Health

The provincial level health practices to be discussed in this section are the community health teams, the health scouts and the social health insurance program. In passing, the barangay health workers, botika ng barangay, inter-local health zones, RN HEALS and essential health care package will also be mentioned. A photo-documentation of health care facilities (hospitals, rural health units and barangay health stations) will close this section.

As will be seen in the succeeding pages, the health related best practices to be discussed originated from elsewhere and were adapted by the municipalities of the province after they were fine-tuned by other municipalities, provinces and national and international agencies. What will be contributed here are the glimpses of the infusion and formation stages, which are usually not discussed when established best practices are presented. Externally generated ideas are not usually immediately absorbed by local decision makers and practitioners, and thus management of initial resistance shall be noted.

Community Health Team

Background

The Mountain Province community health team (CHT) concept is based on the women's health team (WHT) of the DOH/World Bank project on Women's Health and Safe Motherhood, the UNFPA-initiated Barangay Health Committee and the barangay council for the protection of children as found in Art. 87 of PD 603 and Art. 53-55 of RA 8980. It is to some extent, influenced by the Ifugao Ayod community health team concept, especially in its health-related functions.

On March 16, 2006, the DOH and JICA agreed to provide technical assistance to the Maternal and Child Health Project (2006-2010) in Ifugao and Biliran. The JICA-MCH project adopted the WHT concept to strengthen the capability of the local government to deliver quality women's health and safe motherhood services. The WHT is headed by a midwife stationed at the barangay health station and is assisted by a barangay health worker, barangay nutrition scholar and traditional birth attendants, among others, depending on the community. The municipal health officer supervises the teams. (*See Annex H-1.1 for a more extensive discussion of the WHT.*)

The WHT in Biliran was organized in November 2006. The formation of WHTs in the municipalities of Mayoyao, Aguinaldo and Alfonso Lista in Ifugao followed afterwards. The WHT in Ifugao eventually became the Ayod CHT after the governor signed EO 22 on April 22, 2008. Aside from the functions of the JICA-MCH initiated WHT, the Ayod CHT also subsumed the functions of the GFMC initiated Barangay Action Team (Malaria and Dengue) and the UNFPA-initiated Barangay Health Committee. The Ayod CHT added the barangay captain, the barangay kagawad on health and male volunteers to the composition of the team.

The Ayod CHT is envisioned to evolve into a do-it-all community health organization assuming expanded tasks and functions on health programs. Beyond maternal and child health concerns, the Ayod CHT assumes other tasks such as community health education and promotion, malaria prevention, and reproductive health advocacy. Shared responsibility between men and women is emphasized. (*See Annex H-1.2 for a more extensive discussion of the Ayod CHT.*)

After witnessing the Ifugao experience, Mountain Province created the Pinagpagan Health and Social Services Team via EO 2, s. 2009. This is a convergence of all programs to include health, nutrition, malaria action, council for protection of children and the alternative learning system. This provincial program is implemented down to the municipal and barangay levels. Originally, the separate programs were handled by separate teams, committees or councils. Since they all cater to the same clientele, a merger was but logical and cost-efficient, especially at the barangay level. The inclusion of the council for the protection of children also made sense since the

UNFPA program included tackling of violence against women and children (VAWC) as a component.

At present, with the change in administration, health practitioners are now favoring the use of the neutral term 'community health team.' The councils for the protection of children are also being reactivated, so in the provincial level at least, the merged team seems to have reverted to their original states. The succeeding section then presents how community health teams in Mountain Province address the health concerns of children aged six and below.

Best Practices

The CHT requires the barangay officials and local health practitioners to engage in coordinated local health planning and implementation. Previously, the BHW directly works under the technical supervision of the municipal health officer and interaction with the barangay captain is minimal. Thus, barangay health concerns are not given much attention come budgeting time. With the CHT in place, the local decision makers are more involved in the delivery of health service, and are thus expected to be more supportive of the local health needs.

Pregnancy Tracking. CHTs conduct pregnancy tracking by assigning a member to become a "family partner" to ensure that there is individualized, sustained, and focused health care for the pregnant mother and infant. Prior to the introduction of the team concept, BHWs have already been keeping watch of pregnant women in their localities. But after the activation of CHTs, monitoring of BHW performance is now given stronger emphasis. Since they conduct home visits together with local officials, they are more likely to do their tasks more thoroughly. If local officials in a particular community do not participate in the rounds, at least stronger inquiry is done during quarterly meetings.

