Education for Health in Schools and Teachers Colleges

How children can benefit and contribute

The Child-to-Child Trust

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About this booklet

This booklet is written for those who seek guidance about how to plan health education in schools and colleges, and who would like to take a new look at how to do so.

It incorporates experience from those using Child-to-Child approaches in colleges and schools in four countries in Africa, and most of its content derives from the report of a seminar held in Nairobi in January 1992 where experience was shared and where the guidelines presented in the main sections of this booklet were finalised.

The first section of this booklet has been added to reflect not only the experience presented in Nairobi but also a view of Health Education and its planning which derives from experiences with Child-to-Child and related approaches all over the world.

The final section lists important resources available for planners.

INTRODUCTION

Why health is important in schools

Health is an important component of school programmes for three reasons:

* School children study better and are happier at school if they are fit and well. If they learn about health and safety in a way which relates to their life now this contributes to their health.
* School children are part of a family. Sometimes they may even have more school education than their parents. They often look after younger ones when they go home from school, or pass on messages to other children who have not gone to school. It is appropriate, therefore, that good health messages and health practices should be spread from school to home.
* School children are tomorrow's fathers and mothers. If they learn and practice good health knowledge and skills now and develop responsible and caring attitudes now they will carry these forward until the next generation.

Health is not just another school subject

Although health knowledge needs to be taught just like other knowledge, what is important is not what teachers and children know but how they apply what they know to make themselves and other people healthier.

Hence health in school needs to contain four elements.

* Knowledge and skills taught and learnt.
* Knowledge and skills applied and reinforced through the curriculum - e.g. communicating health messages (language), measuring and recording weight, growth, (maths), surveying practices and customs (social studies), understanding causes of diseases (science).
* Health and safety activities applied at school by teachers and children to make their school community healthier.
* Health and safety activities carried from school to families and communities.

Moreover health knowledge and skills cannot be taught in sequence, one after another, like mathematics or geography. All main topics need to be taught from the very beginning of a child's school days and gradually widened and deepened as that child gets older. Thus topics such as Nutrition, Hygiene, Prevention of Disease, Safety, Accepting and Helping the Disabled and Mental Health apply to every child but in different ways.

Just as health relates to all learning and life in schools it applies to all teachers. **Every teacher is a teacher of health.** For this reason health knowledge, and health action, is a vital component of programmes in teachers' colleges. Colleges must practice what they preach.

Schools, Colleges and, indeed, countries need, therefore, to have **health plans** and **programmes** rather than merely relying on health syllabuses and health lessons (which are merely a part of such wider plans).

Children for Health

Once children are seen as partners, as providers as well as receivers of health education and health care, there are implications for learning and teaching in schools.

In the first place we need to understand how children can pass on messages and to whom... and what health messages are easier and more difficult for them to transmit.

What and how children can teach others depends on many factors, e.g.:

* The culture of the community
* The age of the children (and sometimes also their sex)
* The nature of the message
* Who the message is being passed on to, e.g.:
  - younger children;
  - same age children;
  - family and community.
* How the message is being passed on, e.g.:
  - directly;
  - by example;
  - by working alongside others.

Some messages can be passed on easily by one child to another, e.g. *"don't cross the road near a corner."*

Some messages can be passed by a child to a family if it is done tactfully, e.g. *"here is the poster about immunisation I made at school."*

Ministries of Health and Education working together

In recent years, and in most countries, we have witnessed a shift of responsibility with Health Education in schools, once planned and managed by the Ministry of Health, now a responsibility of the Ministry of Education. This has the advantage of ensuring that Health Education has the potential of being infused throughout learning and teaching in schools, but it will only be effective if full cooperation is still maintained with health professionals from the Ministry of Health and that their expertise is fully used and respected.

At **school and college level,** health professionals need to:

* maintain and monitor a school health service parallel and in full cooperation with teaching and learning activities in schools.
* be closely consulted as experts in health knowledge by schools and teachers. Where possible local health personnel need to be involved in presenting new knowledge either in seminars to teachers or directly to children.
* be closely involved and consulted when any school-to-community activities are planned. It is most important that campaigns and other health activities should not be seen just to come from the school. It is far more effective for the same messages to reach the families from a number of sources at the same time e.g. the health worker, the school, the radio, the church, temple or mosque.

At **national, state or provincial level,** health professionals need to be closely consulted in the design of all curricula, materials and testing for health education; in the monitoring and evaluation of the impact of programmes and in the training of trainers and field workers.

