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HEALTH EDUCATION FOR SCHOOL-AGE CHILDREN:

THE CHILD-TO-CHILD PROGRAMME

School Health Services
by

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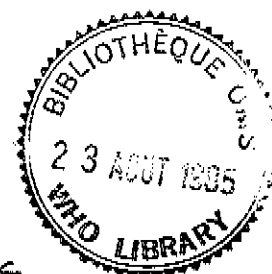
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Health education for the school-age child is a specialized field within the broad discipline of education. There is therefore a professional view of this field, a view which recognizes and seems perhaps to be unduly coloured by a number of important difficulties in the way of integrating health education into established school curricula. This being so, it is worth emphasizing that the author of this paper is not a professional educator but an academic paediatrician whose professional experience has been divided equally between India and the United Kingdom. He writes therefore as one still free to hold the naive conviction that there is an enormous and largely untapped potential for health education among children. At the same time his life-long experience has been one of frustration that educational doors have remained for the most part closed to the bright (sic) ideas germinating in the minds of health workers having a concern for children.

One project in which the doors between professional educators and child health workers have been conspicuously open is the CHILD-to-child Programme. This paper describes the origin and development of this Programme, and reflects on the lessons to be learned from this experience.

The original idea was Professor David Morley's. He had observed infants and young children in Nigeria and other developing countries, and had been struck by the fact that they spent much of their lives in the care of older brothers and sisters. He had himself documented the causes of the appallingly high disease and death rates among these young children. He knew the stark simplicity of the measures which could change this pattern. He believed these older sibling childminders could usefully be taught simple facts about common disorders, and that this new knowledge would bring direct benefit to their young charges, and would indirectly inform their families and communities. He shared these ideas with colleagues in education, who immediately recognized their potential. The further development of these ideas was the product of close collaboration between the two relevant departments of the University of London Institutes of Child Health and of Education, The Tropical Child Health Unit and the Department of Education in Developing Countries respectively.

Development was achieved through what were called conferences but were essentially workshops. The participants in these were staff from the two University Departments together with invited experts in health and education from both developed and developing countries. Multidisciplinary teams constituted in this way met over a period of several weeks to share ideas in free discussion, to prepare teaching material, and to suggest ways of encouraging the use of this material through the developing world.

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The evolution of the Programme can be considered under the three broad headings of:

1. What to teach
2. How to teach
3. How to promote the Programme

1. What to teach. The selection of topics to be taught was based on two broad considerations, their importance in the hierarchy of health problems in the community, and particularly their relevance to the health of young children, and the extent to which there was a realistic role available for a primary school-age child to play in relation to the problem. Ideas initially recommended were grouped under five headings:

- (a) Eating well
- (b) Children as health workers
- (c) Providing a healthy and safe environment
- (d) Children growing up
- (e) Stimulating younger children

Under each of these headings a number of separate projects were identified and developed into teaching material in a form now called Activity Sheets (AS). These were intended for use by primary school teachers, either unchanged or after local adaptation.

Under each heading specific projects were identified as follows:

- A. 1. How do we know if our children get enough food
2. More healthy food for our babies

(Point 1 was later modified to focus more precisely on the assessment of malnutrition by the use of the Shakir strip).

- B. 1. The home management of diarrhoea
2. The care of teeth
3. Children as health scouts
- C. Accidents and their prevention
- D. Observing growth and development
- E. 1. Playing with babies
2. Toys and games

In the light of further experience other AS have been prepared. A full list of the currently available AS appears in Appendix I.

The AS have been prepared specifically for the primary school-age child, and have focused on topics which are likely to fall within the experience of this age-group and which lend themselves to constructive activities. Topics are practically rather than academically orientated. They contribute to the educational objective of a curriculum in which classroom experience relates to the life of the community, but they make little or no concession to the views of parents with more traditional academic aspirations for their children. These traditional aspirations have to some extent been met by a set of English Language Readers developed by the Programme. These are stories written by professional teachers with Third World experience. Each story incorporates a health theme. The language is tailored for reading level 1 (vocabulary 500 words) or level 3 (1500 words). The seven titles are listed

in Appendix II. The subjects covered include water, food, child development, accidents, the management of fever and a role for children. The Readers are usable immediately at the appropriate level in an English medium school or when English is a second language, at a later stage. Alternatively, they can be translated and used at the appropriate level in the local language. Whether in English or local language, the readers can be used in formal class work, or alternatively be kept in class or school libraries for use in free time.

