E" chart test should give valid results. Pointing at a sample of the chart made of plastic, Dr. Bshir continued saying that for the past years they had been purchasing cheap cardboard charts, but they found that they get torn and worn out very quickly; recently, they have been asking for charts made of plastic. "Although they are more expensice (about 20 Lebanese pounds each) he said, "We have found out that they last much longer, and practically every school in Lebanon can afford to buy and keep one of them, since it is impossible for any teacher to make one of them herself." These charts are obtainable at almost all optician's shops or places in Beirut.

Hearing Screening

As has been mentioned earlier, moderate hearing impairment in both ears or severe impairment in one ear may exist without anybody, even the teacher (despite her observations) suspecting it; for that reason hearing tests are important.

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[1] Information obtained from Dr. Bshir on February 18, 1960.

Hearing acuity is best evaluated with the pure-tone audiometer.[1] However, it requires adequate training and experience on the part of the teacher.

The Social Health Center in Beirut recently brought one from the United States, but has not used it yet.[2] At this writing they are still waiting for a specially trained person to teach them how to use it.

According to Dr. Mitchell[3], since the audiometer test is the only accurate hearing test that diagnoses hearing losses in various frequencies and at various intensities, health and/or education departments in Lebanon should buy and keep some of these audiometers in order to loan them to schools that cannot afford to buy them. One audiometer could for example be used by a number of schools in one community so that every school need not buy one. They could even ask for a specially trained person to teach one of its teachers how to use it. This person could be a special supervisor or consultant in hearing testing.

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1 Ibid., p. 46.

2 Information obtained from Mrs. Akra in an interview July 20, 1960.

3 Interview was on Februaty 16, 1960.

Weighing and Measuring

Children are usually very interested in their growth and the changes found when their height and weight is measured periodically. The measuring and weighing that is performed usually at the beginning of each year during the medical check-up is not enough for elementary school children. Good practice is to weigh and measure children three times - at the beginning, midpoint and end of the school year[1] and this job is often the duty of the teacher.[2] Measuring height and weight at certain intervals, plus the teacher's subjective estimate of the nutritional state of the children can well serve in getting medical attention for children who need it and in furnishing motivation for improving health practices.[3]

In weighing, the child is asked to remove his coat and shoes and he is recorded to the nearest one fourth kilogram and one-half centemeter. For measurement, the child is asked to stand naturally with his head, back and heels against the wall. A book placed on the top of his head against the tape and wall, will serve to indicate his height.[4]

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1 Ibid., p. 25.
2 Wheatley and Hallock, Op.cit., p. 62.
3 Joint Committe on Health Problems in Education, Loc.cit.
4 Ibid., p. 13.

Children are usually tempted to compare their measurements with one another. The teacher shouldplace emphasis on the individuality of the child and on his present measurements in relation to or compared with his previous measurements. Rate of growth is not constant; however, children who lose weight or show no gain in weight over a period of three months should be referred to the physician for investigation of the reason.[1]

It should be agreed between the teacher and doctor or nurse as to the manner of recording the data. It can either be recorded on the child's health record, or in tables, or even on physical growth charts that show average or normal growth patterns.

Other tests and check-ups are sometimes performed during the year like checking the teeth of the children. Only periodic examinations by a dentist can discover dental defects and repair them in time before they seriously decay and give the foul odor to the mouth which a teacher can sometimes smell. Dental defects are very difficult to note or detect in their early corrective stages, especially defects in the molars or back teeth.[2] If a school does not have periodic check-ups by a dentist, then it would be the teacher's job to encourage

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[1] Joint Committee on Health Problems in Education, Op.cit., p. 25.

