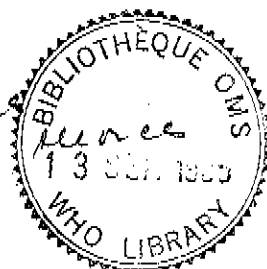




JOINT WHO/UNICEF INTERNATIONAL CONSULTATION
ON HEALTH EDUCATION FOR SCHOOL-AGE CHILDREN

Geneva, 30 September - 4 October 1985

*Health Educ
Child Health Service
School Health*



THE CHILD SURVIVAL AND DEVELOPMENT REVOLUTION
AND THE HEALTH EDUCATION CHALLENGE

A UNICEF issue paper

UNICEF

[School-age children in school are usually exposed to some hygiene and health education. Out-of-school children of the same ages may receive virtually no health education. The CSDR strategy offers an opportunity for energizing health education for young people both in- and out-of-schools. This paper examines health education problems and options for both of these populations from a CSDR perspective, not ignoring that the non-formal education needs are greater than the needs in formal education.]

A strategy and an objective to improve dramatically the prospect for survival and health of children in developing countries - called in short-hand the Child Survival and Development Revolution (CSDR) - were articulated by UNICEF about three years ago.¹ Two basic features of CSDR have profound implications for health education in general, and its specific aspects, such as health education for school-age children. These two features are: first, CSDR is based on the premise of certain technological breakthroughs in health care and parallel important developments in social organization; and second, the primary health care (PHC) approach provides the context for CSDR implementation.

Two legs of CSDR

The programmatic strategy of CSDR stands figuratively on two legs:

- (a) Some recent breakthroughs in health techniques make it feasible to apply measures on a mass scale in respect of several widely prevalent health hazards of children. The technological developments are in the areas of immunization (more heat-stable and easily administered vaccines), diarrhoea management (oral rehydration therapy), growth monitoring (effective use of simple growth charts), and infant and child feeding and weaning (evidence of the efficacy of breastfeeding and indigenous weaning foods).
- (b) Changes in socio-political environment in developing countries represented by enhanced potential of mass communication and education (expansion of mass media, literacy and primary education); greater acceptance of the participatory ethic in development (recognition of community role in primary health care and the deployment of hundreds and thousands of community health workers), and the recognition of the political benefits of widely affordable and applicable health measures and the possibilities for social mobilization for this purpose (the role of social, cultural, political and religious organizations and the potential of collective and individual self-help).

¹ James P. Grant, "A Child Survival and Development Revolution", Assignment Children, No. 61:62, 1983, pp. 21-31.

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted, quoted or translated without the agreement of the World Health Organization. Authors alone are responsible for views expressed in signed articles.

Ce document ne constitue pas une publication. Il ne doit faire l'objet d'aucun compte rendu ou résumé ni d'aucune citation ou traduction sans l'autorisation de l'Organisation mondiale de la Santé. Les opinions exprimées dans les articles signés n'engagent que leurs auteurs.

The PHC context

The development and international acceptance of the primary health care concept is itself a social and political breakthrough which makes the CSDR strategy possible. The PHC rationale and goals constitute the sustaining force for CSDR. The focus on the basic health needs of the majority of the people who have largely remained unserved by the conventional health services, the emphasis on community role and self-help, the strategy of mobilizing and redeploying available resources for the primary health needs of the majority, importance attached to wider involvement of people beyond the health sector and the phasing and prioritization required in moving towards the goal of "health for all" are key features of the PHC approach which are also the building blocks of CSDR. The target groups of CSDR - infants, children and mothers - who constitute over two-thirds of the population in developing countries also have to be the high priority concern of the PHC activities.

Health education implications

The reliance of CSDR on mass-application health technologies and social mobilization and its affinity with PHC have important consequences for health education, in general, and health education for school-age children, in particular. The CSDR strategy implies that:

- health education has to be a more active process in which people actively participate in seeking, creating, disseminating and applying information, knowledge and understanding about health problems and healthful living rather than be passive receivers of information dispensed by authorities in the health education unit of a government department;
- the responsibility for "education concerning prevailing health problems and methods of preventing and controlling them",¹ as stated in the Alma-Ata Declaration and the promotion of "individual and social awareness leading to people's involvement and self-reliance"² has to be shared widely by different sectors of social services and diverse government, non-government, national and local institutions and organizations;
- young people - both in-school and out-of-school have a special role, because they are in a formative stage of life, in: (a) learning about and practising healthful living, (b) helping their families and communities learn about health and change attitudes and practices, and most importantly, (c) ensuring sustainability of CSDR through developing a new culture and attitude about health among the new generation.