Follow-up Visits. BHWs are required to take the blood pressure of parents and weight of the children. In case the clients are not around during the first visit, the BHW concerned will have to make a second visit to ensure 100% coverage. In the provincial reports, a lower capture may be noted because a deadline has to be met in the submission of papers. But eventually, all clients are monitored as reflected in barangay level reports.

Local Health Planning. With the barangay captain and the barangay kagawad for health going with the BHW during home visits and community rounds, they become more aware of the health needs of their constituents. As a result, some barangay officials have:

- allocated a percentage of their annual budget for weighing scales, BP apparatus, medicine, and minor repairs of the BHC; and/or
- increased honoraria of the BHWs.

Thus, the CHT concept has encouraged the BHWs to perform better on the one hand, and made the local officials to be more supportive of local health practitioners on the other hand. Poor performance, if at all, becomes more noticeable on both the side of the BHW and the local officials. In worst cases, it would mean having to replace the BHW, or having to choose another candidate come next election time. Such cases would occur for the sake of providing better health service for the barangay.

On the positive side, more local actors involved in health matters means more likelihood of having healthy parents, grandparents and older siblings. And when primary child care providers are healthy, they are more able to take care of the young children.

External Assistance during Activation Stage. The introduction of new activities that take up time and effort are oftentimes met with resistance, more so if the costs are handled by the target actors themselves. By tapping external assistance for pens, paper, snacks and meals during the initial assessments and rounds, participants are more likely to be less resistive. Once the concept is internalized, they are more likely to conduct the activities on their own as they want to impress the other barangays during the accomplishment sharing. As they gradually see the importance of their meetings and rounds, they would eventually find a way to insert the costs in their annual budget.

Sharing of Accomplishments. Once a year, health teams from each barangay gather to share their accomplishments. To shorten the sharing period, the barangays are grouped into three or four, taking into consideration that high performing barangays are paired with low performing barangays. This way, low performers are encouraged to do better next time and high performers, in turn, are given a virtual pat in the back. The sharing also makes it easier for one barangay to replicate good practices of the other.

Challenges

Lack of Funds. Much of what is discussed in this section is based on the Sagada experience. The municipality is a UNFPA supported area, and the success of the initial stages of CHT activation is attributed mainly to the availability of funding for the municipal level quarterly and annual meetings. Other municipalities may have CHTs that are not as active as that of Sagada.

CHT and Family Planning. Sagada is predominantly Episcopalian (Anglican), a church that leaves the decision-making regarding family planning to the husband and wife. Since CHT involves activities related to family planning education, there may be stronger resistance in predominantly Roman Catholic municipalities. This paper did not examine the CHT experience of Besao, which is also largely Anglican.

CHT+CCT Beneficiary Monitoring. There is some resistance from the BHWs who have to do social welfare related monitoring when they are health practitioners. The resistance became more felt when they were tapped to monitor the conditional cash transfer (CCT) beneficiaries. The CCT beneficiaries are given incentives to motivate them to avail of the services of the local health practitioners, among others, while the BHWs are given additional work to monitor them with no incentives to be given in return. Some of the identified CCT beneficiaries are better off than the BHWs assigned to monitor them.

Addressing Infant Mortality. Together with the upgrading of health facilities, the CHTs can help in addressing infant mortality. For Mountain Province, the causes of infant mortality are shown below:

Causes of Infant Mortality, Mountain Province (1994 & 2009)

1994	
Causes	Number
Pneumonia/ Bronchopneumonia	9
Prematurity	4
Placenta Previa	2
Malnutrition	2
Severe Asphyxia	1
Septicemia	1
Septic Shock	1
Meningitis	1
Liver Disease and Cirrhosis	1
Unknown	

Source: PHO, Mountain Province

2009	
Causes	Number
Pneumonia	8
Prematurity	7
Neonatal Sepsis	6
Asphyxia Neonatorum	3
Accident – Vehicular Fall (All Types)	2
Congenital Anomalies	2
Neonatal Tetanus	2
Unknown	2