[2] Metropolitan Life Insurance Company, Op.cit., p. 10.

the students to visit the dentist periodically and be under his supervision, especially when the sixth-year molars are coming in, so that weak spots or surface cracks in the enamel can be discovered and quickly repaired.[1] The teacher can emphasize the importance of teeth and their regular checking by a dentist, while performing the daily inspections or the less frequent screening tests. She can also go a bit further and make the child understand that what he eats plays a big part in keeping his teeth and gums healthy. She can from time to time talk to her pupils about the different kinds of food they should eat every day like milk, eggs, meat, cereals (Humous, Burghol etc.), fruits, vegetables, butter, fish - liver oils - such materials that are needed for good health and growth. She can make them understand that if they eat too many sweet foods - tooth decay may develop - and that sweets may keep them from being hungry for the kinds of food they need more.[2] At the same time, she can tell them to be careful about cleaning their teeth. None of this requires a wide knowledge of hygiene or nutrition. However, a bit of common sense on the teacher's part is necessary in order to bring out such facts as pupils ought to consider. It does not demand appreciable extra time, and does not mean that the teacher must be designaged as a special teacher of Nutrition, Hygiene or General Science.

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[1] Ibid., p. 11.
[2] Ibid.

CHAPTER VI

STEPS TO BE TAKEN BY TEACHERS AFTER DETECTING DISEASES OR DEFECTS IN CHILDREN

The appraising processes so far discussed include continuous teacher observation of the child's appearance and behavior, the notation of any changes, periodical weighing and measuring, and screening tests for vision and hearing. Three important considerations should be kept in mind by the teacher who has utilized these practices:

1. Every pupil who in her opinion shows signs of a general or local ailment should be referred by the teacher to the proper person in the school-health-service set-up; it could be the nurse if the school has one, the physician who visits the school, or the responsible administrator.

Since most elementary schools in Lebanon do not have a nurse, it is normally the duty of the teacher to refer every sick child to the administrator, who in turn would refer him to the physician who visits the school. However, many Lebanese elementary schools do not even have a physician who visits them. In this case, the administrator should see that the child is sent home to his parents. On his return to school, it would be the administrator's duty to ask for a note from the child which says that he has fully recovered and which may contain come suggestions and recommendations from the physician consulted.

2. It is not for the teacher to determine whether a child has a particular defect or disease. According to Rogers[1], the teacher may have her opinion as to the nature of the case, but the responsibility for diagnosis rests entirely with the physician chosen by the parents of the child in question. Even a school physician (unless his responsibility is broadened to include treatment), can only recommend to the parents that they seek further professional study and advice. The teacher can only determine whether the child shows signs and symptoms which make it advisable that medically trained authorities be consulted.

3. "Teachers have neither the legal nor the moral right to label a difficulty."[2] To label a condition differentiated from all others including many similar conditions, requires great skill and much experience and can only be performed by a medically trained person. According to Rogers, a teacher does not have to decide whether a child has adenoids if she notices that he cannot breathe through his nose, she can only report the condition and not label or diagnose it. At the same time, she does not need to know whether a pupil has myopia or a damaged cornea (and should avoid giving an opinion about it), but she needs to be certain that he holds his book too close,

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[1] Op.cit., p. 14.
[2] Oberteuffer, Op.cit., p. 211.

or that he frowns at the blackboard and makes errors in reading such work.

Upon seeing a rash, a teacher may be tempted to label it "measles". However, her cooperation is most helpful when she sticks to descriptions of symptoms or deviations from normal and describes them to the person responsible in the school-health-service set-up.

Another fact to consider is that not every case suspected and referred by the teacher is appropriately taken care of, nor is the treatment recommended for it always carried out. There are times when the responsible school officials or the parents, or both, are reluctant to do something about a case that has been referred by a teacher. The two cases that shall be mentioned now, and which were related by a teacher in a leading preparatory school[1] in an interview on January 13, 1960, illustrate this. The school has no nurse. Teachers are asked to refer the students whom they suspect as having health problems to the office of the administration. Their cases are then looked into and sent to an infirmary. If the child has paid a hospitalization fee at the beginning of the year, the infirmary takes care of him. If not, he is sent home with a note for his parents suggesting medical help.

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[1] The reader may contact the investigator if he desires further information.