2. How to teach. The AS have been prepared on the assumption they would normally be used by a primary school teacher, but they could of course also be used by youth leaders, health workers, members of women's groups etc. The sheets provide the essential factual information on the subject. They also suggest relevant activities in which to involve children in school, at home or in the community. For example, in measuring malnutrition children can be shown in class how to make a Shakir strip, and then after measuring each other under supervision, be encouraged to measure siblings at home. Other suggested activities include drama, role playing, composing songs, and more ambitiously the conduct of specific surveys. Role playing can be invaluable in deepening children's understanding of the feelings of, for example, a child with a handicap such as deafness or a leg paralysed by poliomyelitis. Drama and song can be most effective in driving home essential facts about specific diseases, good and bad health practices, and the resources available in the local health services.

Considerable thought has been given to the approach to teaching, and guidance is available on this in the book "CHILD-to-child" edited by Audrey Aarons and Hugh Hawes (MacMillan 1979). These authors emphasize the importance of teachers perceiving their role as helping children to help each other and to help their communities. They suggest that in playing this helper role, teachers need to explore with children what the needs, problems and priorities in their community are, to talk over together ways of meeting these problems using what is already available, to have a sympathetic understanding of other people's feelings and views, to design activities which will help, will be acceptable, and which can be easily undertaken, and to be constantly ready to improve programmes in the light of experience gained. Although the AS have been developed particularly for primary school teachers and can be used by them in school without reference to or dependence on health or community services there can be no doubt that active collaboration at local level between health and education workers will enhance the effectiveness of the Programme. Mothers (and grandmothers) may be resistant to new ideas on health practices brought home from school by an eight-year-old child; their resistance is more likely to be overcome if they hear the same ideas in a mothers' group from a community health worker. Moreover health activities organized for children outside school are much more likely to relate to current problems and to make a real contribution to the health of the community, if planned jointly by teacher and health worker. This last point has been clearly recognized by doctors and other health workers across the world, so that many good CHILD-to-child projects have in fact been initiated by health workers rather than teachers.

Finally there is the important and difficult question of how to teach the school-age children who do not attend school. The size of this group varies from country to country, from community to community within countries, and from one age-group to another within communities. These children who are not attending school fall into at least five distinct categories:

1. Children who remain integrated in their family and who are engaged in organized labour. (As an example in Bombay 25% of school-age children are in this category. Usha Naidu, personal communication.)
2. Children who are engaged in some aspect of the home economy (e.g. minding cattle or a younger sibling).
3. Children, particularly post-pubertal girls, for whom the long walk to school is deemed hazardous.
4. "Refugee children" who are part of large societies disorganized by major catastrophe.
5. The "street children" of large cities who have lost contact with family and adult society and live precariously in mutually supportive groups.

These five groups together comprise a substantial proportion of all Third World school-age children. For varying reasons they are more or less disadvantaged. Health education on the CHILD-to-child model would often be relevant to their needs. But each group has its own characteristics and depends for help on special provision outside normal services. Such help is often through voluntary agencies, many of which are familiar with CHILD-to-child material, or through large-hearted individual members of local community groups, many of whom have found CHILD-to-child material helpful.

3. How to promote. At the first working conferences on the CHILD-to-child Programme it was recognized that implementation of the Programme was going to depend on local initiative. The Programme has maintained an office in The Tropical Child Health Unit in London, with a part-time Director, and a full-time Secretary. Programme material has been distributed by this office. The material was sent initially to all anglophone developing countries with encouragement to use it or to adapt it freely to suit their needs. The Programme was launched in 1978/79 in the International Year of the Child. Material was therefore sent to IYC Committees with the expressed hope that these would set up national coordinating committees. Material was also sent to Ministers of Education and Health and in some instances of Agriculture and Community Development. The TCHU had a large mailing list of those engaged in the teaching, training and practice of primary and community health care in developing countries. Material was sent to all on this list as well as to voluntary agencies engaged in such work. The British Council distributed material through its network of offices.

The Programme's strategy was to make its teaching material and ideas as widely known as possible and to be ready to respond to any request for more material. Every encouragement was given to translate the material and to adapt it freely for local use. Feedback reports were requested and some have been and continue to be received. But reporting has never been made a condition for receipt or use of Programme material and knowledge about the way the Programme has developed in different countries is patchy and incomplete.