To sum up, the most important message of CSDR for health education is that the health education process including the involvement of young people in this process, has to become more active, positive, participatory and integrated with other spheres of development; rather than remain a special activity unconnected with development in general, even if some responsibility of "imparting" health education is shared by educational institutions or other non-health organizations.

Deficiencies in present health education for young people

The main weakness of the existing health education opportunities for young people, both in-school and out-of-school, lie in the general absence of the activist stance which, as we have noted, is so important for CSDR as well as the PHC approach. With some exceptions, the present health education programmes for young people have the following characteristics:

- Dissemination of knowledge in school systems is inadequate in terms of content and presentation. Even when the topic headings in the school syllabus provide the opportunity for including relevant health materials in various subject areas such as hygiene, biology, environmental studies, social studies and so on, the treatment of the materials is so abstract, theoretical, pedantic and segmented by subject categories, that the relevance of the materials to life is lost.

¹ WHO-UNICEF, "Primary Health Care", Health for All Series, Alma-Ata, 1978.

² H. Mahler, "The New Look in Health Education", WHO Expert Committee on New Approaches to Health Education in PHC, Geneva. 12-18 October, 1982.

- The content and methods of health-related teaching in educational programmes often deliberately emphasize "scientific facts" rather than the change of behaviour and attitudes. The examination systems and the pedagogic training of teachers are geared to recall of facts instead of acquiring understanding of real problems and applying knowledge to solve these problems. The unstated assumption is that knowing the facts will somehow lead to appropriate behaviour even though the facts frequently have no direct relationship to required behavioural change.
- The lack of a practical orientation and activism in health education content and methods for young people means that there is little carry-over of what is learned into families and communities. The instructional content, methods and the examination system do not generally provide for or encourage practical activities and projects concerned with study and analysis of local and community health problems and appropriate individual and collective self-care and preventive measures.
- A large proportion of the young people in developing countries are not reached by the formal educational system. Approximately half of primary school-age children in the Third World do not complete the full cycle of primary education; most of them do not acquire or attain a functional level of literacy and numeracy. The proportion deprived of second level education is much larger. Non-formal out-of-school education opportunities for these children are few and sporadic. Moreover, most non-formal programmes have narrow and specific objectives and instructional content which exclude health materials. There are very few systematic efforts to reach the out-of-school young people through the mass communications media for educational purposes; even fewer are the efforts to present health information.

The strategies for an "activist" health education for young people

CSDR, implemented in the context of primary health care, not only offers the opportunity but makes it essential that "activism" is injected into health education for young people. Somewhat different approaches have to be followed for young people enrolled in schools and those out-of-school.

In-school strategies

The main purpose of an activist approach for the in-school population will be to help young people acquire relevant knowledge and information, internalize appropriate health attitudes and practices for their personal benefit and contribute to improved preventive, promotive and self-care behaviour in their families and communities.

The main elements of a strategy for achieving the above objective will include:

- (a) re-orientation of teachers, educational management personnel and parents;
- (b) production of resource materials for teachers and student activities;
- (c) review and modification of curriculum materials, identification of needed changes in the teaching-learning process, and reform in the student evaluation and examination process;
- (d) involvement of children in activities within their families and in communities;
- (e) use of the school as a physical base for certain CSDR activities in the community.

Reorientation of teachers. The pedantic and the theoretical nature of the health content in the school curriculum has its counterpart in the kind of training teachers generally get in respect of their health education functions. Few training programmes prepare teachers for the activist approach proposed here. A two-pronged effort is needed to remedy this situation. The health-education content of the pre-service teacher-training needs to be reviewed and modified to make it practical and relevant for an activist health education approach. This process, however, takes time since change in an established academic programme faces many bureaucratic and "professional" obstacles. An interim and more easily accomplished solution is short in-service training courses for teachers to introduce the activist approach.