PLANNING HEALTH ACTION IN PRIMARY SCHOOLS

(The Child-to-Child approach in schools and communities)

This guide, based on the experience gained from Child-to-Child projects, has been prepared as a resource for organisers and trainers who wish to use the Child-to-Child approach to health education in primary schools. It may be freely reproduced or used as a basis for any other material generated at national level.

CONTENTS

The Purpose and Value of Health Action

This guide describes and analyses a programme which:

- Invites schools to agree health priorities and take health action in order to improve the well-being of the children who study in them, their families and their communities;
- Encourages children to take action individually and as a group to help others through the Child-to-Child approach.

It is hoped that such a health action programme could lead to the following:

- It will improve the health status of the school and community, and at the same time encourage children and adults to be more health conscious and adopt better preventive health measures.
- It will increase the health knowledge and skills of children and improve their attitudes to good health. Because they are involved in 'doing', the children will retain their knowledge better when they become parents and community members in the future.
- It might improve the attitudes of the children through giving them increased responsibility, and the attitudes of the teachers to the children as they realise how much responsibility the children will assume.
- It will strengthen relationships among children of different ages.
- It will improve the teaching of other subjects, especially basic skills at school through linking learning these skills to applications such as health, growth and nutrition which are interesting and valuable to children. It is also a methodology which links classroom learning directly with community needs. Such a methodology can be applied to other school subjects.
- It will involve parents more closely with the schools as partners in health activities.

- Describing relationships between:
  - school and health workers;
  - parents and community.
- Finding out about the health knowledge of pupils and teachers (e.g. using questionnaires);
- Finding out about approaches to teaching health (what is taught and how).

This could then be compared to information collected in subsequent years to find out what, if any, changes had taken place.

- Identify who is responsible for monitoring and evaluation. At this stage it is important that someone both at the project level and at the school level is given a clear responsibility for monitoring. In this way it will happen.
- Create guidelines for monitoring. Very simple guidelines can be made.

From the beginning of the project it is valuable to conduct on-going evaluation.

This would include seeking answers to questions such as:

- Were sufficient people consulted in the setting up of the programme?
- Were the objectives set appropriate and achievable?
- Were the schools adequately selected according to effective criteria?
- Was sufficient background information gathered?
- Was enough time given?

The Child-to-Child booklet ***Doing it Better*** gives helpful advice on what questions to ask and how to ask them.

At this stage it is important to review and revise the original objectives.

Resources for Planning

The project team needs to consider existing resources which can be used as guidelines in the designing of the plan:

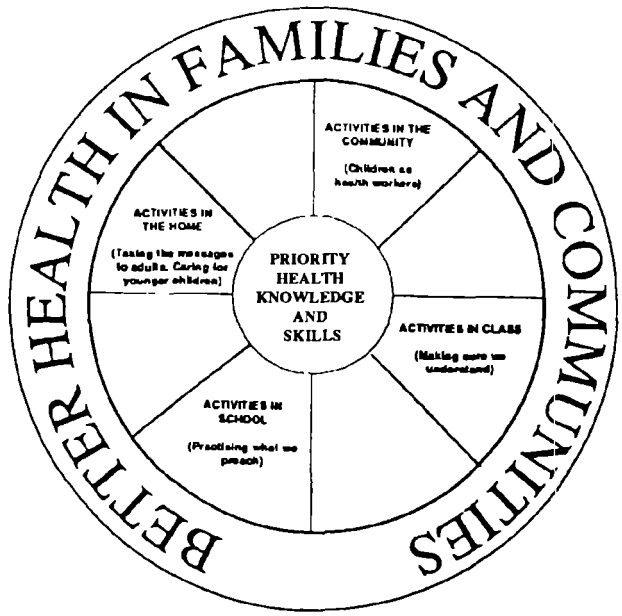
- The existing school health education syllabus - what Child-to-Child activities can be incorporated into it?
- The existing subject syllabuses which have a health education component such as social studies or environmental and agricultural science - how can they be supported and strengthened by the use of the Child-to-Child approach?
- Other school subject syllabuses such as science, mathematics, language and art - how can they contribute to a Child-to-Child action plan?
- Information about other school activities such as assemblies, health inspections, school gardens where Child-to-Child activities would be appropriate.

Implementation

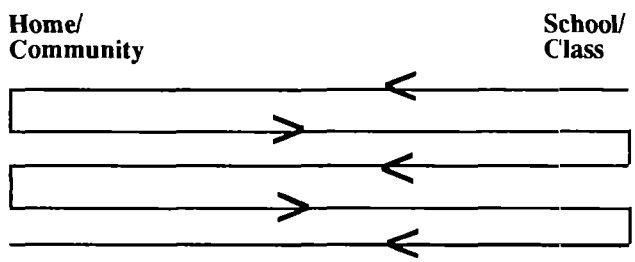
Putting the plan into action is the most important part of the project.