Source: PHO, Mountain Province

Health Scouts

Background

The Mountain Province Health Scouts are children who are either grade 5 or 6 pupils or first year high school who address some of the health concerns of their peers and other members of the community. Since the DepEd has only one physician for the whole division and a limited number of school nurses, a mechanism similar to the barangay health workers has to be put in place at school and the community, where the children spend most of their time. This time around, the actors are also children. The health scouts concept is very similar to the Child-to-Child Approach (*see Annex H-2.1*), the Bulilit Health Scouts (*see Annex H-2.2*) or the Little Doctors and Nurses of the school nurses. There are existing health scouts in Bauko and Sagada. On the ground, this approach is very much interconnected with the Teen Health Quarters (THQ), which is a center-based approach. The health scouts allocate some of their

free time for THQ duty, but should do their role anytime they are needed at school or in the community. The health scouts are supervised by the school nurse at the school and community level and by the Provincial Health Office and DepEd Division health arm at the provincial level. Bontoc had health scouts in the past, and were supervised by the municipal RHU personnel.

To become health scouts, prospective children must undergo a series of training-workshops covering the following topics, among others:

- Health and Nutrition
- Adolescent Reproductive Health
- Environmental Sanitation
- Drug Abuse Prevention
- First Aid

Trainings are conducted after school hours. Some facilitators who do not reside near the school (e.g. 1½ hours walk away) and find it difficult to conduct trainings after class hours may do so during weekends.

Best Practices

In actual practice, health scouts are able to provide service to young children under the following instances:

In the community

- Health scouts able to help midwife/BHW bring young children to the health center, or in the case of home visits, locate where young children are residing, or in case they are not at home, where they usually are (during mass vaccination, mass weighing).
- Health scouts alert the midwife/BHW in cases when they are needed.

At home

- Older sibling who is a health scout may help in cooking meals, and may suggest what meal can be prepared, taking into consideration proper nutrition requirements.
- Older sibling baby sits younger child.
- Older sibling alerts parents in cases when they have to address some health concerns. Older sibling may also alert midwife/BHW in case the parents are not around.

At school

- Health scouts are responsible for cleaning the restrooms.
- Health scouts are the first responders when accidents/ emergencies happen at the playground or inside the classroom.
- Health scouts alert the school nurse in cases when they are needed.

Their future families

- As future parents, health scouts they would be more prepared to handle home-based care for their children.
- Health scouts would be able to see the importance of starting a family at a much later date and avoid teenage pregnancies.

Facilitators' Idea Exchange. The modules provided to the facilitators were rather long and detailed. The facilitators sought each other's help on how they could simplify the lessons.

Fund Raising. In Ankileng National High School, vendors allowed to enter the school are required to pay fees. Previously, the collection was handled by the student body organization, but is now being handled by the health scouts. The collection will be used to buy cleaning materials for the restrooms.

Scheduling of Activities. Routine activities are scheduled so as to distribute tasks and responsibilities (such as cleaning of restrooms and collection of fees from vendors). The schedule is then posted in an area where all can see.

Challenges

Pesticide Use vs. Organic Farming. Health Scouts are strong in Bauko, an area known for the production of temperate vegetables. The challenge for them and their facilitators is to promote organic farming and the reduction of pesticide use.

Curriculum Integration. Topics covered during the training of health scouts are not yet fully integrated in the curriculum. The challenge is already spelled out in Sagada's Reproductive Health Code IRR: to integrate all topics in all subject areas of the curriculum in the intermediate levels of elementary education, all levels of secondary education and in the alternative learning system (ALS).

Stronger Involvement of Elementary Pupils. The current emphasis of health scout training is on the high school students. Little or no trainings were done with elementary pupils yet. The Bulilit Health Scouts module (*see Annex H-2.2*) serves as an example of topics that could be handled by grade five and six pupils.

Peer Counseling. Several incidents led to the training of peer counselors in the schools of Mountain Province: the mass hysteria in Bontoc, the landslide disaster in Kayan (Tadian), and the death of a child caused by another child while at school in Baguio. While this program could stand on its own, it could be integrated with the health scouts program so as to identify and spread specialists from among the scouts, instead of a few getting all the advanced trainings and in the end getting all the pressure and fatigue as well.