A formal evaluation of the Programme was made in 1981. One thousand six hundred questionnaires were sent out; 219 were returned of which 113 were completed and related to CHILD-to-child activities. These established that the Programme was active in at least 57 countries in seven broad geographic regions of the world. Forty per cent of respondents had initiated activities on the basis of written information received from the London office. Fifty per cent had received material by post from outside their own country. In 87% of instances projects had been initiated by more than one type of professional: nurses, doctors, primary school teachers and health educators were most frequently involved, in that order.

In countries where the primary school curriculum is planned nationally, initiative for the introduction of CHILD-to-child material has to come from within the curriculum planning body. This was the pattern achieved in Brazil, by Mrs. Maria Dantas, a Professor of Education who took part in the original CHILD-to-child conferences. She started by presenting CHILD-to-child ideas in national ministries of health, education, agriculture, justice and social welfare and also to university teachers. These ideas were welcomed by teachers as a "break-through" in the process of making formal education both practical and relevant. CHILD-to-child material was translated into Portuguese and published by the Federal Department of Education. Seven AS were selected, Accidents, Diarrhoea, and More Healthy Food for Babies having the highest priority. Later three further AS were produced on Malaria, Chagas' Disease, and Trachoma for use in areas where these diseases were endemic. The book CHILD-to-child was translated and five thousand copies distributed. A good television programme highlighted the "invisible force" released when children adopt an adult role. Regional workshops for pre-school education helped to spread knowledge and understanding of CHILD-to-child ideas. Lines of communication to all levels of formal education and also to interested non-governmental agencies were established. A national team visited states to take part in local workshops with teacher trainers, writers, curriculum designers, local administrators and supervisors. In this way a massive momentum was generated which might well be deemed a model for other countries. Nevertheless it has proved difficult to assess teachers' and pupils' attitudes to these new ideas, and firm data on the numbers of schools, teachers and pupils using them are not available.

Interdisciplinary workshops, either national or more local, have proved extremely useful in promoting the CHILD-to-child Programme in a number of different countries. Sixteen such

workshops have so far been conducted. Success depends on achieving the active participation of workers from both health and education and from both high level administration and community level practice. An influential political presence is invaluable. Such representation is unlikely to be achieved without very effective local leadership together with careful joint planning by the local leader and Programme staff in London. These workshops have two broad objectives, first the adaptation and development of teaching material for local use, and secondly the planning of its introduction into schools or for use of children not attending school. The first activity is fun and generates understanding of the Programme's potential and general enthusiasm, but this enthusiasm can be rapidly dissipated unless implementation follows. The latter depends critically on senior administrative and political presence with the power to translate ideas into action.

Discussion

From the way in which the ideas embodied in the CHILD-to-child Programme have been received and implemented in some 70 countries in the developing world, there can be no doubt of their essential rightness and practical value. Nevertheless it would be helpful to know in much sharper detail how the Programme has fared in different countries, and so be able to identify more confidently the ingredients of success. The need for this information is well recognized. A study of all country reports on file, backed up by field observation of selected programmes would make a good educational research project and would be likely to yield the sort of information required.

There is obvious scope for extending very much more widely the use of the teaching material at present available. Through liaison with the International Catholic Child Bureau, the Programme has been introduced this year by Dr Lucien Michon into francophone West African countries. Further extension of the Programme will be best accomplished through national workshops. One is planned for Bombay in 1986. A substantial increase in the number of workshops undertaken would require an enhancement of resources available to the Programme. The present teaching material needs to be reviewed and updated. A recent very successful workshop in Ahmedabad, India revealed the need for a revised AS on the Evaluation of Malnutrition, and for new AS on Water, Immunization and Worms.

CHILD-to-child clearly has an important role in the massive task of health education in developing countries to which the world is now committed. It is hoped that this conference will help to define more clearly how this role should be played.

APPENDIX I

Some activity sheets that are available from CHILD-to-child:

Shakir strip
Our babies growing up
Playing with younger children
Toys and games
More healthy food
Care of children with diarrhoea
Our teeth
Health scouts
Our neighbourhood
Accidents
Handicapped children
Understanding children's feelings
Looking after eyes
Let's find out how well children see and hear
Caring for children who are sick
Early signs of illness
A place to play
Helping the severely deaf child
Growing vegetables in containers
The management of little children's stools

Titles in the CHILD-to-child Reader series:

Accidents
Dirty Water
A sad story
A simple cure
Good food
Teaching Dani
The Answer team
Down with fever

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