The following diagram illustrates three vital questions:

- Where do Child-to-Child activities take place?
- Who is involved in Child-to-Child activities?
- What activities promote Child-to-Child learning?



Where do the Child-to-Child activities take place?
Child-to-Child activities link learning at school (both in and out of the classroom) with finding things out, and sharing knowledge and skills with others in the home and community. The activities need to go backwards and forwards between school and home:



Who is involved in Child-to-Child activities?
There are many people involved in the Child-to-Child activities. The interaction will be different depending on the particular health activities. This table shows what a child/ children might do for others.

Child	deliver messages to	young children a young child
	provide examples for	same age child same age children
Children	teach skills to	
	work on health activities with	family community

Note: It is important that children are not exploited in the name of Child-to-Child. There are certain community activities, e.g. digging latrines, which although very important for health, are best done by adults and not children.

Once a school or a teacher has identified a health theme it can be emphasised and reinforced in many ways. A theme such as malaria, safety, flies and hygiene or playing with younger children can be developed in class, across the curriculum, in school, at home and in the community at the same time.

Often such themes can profitably begin with a survey undertaken by children in the community:

e.g. Treatment of malaria ... what do families do?

Kitchen safety at home ... how are babies protected?

Food covers ... how are they used?

Who plays with little children and how?

Organisation and Management

The teacher's role
It will be important for one teacher to be appointed co-ordinator of Child-to-Child activities in a school. This teacher needs to be a senior and respected member of staff. However every teacher in the school needs to feel personally responsible for the activities in his or her class.

The role of the Head and of the school staff
Unless the Head is committed to Child-to-Child the school is unlikely to become a model of good practice. The whole staff (under the Head) needs to be aware of Child-to-Child plans and to review progress towards 'making our school a healthy one'.

The organisational role of health committees
If more than one school is involved in the project there might be a coordinating schools health management committee and a school health committee at each school. School health committees help keep schools healthy places, they can organise and monitor priorities in action plans and can help to maintain links between schools and their communities.

Membership of the School Health Management Committee can include:

- Child-to-Child co-ordinators from each school;
- Community health workers;
- Representatives of PTAs from each school;
- Health officers;
- Social workers;
- Zonal extension workers;
- Inspectors of schools.

Membership of the School Health Committee will be as follows:

- Selected teachers from different classes;
- Parents;
- Community health workers;
- Children.

It may be a good practice to have a larger committee including health workers and parents which meets from time to time to review plans and achievements and a smaller committee including teachers and children which organises day-to-day activities.

The health committee will:

- draw up action plans;
- organise and monitor priorities in action;
- keep schools healthy,
- help to maintain links between schools and their communities.

Activities between schools and communities
Sometimes individual schools can share experience with others and present joint experience to the wider community through:

- Radio and television programmes;
- Newsletters;
- Visits between schools;
- Video programmes wherever applicable.

(All these have been achieved in Uganda.)

Communities can help schools through:

- Drawing up action plans;
- Supervising activities and monitoring progress;
- Obtaining resources and disseminating information to other people;
- Creating links with on-going programmes out of school.

Resources for Teaching

Materials for teachers
It is vital for teachers to have nationally produced health education material such as that available in Uganda, or books and charts such as ***Child-to-Child in Zambia***, as well as Child-to-Child activity sheets and the book ***Primary Health Education.*** However, all are in short supply.

Child-to-Child story books are popular with both teachers and pupils (some titles such as ***Diseases Defeated*** particularly so), but the system cannot afford to supply them. Schools must therefore seek to obtain and **retain** resource materials, possibly in conjunction with small resource centres in colleges or some other local place.

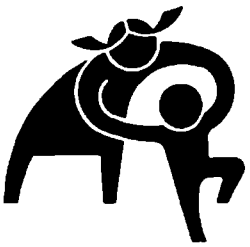
Making and collecting together material generated locally
There are many opportunities for groups of schools to generate their own resource materials. These can include:

- Suggestions for teaching and activities;
- Stories and poems written by teachers and children (as much material as possible should be generated from the children themselves);
- Collections of plays, songs or practical activities which have been made and used successfully in the local area.

Note: Any resource materials made and used whether from outside or locally should indicate **action which children should take**, not just in school but at home as well.