Social Health Insurance Program

Social Health Insurance Program (SHIP), also referred to as alternative community health insurance, exists in some municipalities of Mountain Province. SHIP encourages parent-members to avail for themselves or their children of inpatient or outpatient hospital services or seek consultation from the rural health physician since the costs, or part of it, will be refunded. Three municipal level programs will be discussed here: the Besao Og-gbo for Health, Sagada Health Insurance Program and Paracelis Peso for Health. The portions of the Children's Code of Sabangan and Tadian pertaining to a health care financing program shall also be presented towards the end of this section.

Background

In the Philippines, the Bukidnon Health Insurance Program started in 1994 with an annual premium payment of P720 per member that can provide members and their beneficiaries with free consultation, medicine, laboratory and diagnostic tests, dental services, doctors' fees, and hospitalization expenses. In one year, a family can avail of medicines amounting to P1,500, laboratory and diagnostic services of up to P500, hospital expenses of up to P5,000, and dental services amounting to P500. (PIDS 1998)

Meanwhile, Peso for Health, another health insurance scheme, took flight in 1995 in the Guihulngan District Hospital of Negros Oriental. The scheme provided three brackets to choose from. For Bracket A, households can become members by paying a membership fee of P10 and contributing one peso per family member each month thereafter. After six months or when the equivalent amount has been paid, members are eligible for a benefit package that includes up to P200 worth of medicines and a percentage discount in laboratory and diagnostic services during hospitalization. The Bracket B benefit package requires a monthly contribution of P5. In return, members can avail of up to P1,000 worth of drugs and medicines and a percentage discount on hospital services. Outpatient services with up to P100 in medicines can be refunded. Bracket C requires a monthly contribution of P10 with a corresponding P2,000 worth of medicines for in-patients and up to P200 for outpatients as benefits. (PIDS 1998)

Initially only Bracket A was available and outpatient services weren't covered. The project holder also saw the importance of transferring the operations to the rural health units to make it community-based (PIDS 1998). When the Bayawan District Hospital/ Sta. Bayabas Inter-Local Health Zone of the same province adapted the scheme, it included outreach services in the micro-insurance benefits. The Bukidnon and Negros Oriental experiences eventually reached Mountain Province.

Besao Og-gbo for Health

The initial plan was to set up a program that covered the Besao-Sagada district health zone. It was called the BeSag Social Health Insurance Program (*see Annex H-3.1*). The plan required the Sagada MLGU to contribute a larger sum, since accordingly, the Besao District Hospital admits more patients from Sagada, and they are the ones that use up the medicines of the facility. Stakeholders from Sagada resisted the idea since their municipality will be giving more funds to a hospital that is located at another town. With their local chief executive willing to give more than what was being asked, they decided to manage their own health insurance program.

Besao then came up with Besao Og-ogbo for Health, which was registered with the SEC on December 17, 2003 (CN200324725). After the MOA signing with the mayor, a subsidy of P20,000 for that year was approved by the Sanggunian. The counterpart from each barangay would be one peso per individual. A membership fee and monthly dues were to be collected from interested members. Those with no visible source of income will pay a P20 one-time membership fee and P10 monthly contributions. Those who have a regular source of income will pay a P20 one-time membership fee and P20 monthly contributions.

Meanwhile, the Besao Multipurpose Cooperative also started its own Social Health Insurance (SHI). Probably started a little earlier than Og-ogbo, it targetted co-op members only. With its limited potential membership and no external source of funds to augment members' contributions, it was bound to face rough sailing. Their scheme was also too good to be sustainable -- membership claim was per individual, so if one member maxed out his claims, his wife may still avail until she also maxes out for the year. In the end, the cooperative faced a smaller membership with more disbursements per household and saw a loss of funds.

Sometime September 2007, Besao MPC SHI and Og-ogbo agreed to merge. With the merger, the co-op took care of membership records, collection of premiums and refund disbursement. Meanwhile, the hospital took care of identifying which prescriptions could be reimbursed and approving and recording of approved claims. The merged setup efficiently divided the tasks according to expertise and distributed workload between the partner agencies, but took too many steps and was rather tiring and cumbersome for the client. The client, who is also the patient or is taking care of a patient, has to go to the hospital billing section to submit prescription and official receipt. After the hospital personnel approval, the approved claim is recorded, then a note is made on the official receipt indicating amount of refund. The client then goes to the co-op to claim the approved amount. There is still a possibility for the client to return to the hospital (say, to look after the patient). This situation is prompting some decision makers to think that reverting back to the original setup might be better for those being served. All funds, tasks and records will be with Og-ogbo, Inc. through the hospital. The co-op could still serve as a depository facility.