Case IX. A boy of about fourteen years of age seemed not to hear or understand what was discussed in the classroom. He frequently said to the teacher "What, Sir?" The boy was moved to the front of the class but still seemed to that teacher not to hear what was said. He was reported to the office, but nothing happened. After reporting him the second time, a member of the school office staff came and told the teacher that he met the boy and spoke to him. He also said that the boy understood well and heard what was spoken to him. However, the teacher still thinks that the boy has a hearing defect; and he himself does not have the power to refer the boy to the infirmary. The school had no parent - teacher meetings[1] the teacher said (this was confirmed by 6 or 7 elementary teachers), so that the boy's case could be discussed with his parents, nor does it have a nurse or special physician that visits it. He had dropped the boy's case since he had neither the means nor the time to follow it up.

Case X. Around the beginning of the year, a boy of about twelve or thirteen years old was suspected by the same teacher of having a visual defect. After sending him to the office and finding out that the office did nothing

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[1] They had parent-teacher meetings only for the sixth high; this year however, they began to having them for all classes. (1959-1960)

about it (probably because he had not paid his hospitalization fee at the beginning of the year), that teacher sent a note to the boy's mother in which he told her that he thinks her son has eye-sight trouble and needs to be seen by an optician. Again, nothing happened. After sending the second note, the boy came to the teacher and told him that his mother was meaning to take him to the doctor. Only at the end of that year did his mother take him to a doctor who gave some pills to take. At the beginning of the next year, the boy, again that teacher's same student, was still having to sit at the front of the class, and was still seeing practically nothing on the board. He was still taking the same pills which had been prescribed by his physician.

Towards a more successful follow-up programs

Health appraisal is itself only a means to an end. It should be followed up appropriately by teachers, parents, and school doctors or nurses, each supplementing the other so that, according to the Joint Committee on Health Problems in Education of the NEA and AMA, their united effort will permit those children with remediable defects to be restored to good health. Those whose defects are not remediable can thus be helped to compensate for their defficiencies and enabled

to benefit more from their educational experiences.[1]

Follow-up is necessary since all appraisal procedures - observations, screening tests, medical and dental examinations are all wasted and ineffective unless children with defects or who need professional services receive the necessary treatment and correction. "It is a waste of time, and poor health education, to continually screen and examine children and each year record the same untreated and unremedied defects."[2]

For the purpose of a successful follow-up scheme in Lebanese elementary schools, the following factors should be considered:

A. There should be a clearly established channel through which the teacher knows what the doctor or nurse who visits the school or else the physician consulted by the parents recommends and suggests regarding the health of the child whom she refers. Such a step is important because:

1. The teacher will have a better understanding of the child's needs as outlined by the physician when the child returns to school; and, according to Wheatley and Hallock, she will be able to cooperate intelligently with the parents and physician in carrying out plans for the child's welfare.[3]

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[1] Op.cit., p. 7.
[2] Ibid., p. 50.
[3] Op.cit., pp. vi-vii.

2. A teacher can do a great deal in encouraging and helping pupils to do what the doctor recommends; she can also be a useful agent in changing some of their health habits when there seems to be need for improvement.

3. According to Rogers[1], even after a treatment of a defect is carried out, it may not mean that the child will be cured. For example, even when the child gets properly fitted glasses for his defective vision, he may not be able to work as easily with glasses as a child does with normal eyes. He may for example need to be placed where there is a very good light on his work or where he can see the blackboard more easily.

4. Sometimes a child is not fully recovered, but is thought by the physician to be better off in school than at home. The teacher should know about such a child so that she can do her best in protecting him from overexertion[2], permitting him periods of rest and not letting his school work become a source of worry to him.[3]

Thus for the above reasons, it is desirable that the teacher know the conclusions of the physician or nurse who visits the school in each case she refers. At the International College, the administration informs the teacher of

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1 Op.cit., p. 14.
2 See case VI in Chapter I.
3 Ibid., p. 16.

the school or infirmary physician's suggestions if there are any that the teacher should know.

There are times when children, after check-up, are discovered to have diseases that require the teacher's daily observations and remarks. That is why it is always advisable for the teacher to write down her remarks about any condition and observations of certain children whom she suspects as having a disease or defect. The administration could in this case prepare certain cards in the following manner and distribute them among the teachers:

Pupil Health Report Form

Name of the pupil:_____

Grade:_____

Date:_____

Hour of day:_____

Remarks of the Teacher:

Signature of Teacher.