Materials made by teachers, parents and children
Much useful and effective material is made by children often with the help of adults; examples which could be made by schools include:

- Latrine covers;
- Food safes and food covers;



INTRODUCING CHILD-TO-CHILD APPROACHES INTO TEACHERS' COLLEGES AND ASSOCIATED SCHOOLS

This guide has been prepared as a result of the experience gained so far in three countries: Sierra Leone, Zambia and Uganda. The material it contains may be freely reproduced or used as a basis for any other material generated at national level.

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The purpose and value of the approach in colleges

Introducing the approach in and through colleges should serve the following purposes:

- It emphasises the importance of all students and the children they teach acquiring basic health knowledge and life skills which every educated person has a right to know and a duty to pass on to others.
- It emphasises the importance of confirming such knowledge and learning such skills through doing.
- It shows that such knowledge and skills may be reinforced across the curriculum and, by so doing, learning in all subjects can be made relevant to local needs.
- It links the college more closely with the community around it and confirms the importance of the college being aware of the health and development needs of that community.
- It links the college more closely with the nucleus of schools around it.
- It helps students to develop approaches, e.g. drama, which enable children to pass on knowledge and skills to other children in school and out-of-school.
- It confirms, in students, confidence in the power of children as communicators and hence increases their respect for the children they teach.
- It makes students more aware of themselves as an example and the power of children to communicate that example. This should make them more conscious of what they say to children.
- It gives students confidence and practice in using activity based and problem solving methods with the classes they teach.

- Longer courses in-country on active approaches to health education or Child-to-Child approaches in schools or teacher education, sponsored by aid agencies
- Components within university courses for teacher educators;
- Local training is preferable to international training but outside funding for training possibly obtained through the efforts of Child-to-Child London may still be necessary:
  - In Sierra Leone, now that Child-to-Child is in the schools, the approach has been integrated in college training and the primary school curriculum.
  - In Uganda, now that a series of training workshops has produced a core of trainers able to spread the approach.

However, there is a certain **minimum** training which must be provided if the new approach is to have any chance of being effective.

This includes:

- Awareness courses for all concerned: staff of college; heads of schools; community liaison personnel.

  All should be aware of competencies, programme and strategies, why the new approach is desirable and important and the part they have to play.
- Longer training (at least one week) for a group of facilitators at college and school/community level. These persons must be in possession of all basic Child-to-Child material such as activity sheets and story books and should also be involved in making their own plans and materials. This will help them to establish a feeling of ownership of the project.

It may be easier to use weekends if a full week is not available.

Arrangements for evaluating and monitoring the approach

A baseline survey (including a needs assessment of the community)
In the initial stages of introducing the new approach into colleges it is useful to conduct a baseline survey. It should be possible to:

- Describe the college and its activities prior to the introduction of the new approach, e.g. how far were students involved in health, hygiene, community activities and what resources were available to them?
- Analyse the curriculum and methodology, e.g. to what extent was health taught and how? Were 'child-involved' methods introduced?
- Conduct a simple test of knowledge and skills of both students and tutors prior to the introduction of the approach.

Evaluation of the planning stage of the programme
From the outset all activities connected with the programme need to be continuously evaluated. This would include seeking answers to questions such as:

- Were the right people involved in setting up the programme?
- Were the objectives set appropriate and achievable?
- How far was the sensitizing process effective?
- Did the initial training achieve its purpose?
- What level of commitment was there?

Responsibility for monitoring and evaluation
A two-tier system may be best:

- The local planning committee encourages monthly monitoring based on a *pro forma*.
- A national co-ordinating team makes periodic assessments.

The approach in colleges

Through 'Core' Subjects
Where Child-to-Child is used as an approach to introduce a more comprehensive and effective programme of health education into colleges, certain subjects will be used to introduce the key concepts and skills (which must be medically accurate).

There are different patterns of achieving this; either through one or two subjects: e.g. physical and health education (Sierra Leone); science (Uganda); or through a number of subjects as in Kenya or Zambia.

In each case it is necessary:

- To check whether all key concepts have been effectively covered;
- To ensure that an action-based approach is both recommended and used, e.g. if surveys, drama or discussion groups are recommended for children they should also be undertaken by students;
- To check whether medical/nutritional messages are up-to-date and correct.

Through 'Education' Subjects
Two applications of Child-to-Child approaches are relevant.

- ***Through general and specific teaching of classroom methodology***

  This needs to reflect:
  - the technique and value of using children to help each other;
  - the gain to children of teaching and communicating to others;
  - the possibility of cross-age tutoring.

  Children can be involved in group work, discussion groups (which need more guidance at primary school than secondary school level), doing surveys and many other activities.
- ***Through the practical study of child development***
  Rather than merely acquiring a passive knowledge of the stages of child development students need to become aware of the role of adults and other children in promoting this development.