As the Besao Og-ogbo for Health undergoes organizational changes to be able to address its clientele better, it continues to make improvements in other aspects of the program. The table below illustrates the difference of how it started and its standing as of the end of 2010.

Year	2003	2010
Maximum Annual Benefit	P500	P1,500 inpatient or P800 outpatient
Municipal Subsidy	P20,000	P60,000
Barangay Subsidy	P1 x NSO population	P5 x NSO population
Active Members	437	486

Source: Besao Og-ogbo for Health.

The barangay level details of the *og-ogbo* will be discussed in the Besao municipal sub-section of this chapter.

Sagada Health Insurance Program

Sagada had a community-based health insurance scheme prior to the attempt to activate the BeSag Social Health Insurance Program. Its membership was limited to the health practitioners and some mothers. Since it had no external support, the most remembered use of funds was only for the cost of syringes and needles for hepatitis vaccinations.

Upon the introduction of the BeSag SHIP, the mayor at that time pledged a support of P240,000 a year plus mandatory and higher monthly contributions of municipal and barangay officials and employees. The individual contribution of the mayor was P1,000 monthly. The strong support of the mayor was one main reason why Sagada decided to manage its own health insurance program – the Sagada Health Insurance Program (SHIP).

The Sagada experience is somewhat opposite that of Besao. With the succession of other mayors, the municipal contribution went down (currently half the original at P120,000). The new officials also resisted the mandatory contributions and opted not to join the program. From a membership of over 1,000, SHIP has now only about 750. Not withstanding the disappointing changes, SHIP still continues to serve its catchment area. Members can avail of refunds up to P700 for outpatient services and medicines or P1,000 for inpatient services and medicines. There is a maximum of P100 refund per prescription.

Sagada offers lower benefits and stricter rules compared to Besao. Those involved with the SHIP are a bit concerned about Og-ogbo's capability to sustain the benefits it offers. The Sagada populace, meanwhile, is seen by outside observers as *managsakit* (easily gets sick). If true, then its colder temperature is partly to blame. That, or they are less hesitant to seek medical help. The first hospital in the province, afterall, is built in Sagada so its population has a longer history of interaction with doctors.

Paracelis Peso for Health

In Paracelis, the insurance program used the name Peso for Health but offered a scheme much closer to the social health insurance mechanics. There is a one-time membership payment of P20 and then annual dues of P250 per household (regardless of household size). Households can then avail of medical assistance at P750 for outpatient and P1,000 for in-patient services.

In its Municipal Children's Code (Art 2, Sec. 6.3), Paracelis recognized the importance of the Peso for Health program:

> The Municipal Government shall ensure the availment of health services and shall regularly allocate funds for drugs and medicines to provide quality health services more accessible.
>
> The Peso for Health Program developed for the municipality shall be institutionalized in the district hospital. Peso for Health Program is a community ownership, management and accountability by the people themselves. It is cooperative endeavors whereby healthy people help sick people get well. It enhances community empowerment and participation to care for ones own health (a concrete example of health in the hands of the people"). The Peso for Health Program shall help address the inadequacy of funds for health through the continued contributions of each member. It promotes community empowerment through partnership and participation while expanding health insurance coverage to every family member.

Sabangan

In Sabangan, Art II, Sec 6.4 of their Municipal Children's Code institutionalizes Peso for Health and the PhilHealth Indigency Program:

> The Municipal Government through its Municipal Health Office shall ensure the accessibility, affordability and availability of quality health services for the people. The same shall endeavor to make the Rural Health Unit Philhealth accredited and finally be certified Sentrong Sigla. This will ensure the quality of health services.
>
> The Municipal Government shall continue allocating funds for the enrollment of indigent families under PhilHealth. The Municipal Health Office shall endeavor to improve its existing Peso for Health Financing Scheme.
>
> The Municipal Government shall endeavor to provide all Barangays a Barangay Health Center where adequate health services will be served.

> The Municipal Government shall continue to support the PhilHealth Indigency Program and shall endeavor to increase enrollees until universal coverage is achieved.