Remarks and recommendations of the Physician:

Signature of Physician.

In case a school is not visited by a doctor or nurse regularily; the administrator should ask for the remarks and signature of the physician consulted by the parents.

Such cards would be passed by the teacher to the administration after remarking on them as soon as she suspects of a case of illness or disease and finds it necessary to refer it. Such cards would again be passed by the administration to the school or parent's physician.

Because teachers should know about the physician's remarks and recommendations in any given case, it is the administrator's duty to inform them of it through meetings with them. Often such health problems could be discussed in Teacher-Meetings.

B. "Teacher-Parent" conferences or meetings are necessary. These could be done periodically - at the time of the physical check-up and as the need arises for them. After the physical check-up, teachers can greatly help the administrator in carrying the school physician's remarks and suggestions to the parents in case there are any pupils who need further check-up and treatment. Through meeting with the parents, teachers can stimulate corrective or preventive action. Through showing their interest in the child, they can lend influence in overcoming any reluctance of parents to have their child examined or treated by their physician. If we refer back to

case X in this chapter[1], one can easily note that if there had been Parent-Teacher-Meetings at I.C., the boy with the defective eyesight could probably have received a corrective treatment before the time he actually received it.

Another purpose of these conferences, is for the teachers to help parents in poiting out to them places to go for treatment of their children, in case these parents are poor. The administrator may know of some physician who can treat children with little or no charge whatsoever. At the same time, teachers may ask the parents to contact the Ministry of Health where they may get help for their children free of charge.

However, it should not be forgotten that whenever it is felt by the teacher, administrator or both that there is a need to confer and meet with the parents in order to discuss things connected with the health of a child, or whenever the teacher needs to secure information from the parents regarding the physician's recommendations for their child(if the physician was not the school physician), a meeting should at once be planned by the administrator and teachers and held with the parents.

However, teachers and the administrator often meet the difficulty that parents are reluctant to be present at such

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[1] Refer to p. 71.

meetings and often do not attend them. In this case, it is the duty of the administrator to ask the child's teacher to home visit the parents. He can organize a suitable time for this and make transportation available. These meetings with the parents would serve as a bond between the teacher and the parents. Through the exercise of a little tact, much can be accomplished towards getting the child to have the medical attention he needs, or securing the treatment recommended by the school physician. The teacher can make the parent understand that she is coming to cooperate with the parent in planning for the child's welfare; and if necessary she can, within certain limits, change the child's educational program to fit his health needs as outlined by the physician.

From what has been mentioned so far, it is clear that the school administrator plays a major role in the development of the school health program. He can collect observations from teachers, nurse, physician, and pass back the physician's recommendations to the teachers. Besides doing this, he can provide time for Teacher-Meetings and Parent-Teacher conferences, and arrange time and transportation for teachers to make any needed home visits. He can encourage the discussion of health problems in Faculty Meetings and create the special environment for it. His interest, cooperation, and active participation are very important for the effective functioning of a coordinated health program for the

school children under his administration.

However, no matter how capable the school administrator is in health appraisal matters, he is handicapped without a nurse or physician visiting his school. Interviews with some administrators reveal that there are still some schools, even in Beirut, that are never visited by a nurse or physician. In this case, it is really the duty of the Ministry of Health to contribute funds for the training of trained nurses to go around visiting schools and helping teachers to become aware of proper health appraisal processes. Teachers will then refer to these nurses only those pupils whom they suspect of having a disease or defect. The Ministry of Health can also appoint and pay a few doctors to perform medical check-ups in the schools which are not visited by a special physician. Representatives from the Ministry of Health would also check and see if these exams are actually done, and properly performed.

Conversations with the elementary teachers interviewed, the encouraging reception exhibited by them in welcoming every opportunity to broaden their understandings of children's health needs, and the enthusiasm they showed in describing health problems which they succeded in detecting, - all these leave a striking impression that teachers are increasingly realizing the role that they can and should play in the

field of health appraisal. It is hoped that the suggestions given in this study will serve to act as an incentive for teachers and administrators to go on and explore other possibilities for improving health appraisal and follow-up procedures.