The college as a resource centre for schools
Colleges can also develop as resource centres for schools using the Child-to-Child approach. The college can:

- Keep resource books on health and education and lend them to teachers;
- Organise writing workshops so that teachers in schools can make lesson plans, activity sheets and story books for use in schools;
- Act as a 'bank' for collecting songs, plays, stories and records of activities undertaken by schools in the area (particularly when these have been produced in the local language) so that these ideas can be preserved and shared;
- Organise exhibitions of materials (e.g. pictures, toys and crafts) which can be held in the associated schools;
- Let schools perform dramas and concerts or have competitions at the college as this helps to create enthusiasm;
- Provide continuous, long-term support for the teachers working with the Child-to-Child approach;
- Link particular students with particular schools to increase their involvement.

Training in colleges and schools

College Child-to-Child organising groups need also to be involved in planning and conducting short training courses, both for other college lecturers and for teachers in schools. Such training needs to be carefully planned to be effective. Usually it is necessary to include three elements:

- Remind people attending of what the Child-to-Child approach involves and what distinguishes it from other methods of teaching (many people still have wrong ideas about it);
- Remind them of the overall content of the programme that has been planned in the college and school and call their attention to the material which describes it;
- Concentrate on just one priority activity as an example and involve the participants closely in that activity.

Evaluation of the 'doing' and 'outcome' stages in colleges

What needs to be evaluated?
In order that Child-to-Child approaches survive in colleges, and improve and develop as each successive intake of students enters the college, there is need for an in-built system of evaluation.

This comprises an evaluation of the programme (is it being efficiently carried out?) and an evaluation of the outcomes.

- What have students **done** during their time at college?
- What do they **know** now that they did not know before?
- What can they **do** now that they could not do before?
- How do they **say** that their attitudes have changed?
- What **behaviour** shows that their attitudes have changed?

Who evaluates?
Evaluation should be performed at all stages and all levels. The tutors, teachers, students and children should all be involved. The community or any group within the community can also evaluate and the consequences at community level should also be evaluated.

Evaluation in colleges may be done:

- By the Child-to-Child organising group and committee using a *pro forma* for self-evaluation;
- By the students themselves who could, for instance, devise a 'health competency certificate' with the help of their tutors and administer it to other students. (Medical advice is needed to ensure that the questions and the expected answers are correct);
- By an outside (and friendly) monitoring team - possibly from the central Child-to-Child organising group or another college.

Remember!
The sole purpose of evaluation
is to help the college
do better

INTRODUCING CHILD-TO-CHILD APPROACHES THROUGH NATIONAL AND LOCALLY-PLANNED CURRICULA

This guide has been written as a result of experiences gained so far in the project in four countries, Kenya, Sierra Leone, Uganda and Zambia, together with some ideas deriving from related projects. The contents may be freely reproduced or used as a basis for any other material generated.

CONTENTS

Why Use Child-to-Child Approaches?

What factors might motivate countries to introduce the Child-to-Child approach into their education systems?

- The worldwide spread of Child-to-Child approaches and worldwide interest in them;
- More commitment of governments to health and health education. This has arisen as there is evidence that in all countries the health of individuals and communities depend more on lifestyles than on health services;
- More commitment to children and to the goals of *Education for All.* (Following the World Summit for Children, governments are being asked to report on what they are doing on behalf of children, at international meetings);
- The recognition that there has been an informal system of Child-to-Child in the past in all societies. This now needs to be built on, extended and formalised.

Defining the scope of Child-to-Child approaches

Three related but separate issues are involved:

- The introduction of a co-ordinated approach to health education through the national curriculum;
- The possibility of extending such an approach beyond health so that children are involved more regularly in assisting each other in and out of the classroom and in spreading messages from school to community;

- Some messages can be passed on to other children and families by younger rather than older children.
- The UNICEF booklet ***Facts for Life*** contains a number of such messages.
- Recently Zambian teacher trainers and curriculum personnel have agreed a set of minimum health competencies. Such objectives can serve as a check-list to monitor present curricula and in the making of new curricula.
- In some countries where Child-to-Child is well established, e.g. Zambia, Child-to-Child has moved into the field of environmental health. Eleven messages have been identified and will be integrated into the curriculum using the Child-to-Child approach.

Learning and communication skills

Skills which children would need to acquire in order to pass on such objectives to families and communities will be important. They may include the following:

- Health skills which can lead children to influence others by example;
- Skills in communicating messages, e.g. through plays, drawing and songs;
- Listening and observation skills, what to look for and how;
- Decision making skills; what to communicate and how;
- Social skills involved in approaching elders which may be developed among groups of children (often through role play);
- Information gathering, analysing and reporting.