Tadian

In Tadian, Art II, Sec. 14.7 of their Children's Code states that:

> The Municipal Government through the Municipal Health Office must come up and institutionalize a health care financing program to augment the capability of the local government to make health services more accessible to the people. It shall foster community and people's ownership, management and accountability. The program must also in the form of cooperative that enhances community empowerment and participation that expand health insurance coverage to every family member.

It continues with Sec. 14.8 emphasizing that "the municipal government shall ensure the allocation of fund for Philippine Health Insurance Corporation PHIC for qualified indigent members."

Best Practices

Social health insurance is a field tested best practice that evolved elsewhere before it reached Mountain Province. The contributions, therefore, of the municipalities are minor tweaks that made the introduction of the innovation easier to absorb.

Local Branding. Since the social health insurance program was developed elsewhere, there is a need to increase acceptance through enculturation. The program was related to *og-ogbo*, which is similar (but collection is done only when there is a need to extend help to someone who is already sick). The promotional brochure was written in English and the vernacular, making it easier to understand and more connected to the local culture.

Ownership. The activation of the program required the acceptance of the decision-makers to support the project. The inter-local setup was rejected, but municipal level support became stronger. Thus the sense of ownership became more pronounced

Challenges

Local Social Health Insurance vs. PhilHealth. The social health insurance program was intended to make district hospitals more accessible to the community in terms of costs involved. Support from local chief executives weakened with the introduction of the PhilHealth Indigency Program. Elective officials could now gain political mileage by distributing PhilHealth cards containing their name and signature. Since local social health insurance was intended as a complementary service to PhilHealth, it now took a few steps backstage as PhilHealth gained more reach, taking the

limelight once again. Since PhilHealth cannot address all patients' needs, there is still a need for local social health insurance programs to exist.

Outreach Services. While the local social health insurance was able to provide inpatient and outpatient benefits, outreach services were not mentioned. Thus, clients living far away from the hospital or RHU may not be able to utilize the services of the doctors. Outreach services needs to be tied in with the social health insurance so that professional health practitioners do not merely wait for patients to arrive; doctors and nurses must also find time to make their services available to communities where there are members paying for the social health insurance.

Other Best Practices

Barangay Health Workers (BHW). The BHWs have been institutionally recognized nationwide as the front liners of health service delivery, but much has to be said yet about the progress of the local governments in recognizing their valuable contribution through the establishment of barangay health centers and the augmentation of their honoraria, among others. This has been partially touched in the discussion of CHTs, yet there is a need to further highlight the changes through the years, much like the discussion of day care centers and day care workers in the next section. As this concern does not fall under the scope of this documentation, the challenge lies in succeeding research endeavors.

Botika ng Barangay. Botika ng Barangay was seen as the instrument that could champion herbal medicine, generic drug and rational medicine use in the communities. In these aspects, it is considered a failure. But some Botika ng Barangay continue to thrive and gain financial success. With its presence in the far flung communities, the BnB, as a community-based drugstore, has somehow made medications more accessible. Stripped of its original mandate, however, it runs the danger of peddling *magic* pills instead of being an instrument of real and inexpensive health care.

In Mountain Province, the role of the Botika is important in making the necessary medicines available within the municipality. The central *botikas* of Besao, Sagada and Paracelis are important in complementing their active social health insurance programs.

Inter-Local Health Zones (ILHZ). ILHZ is a scheme that enables agreements between municipalities and provinces to tackle health concerns in a coordinated manner. This is especially important in providing financial counterpart to district hospitals. In the Philippines, such concept started in Negros Oriental as Inter-LGU Health Systems even before DOH national office starting piloting the ILHZ.

In Mountain Province, the failure of the BeSag Social Health Insurance Program shows one example of the difficulty of making LGUs help each other in the area of health. On the other hand the inter-local agreement between Ifugao and Mountain Province for simultaneous fumigation to combat malaria shows how the concept can succeed in this part of the Philippines.

Registered Nurse for Health Enhancement and Local Services (RN HEALS). With the oversupply of nurses in the Philippines, the RN HEALS (previously called NARS) was designed to give opportunity for nurses to gain experience by serving in a hospital setting for six months and in a community setting for another six months. Together with the CHTs, RN HEALS assisted mobilizations for mass immunization and weighing were able to reach more target clientele.

Essential Health Care Package (EHCP). The EHCP is discussed under the social welfare section for day care centers and the education section for kindergarten and grade one pupils.