An illustration of an activist approach in which teachers and pupils actually served as health workers in their communities is provided by a cluster of 30 schools in Kangazha district in the hilly hinterland of central Kerala, South India.¹ The project got off the ground with a four-day training of 30 teachers from 10 selected schools in the first phase. The training was intended to prepare teachers for a set of specific health tasks identified as important for protecting the health of children in the community. The tasks were:

- (1) identification and treatment of common ailments, such as scabies, skin sepsis, taeniasis, trachoma and conjunctivitis;
- (2) identification and correction of common nutritional deficiencies, such as deficiency of Vitamin A and iron;
- (3) treatment of minor wounds and injuries and first-aid for emergencies;
- (4) identification of children with growth failure leading to recognition of chronically ill children;
- (5) screening of defective vision;
- (6) recognition of infectious illness such as mumps, chickenpox and application of quarantine practices for prevention of their spread; and
- (7) fostering health habits in children.

In this particular example, the school, in effect, became the first tier of health care for children and teachers assumed specific health care responsibilities. In subsequent phases of the project, the pupils also became involved in the health care tasks not only as beneficiaries but as active participants and the activities extended to the respective communities. What health care tasks (in contrast to health education tasks) the teachers and pupils should be engaged in would depend on what public health services and facilities exist in the community to attend to critical health problems.

For the acceptance and successful implementation of the activist approach, it is not enough just to train the teachers. The objective and philosophy of the activist approach have to be understood and accepted by the policy-makers and the management of the school system as well as by parents of the children. The opposition or even disinterest of the management and parents can kill any new initiative. It is, therefore, essential that specific provisions for orientation of the concerned educational policy-makers and managers, and parents and community leaders are included in the plan for introducing an activist approach to health education. This aspect is frequently neglected in many projects.

Production of resource materials. The training of teachers has to be complemented by the supply of resource materials which would provide essential information and ideas for action to teachers. The resource materials may include simple instructional aids and suggestions for improvisation of instructional aids from easily available objects in the local environment. The resource materials will serve as an inventory of ideas, information and teaching aids from which teachers will make the appropriate selection. The general quality of curricular materials and the inadequate treatment of health aspects in the curriculum and textbooks make the availability of resource materials especially critical. Provision for resource materials has to be made within a project when a new initiative in health education is taken or in a central curriculum and instructional materials unit. A good example of relevant resource materials is the publications of the Child-to-Child project by Dr David Morley of the Tropical Child Health Unit, Institute of Child Health in London, England. Within the nutrition aspects of health education, UNESCO's publication New Developments in Nutrition Education provides useful information and describes pedagogic options.²

¹ M. V. Joseph, "Teachers and Pupils as Health Workers", in UNESCO-UNICEF Co-operative Programme, Mobilizing Education to Reinforce Primary Health Care, Digest No. X, pp. 55-72, Paris, 1984.

² Sheila A. Turner and Richard B. Ingle, "New Developments in Nutrition Education Series", No. 11, UNESCO, Paris, 1985.

Curriculum modification. Curricular reform and development is generally a slow and complicated process. It takes several years to make any significant change in the school curriculum on a national or regional scale and to undertake the concomitant tasks of preparing textbooks and instructional materials, preparing teachers, and making necessary changes in the evaluation and examination system. This is why it is important to seek opportunities for taking initiatives in "activist" health education on an ad hoc basis through in-service teacher training and preparation of supplementary resource materials within the latitudes generally permitted by the existing curriculum. In the longer term, however, it is essential to make the necessary modifications in the curriculum, course syllabuses, textbooks and the examination system so that the activist approach in health education becomes an integral part of the educational programme rather than remain co-curricular activities dependent on the ingenuity of individual teachers. The process of this curricular modification will have to begin with a "critical review" of treatment of health materials in the existing curriculum, textbooks and instructional practices and the identification of required changes.