Agreeing strategies

Strategies for managing health as a coordinated input into the curriculum

Two have so far been practised:

- A separate panel (or sub-panel) with a teaching syllabus and health material as in Sierra Leone and Uganda.
- A co-ordinating group working with other subject panels to negotiate the insertion of health topics into their subject syllabus and materials. Special supplementary material may be chosen or commissioned as in Zambia. There is a considerable advantage to have one named specialist co-ordinator to facilitate the inclusion of health into different disciplines.

The table below shows the advantages and disadvantages of the two alternatives.

An ideal situation would be to have both a separate panel to plan minimum health content and a coordinating group to plan health across the curriculum. However no country has so far chosen this option

Separate Panel	Co-ordinating Group
Advantages	
Ensures that essential core material is taught. Planners are free to develop material at their own pace. They can easily co-opt professional expertise.	This can easily map out a broad and relevant curriculum across subjects. It involves many more people in thinking widely about health. It ensures that health gets into examination subjects which may be considered higher status, such as Maths.
Disadvantages	
They may pose a greater threat to an over-loaded curriculum. May restrict the concept of health across the curriculum. May be considered of lower status than other subjects. May encourage a restrictive view of health.	May miss out on expertise. Difficult to arrange content in a proper sequence. Delay in reaching consensus. More expensive, especially in people's time.

- Relating development of learning skills in science, such as observation, raising questions, making hypotheses, interpretations of results, to practical action, etc

Mathematics
- Budgeting in relation to good nutrition;
- Weighing, measuring and estimating in relation to child growth and development;
- Estimation in relation to spread of disease and growth of population;
- Geometrical drawings in relation to making board games on health, etc.

Social studies
- Understanding concepts such as living together and depending on one another in relation to health;
- Developing social skills of communications with peers and adult community members;
- Developing skills such as mapping (e.g. in relation to attitudes towards disease);
- Developing attitudes of understanding and empathy (e.g. in relation to the disabled; to people with illnesses such as AIDS).

Arts and crafts
- Developing skills of poster making to convey messages;
- Developing design and production skills, e.g. with metal and wood, for the production of household items, such as meat-safes, or toys, e.g. building blocks.

Music and dance
- Developing skills in writing and performing songs and dances around themes appropriate for health, etc.

Creative activities (for younger children)
- Developing skills, e.g. picture-making and cut-outs, which they in turn can use for stimulating babies;
- Developing (in older children) the production of activity material they can use in pre-reading activities with pre-school children.

Religious knowledge
- Developing attitudes of empathy and concern for those less fortunate in society, e.g. those who are orphans, those who are disabled. Emphasising the links between mental, physical and emotional health.

Physical education
- Emphasising the importance of physical fitness as a means of maintaining good health and combatting disease.

Co-ordinating the Work of Individual Subject Panels

The following steps are recommended:

- Agree purpose and approach. Why are we introducing Child-to-Child approaches and how?
- Appoint an evaluator to achieve quality control throughout the process;
- Agree competencies to be taught;
- Differentiate 'carrier subjects', e.g. science, from supporting subjects, e.g language. Review how competencies fit into both carrier and supporting subjects,
- Design scope and sequence charts in individual subjects. Particular subject panels may consult during this stage;
- Decide how assessment specifications can be related to scope and sequence;
- Review by co-ordinating body of scope and sequence charts together with objectives;
- Revise scope and sequence charts as necessary to avoid overlap and achieve maximum co-ordination between subjects;
- Provide suitable examples of how content can be varied to suit local needs;
- Review materials available already in school and from other sources;
- Develop detailed curriculum and materials;
- Plan of action for production and distribution of materials

Evaluating the Curriculum Process

The process of curriculum design to incorporate the Child-to-Child approach in health education and other areas of the curriculum needs to be evaluated at the planning stage, the doing stage and the outcome stage.

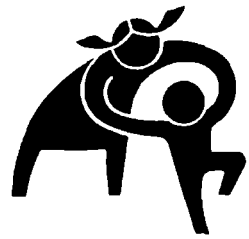
Documents for monitoring the curriculum in the field may also need to be prepared.

The following are key questions which may need to be answered:

At the planning stage
- Were the priorities correctly identified in collaboration with the Ministry of Health and checked with appropriate expertise from the university, NGOs and international agencies?
- Was currently available material effectively surveyed?
- Were resources in terms of money, manpower and time considered?
- Were arrangements for co-ordination between panels well described and discussed?
- Were objectives clearly stated and achievable?
- Were alternative arrangements for publishing the final product discussed and costed?