If even one Lebanese child gains a better chance for a full and productive life through the influence this study may have, it would have been more than worth the time and energy expended upon it.

RECOMMENDATIONS

Up to this point, the thesis has confined itself to the teacher and what she can do. This section is devoted to recommendations for administrative and governmental actions which are believed to be most likely to further the aim of improved health appraisal in the elementary schools of Lebanon, at least expense and with speediest effect.

Recommendation I: Elementary Teacher-Training in Lebanon, be it in high schools, colleges or universities, should include in its curriculum a course in school health. In addition to it, the Ministry of Health and Ministry of Education should provide for some filmstrips on the subject of health appraisal, which show signs and symptoms of ill-health that the teacher ought to look for in her pupils. These filmstrips could be imported from the United States or some other place where they have a variety of them, and shown, together with appropriate comment and discussion, to the students of teacher-training as a definite part of their program. These filmstrips however, could also be shown to elementary school teachers since most of them do not have training pertaining to school health. These educational filmstrips would be welcomed as a break in the regular routine for them, and at the same time, teachers would improve in the recognition and retention of signs of illhealth as

as they see them in pictures.

Recommendation II: Nursing-Training in Lebanon is necessary because of the lack of properly trained nurses. There are still many schools in Lebanon especially in the rural areas, that are not visited by a physician or a nurse. It would be the job of the Ministry of Health to make resources available to train enough nurses so that every school may be visited not less often than twice a week. These nurses would report to the Ministry of Health the cases that need the treatment or consultation of a physician, and the Ministry in turn would send the physician needed. The nurses would also perform vaccinations, screening tests and health observations of pupils. They could also train the teachers to help them in the tasks of screening, health observation and appraisal of the pupils.

Recommendation III: The Ministry of Health should make money resources available for some doctors to perform medical check-ups for elementary pupils in the schools that do not have a special physician. A doctor and a nurse could be appointed for every 2500 pupils in order to perform such check-ups about two or three times during the elementary school years.

Recommendation IV: Conferences held (prefarably during summer or school vacations) by educators and medical practi-

tioners[1] should be encouraged in Lebanon. The Ministry of Health and the Ministry of Education should share the expenses and supply resources for such conferences. All Elementary teachers in Lebanon should be required to attend at least one of them and share the activities and ideas supplied through the various lectures given in these conferences.

Recommendation V: The Ministry of Education should make resources available to the school administrators, and require them in turn to make a certain amount of the time of their teachers available for health appraisal activities and home visits.

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[1] Refer to page of chapter I.

APPENDIX A

Oral Questionnaire Addressed to the Elementary Teachers in International College, Beirut.

1. Name
2. Nationality
3. Years of experience in teaching
4. Years of teaching at I.C. Which classes do you teach?
5. How much training in health have you had at school? At University?
6. Do you meet with parents in order to discuss health problems of your students? Yes ____ No _____ If yes, how often? _____
7. Do you discuss health problems in faculty meetings? Yes _____ No _____. If yes, do you have definite times for the meetings? If yes, is a member of the medical profession present?
8. Do you have a nurse or other health facilities here in this section of I.C.?
9. To whom do you refer cases of illness?
10. Do you have any system of personal health inspection that you practice on your students? How often? ____ Describe what you do.
11. Have you had any cases when you discovered that the physical state of a certain pupil was affecting his performance

in classroom? If yes, give details.

12. As an average, about how many times a week have you detected illness in a child? What symptoms bring illness to your attention?

APPENDIX B

Oral Questionnaire Addressed to Thirteen School Administrator in Beirut and Choueifat May 20, 1960:

1. Is your school a boarding one? Do you have a school doctor, is he with a contract?
2. Is there a school nurse, an infirmary? What do you do when you have pupils with contagious diseases?
3. Who is responsible for noticing and reporting health problems?
4. Do you feel that teachers are the proper people to notice and report health problems?
5. To whom are cases of illness referred?
6. Do you have any idea regarding any specific previous training in health that your teachers have had in their schools?
7. Do you have children in your classes who ought to be wearing eye glasses and they don't?
8. What regular checks to you perform on your pupils? Is this done at the beginning of each year?

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