Involvement of children in health promotion

The essence of an activist approach in health education is that children not only learn about health but they practise what they learn for their own benefit and for the benefit of their families and communities. The contribution children can make towards changing health behaviour and practices in the families and making at the same time health education a living experience is frequently underestimated. In the Child-to-Child project, for example, it has been shown in diverse situations in over 50 countries that primary and secondary school children can participate effectively in such activities as: serving as health scouts in the community, observing early signs of illness among children, finding out about problems of vision and hearing among children, caring for teeth and eyes, finding out about healthy food for babies and children, caring for children who are sick, caring for children with diarrhoea, and preventing accidents among children.¹

In the Kangazha project in Kerala, mentioned earlier, students were involved in a village health programme and each team of students was engaged in a seven-point action scheme with the following targets:

- (1) get 10 under-five children immunized;
- (2) get 10 under-five children to take Vitamin A prophylactics;
- (3) organize compost and soakage pits for 5 homes;
- (4) chlorinate 5 wells;
- (5) organize kitchen gardens for 5 homes;
- (6) reach 10 families with simple nutrition messages;
- (7) give a simple lesson in dental hygiene to 10 families.

It is reported that this activist participation not only benefited the community children and households but also made the participant students more sensitive to their own health needs and what they could do themselves to meet them. The students habitually overshot the targets set in the seven-point action scheme.

School as a physical base for CSDR. Primary school is one public institution which is most widely spread out in the countryside of developing countries, more so than the health facilities. The primary and secondary teachers in many rural communities constitute a nucleus of educated people and can be the opinion leaders in their respective communities.

With an activist approach in health education, and with the involvement of teachers, students and parents, the schools can be the physical base for CSDR activities for the community for such purposes as: storing immunization, oral rehydration and growth monitoring

¹ David Morley, "Involving School Children in Community Health: Suggestions for Curricular and Co-curricular Activities", in UNESCO-UNICEF Co-operative Programme, op. cit., pp. 1-54.

supplies; organizing health information and education activities for people in the community; keeping supplies of health education materials for the community, such as posters, brochures and booklets; organizing surveys and data-collection in the community for monitoring CSDR activities; and maintaining and storing records for the community in respect of immunization, growth monitoring and incidence of diseases. In all of these activities, the school's complementary role has to be closely co-ordinated with that of the public health service. The involvement of students and teachers in these activities will make health education real and meaningful for students.

Out-of-school strategies

The obstacle to reaching the out-of-school young people for health education purposes is that out-of-school educational opportunities in developing countries are limited and sporadic. It is difficult to imagine institutional vehicles for health education on a systematic and sustained basis on a large scale other than non-formal education programmes for out-of-school young people. The fortune of health education for young people who are out-of-school is, therefore, tied to a large extent to the development and effectiveness of non-formal education.

It needs to be recognized, however, that full advantage is not often taken for health education of existing literacy, skill-training, agricultural extension and other non-formal education programmes. It is necessary to consider at the national and regional level, in the course of making policies and plans for these educational programmes, the ways of incorporating health education elements in them. It would be generally impractical to establish a special institutional and organizational structure exclusively for health education for out-of-school children and youth.

Mass communication media constitute one of the few institutional vehicles, other than education programmes, for communication with both out-of-school and in-school young people. The media evidently are important instruments for conveying health messages to the general population. Special media programmes for youth can be the means for carrying information on health directly to youth and for spurring cultural, social and religious organizations for youth into action with relevant ideas and suggestions. In countries where media outreach is limited, traditional means of social communication, such as folk theatre, can be put to use.

Linking in-school and out-of-school efforts

The two spheres of activities need not and should not be seen as parallel and unrelated. The aim of health education based on the primary health care approach is to reach all the people with relevant information and understanding and to involve all the people in individual and collective efforts. The health education activities for young people also should inspire them to work as a community and for the community.

The opportunities for community involvement of school students have been mentioned earlier. The school-going youth, as the more privileged among the young people, should seek ways of working with their out-of-school compatriots in community projects. Certain of the community out-reach activities of schools in the form of propagating relevant health knowledge and skills can be especially designed for out-of-school youth. Mass media can be aimed at both in-school and out-of-school youth.

International cooperation

WHO, UNESCO, UNICEF and others concerned about child survival and development within the framework of PHC can be of assistance to developing countries' efforts by co-operating with a few interested countries in assessments of existing health education activities for young people. Such assessments, when countries are genuinely committed to making headway in health and survival of children, would lead to the formulation of appropriate policies, objectives, strategies and action programmes. The lessons learned from this process can be helpful to other countries as well.