At the doing stage
- Were there sufficient resources available to writers (manpower, materials, time)?
- Were classroom practitioners sufficiently consulted?
- Were co-ordination mechanisms maintained during the writing process?
- Was appropriate thought given to good illustrations and interesting ways of looking at the text?

At the outcome stage
- Was the final product clear and manageable by teachers in schools?
- Did they find it interesting and useful to teach?



A DRAFT HEALTH EDUCATION CURRICULUM FOR TEACHERS TRAINING COLLEGES IN ZAMBIA (EXTRACTS)

This extract is taken from a longer document. It contains the content and process objectives from a curriculum for Teacher Training Colleges now under discussion at the Curriculum Development Centre in Zambia.

Objectives 1

Minimum health competences that all teachers in Zambia have a *Right to Know* and a *Duty to Pass on to Others.*

Seven themes were identified as follows:

Theme 1: Child growth and development
Theme 2: Nutrition
Theme 3: Hygiene
Theme 4: Safe life styles
Theme 5: Safety
Theme 6: Disability
Theme 7: Prevention and cure of diseases

The minimum health competencies were listed as follows:

Theme 1: Child growth and development

Teachers should:

1. * Be aware of the main stages of growth and development (physical, social, mental and emotional) of babies and young children.
   * Be able to monitor such growth through observation and recording and to explain how to do this to others.
   * Appreciate the importance of recognising and promoting good development in young children and its effect on their later adult lives.
2. * Be aware of the importance of play, toys, games and language in the mental, physical, social and emotional development of babies and young children and of the value of different types of toys, play and language use.
   * Encourage and enable older children to develop and practise the skills of making toys, games, stories and songs and using them with babies and younger children.
   * Encourage and enable older children to develop attitudes of responsibility and enjoyment towards creative play and younger children.
3. * Be aware of how disability can be caused through poor attention to child growth and development.
   * Be sensitive to the development needs of disabled children.
4. * Know the importance of breast-feeding and the relation between breast-feeding and mental and emotional development.

Theme 2: Nutrition

Teachers should:

1. * Be aware of the link between good food and mental and physical growth.
   * Be aware of the types of food which promote such growth.
   * Recognise and (as far as possible) practise good nutrition for self and children.
   * Recognise signs of poor feeding and malnutrition in children.
   * Become concerned with importance of good feeding as a basis for future health and happiness of self and children.
2. * Appreciate the importance of breast-feeding and good weaning practice.
   * Develop skills in passing on breast-feeding messages and resisting pressures against breast-feeding.
3. * Develop awareness of local food customs and their effects.
   * Develop attitudes of openness to change in food habits without taking risks with possibly poisonous substances.
4. * Be aware of locally available good food and how to provide it within the means available to a family.
   * Appreciate importance of good buying, growing, preparing and storing of food to make the most of what is available and affordable.
   * Develop and spread 'foodwise' attitudes.

Theme 7: Prevention and cure of diseases

1 Diarrhoea

Teachers should:

* Understand the causes of diarrhoea (and its link with hygiene).
* Know that dehydration can kill (particularly babies and young children).
* Know how to rehydrate others with diarrhoea and recognise danger signs of acute dehydration (when medical help is vital).
* Develop, and promote in children, skills of mixing appropriate rehydration drinks and giving them to young children.
* Develop, and promote in children, skills of passing on the 'diarrhoea message' appropriate to cultural conditions in families and communities.
* Develop, and promote in children, attitudes of awareness of the power of families (including children) to save lives through rehydration.

2. Malaria

Teachers should:

* Be aware of the causes of malaria and how it can be prevented by preventing mosquitoes from biting people, particularly at night.
* Acquire, and promote in children, skills of:
  - Destroying breeding places.
  - Helping those that have fever.
* Develop, and promote in children, awareness of the importance of controlling the disease through family and community action (including child action).

3. Coughs, Colds, Pneumonia

Teachers should:

* Be aware that pneumonia in babies and young children, if untreated, can cause death.
* Develop, and promote in children, skills of recognising danger signs of pneumonia in babies and of communicating the urgency of taking action to other members of the family.
* Develop, and promote in children, attitudes of responsibility towards watching and reporting this 'Killer Disease'.
* Develop, and promote in children, ability to differentiate between colds and pneumonia and recognise the importance of giving antibiotics only for serious cases and not for all colds.

4. Immunization

Teachers should:

* Understand that six 'Killer Diseases' can be prevented by immunization. (Tuberculosis, Diphtheria, Whooping Cough, Tetanus, Polio, Measles.)
* Be aware of when and how often immunization is necessary.
* Acquire, and promote in children, skills of passing on the immunization message to families and communities
* Develop a personal commitment to ensuring the immunization of members of families and promote that commitment in children.

5. Worms

Teachers should:

* Know major causes of different kinds of worm infestation.
* Know link between worms and poor toilet habits.
* Practise, and promote in children, better hygiene, e.g. wearing shoes, disposal of faeces, clean latrines, good food habits, including washing hands with soap.

Objectives 2

Teaching skills and lifeskills which all teachers of health education need to acquire and possess

By the end of their training teachers should have acquired:

1. * Skills of analysing health contexts, health needs and health attitudes with a view to establishing priorities for choosing content and methods of presenting such content.
   * Skills in preparing schemes of work and individual lessons in health education; such schemes and lessons need to emphasise active learning, Child-to-Child interaction as well as links between learning in school and health action in the school, family and community.
   * Skills in appropriate methodology for these purposes, e.g:
     - Use of discussion groups, games and simple simulation techniques.
     - Use of story telling and writing as a means of communicating and reinforcing health messages.
     - Use techniques of role playing; drama; puppetry in order to clarify health ideas, motivate learners and transmit health messages.
     - Make visual aids (special attention being paid to techniques of improvisation and the use of the environment as a resource for teaching and learning).
     - Use of pictures and other visual aids not only to clarify health messages but also to promote thought and discussion.
     - Use of information gathering and survey techniques to enable children to find out more about their families, school and their local community and its health.
   * Skills in integrating health ideas and activities in other school subjects.
   * Skills in interpreting and communicating public health messages to pupils and to their families and communities.

Some Useful Publications*

1.	**Complete pack of Child-to-Child Activity Sheets**	£2.00
2.	***Child-to-Child and the Growth and Development of Young Children*** - A Report and Resource Book from the International Seminar held in Nyeri, Kenya.	£2.00
3.	**Audrey Aarons.** ***Approaches to Learning and Teaching*** A guide to taking action for health education with the Child-to-Child approach - for leaders, trainers, teachers and writers.	£1.50
4.	**Hugh Hawes et al.** ***Doing It Better.*** A simple guide to the evaluation of Child-to-Child projects and programmes.	£2.00
5.	**William Dodd and Christine Scotchmer.** ***How to Run a Workshop.*** A short guide based on experiences from many countries.	£0.75
6.	**Child-to-Child readers:**	
	Dirty Water **(level 1)**	£1.05
	Good Food **(level 1)**	£1.05
	Accidents **(level 1)**	£1.05
	Not Just a Cold **(level 1)**	£1.05
	A Simple Cure **(level 2)**	£1.20
	Teaching Thomas **(level 2)**	£1.20
	Down with Fever **(level 2)**	£1.20
	Diseases Defeated **(level 2)**	£1.20
	Flies **(level 2)**	£1.20
	I Can Do It Too **(level 2)**	£1.20
	Deadly Habits **(level 3)**	£1.20
7.	**William Gibbs and Peter Mutunga.** ***Health into Mathematics.***	£3.50
8.	**Beverley Young and Susan Durston.** ***Primary Health Education***	£4.50
9.	**Hugh Hawes, John Nicholson and Grazyna Bonati.** ***Children, Health and Science*** - This book, designed for science teachers in primary and secondary schools, contains an introduction to Child-to-Child approaches and discusses the links between these and good science teaching. It also contains 20 specially selected Child-to-Child activity sheets.	£1.00
10.	**Grazyna Bonati and Hugh Hawes (Eds).** ***Child-to-Child: A Resource Book.*** This resource book includes 1, 3, 4 and 5 above plus many examples of Child-to-Child around the world.	£5.00
11.	**Hugh Hawes et al.** ***Child-to-Child Approaches in Colleges and Schools in Africa.*** Report of a Conference held in Nairobi, January 1992	£2.50
12.	**David Werner & Bill Bower.** ***Helping Health Workers Learn.*** A book of methods, aids, and ideas for instructors at the village level.	£5.50
13.	**Clare Hanbury & Sarah McCrum (Eds).** ***We Are on the Radio.*** A guide to adult organisers for making health broadcasts with children.	£3.50

Ready Mid-1992

14. ***Children for Health*** - A book describing why and how children should be involved in spreading the messages contained in UNICEF's new edition of "Facts for Life".

* Available from TALC (Teaching-Aids at Low Cost), PO Box 49, St Albans, Herts AL1 4AX, UK. Tel. (0727) 53869. Fax. (0727) 46852.