The action-oriented school health curriculum in the Eastern Mediterranean Region

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Definition of the action-oriented school health curriculum

The action-oriented school health curriculum (AOSHC) is an innovative approach based on the adoption of a teaching and learning methodology whose main feature is a "discover, do and use" principle, as a result of which school children acquire the motivation and skills to perform actions beneficial to themselves, their society and their environment. In the process they develop positive human qualities and attributes that enable them to lead healthy lifestyles and be effective contributors in the overall social development process. The curriculum calls for parents, teachers and children to get together and take action to improve their school environment.

The term "schools" refers to all general education institutes, including village Quranic schools. The approach used is similar irrespective of schooling level, but contents are adjusted according to the children's age and capacity for learning.

As a starting point it has been agreed to use the AOSHC in primary schools as they are the most widely spread, and primary-school children are at the best age to have instilled into them correct behavioural patterns.

In the action-oriented school health curriculum the term "health" refers to a broad definition of health which encompasses lifestyle, basic needs of life, primary health care, a basic education, nutrition, healthy environment and the ability to lead a socially productive life. In short, it refers to a better quality of life. "Curriculum" refers to what is taught, how it is taught and relevant school activities.

The health curriculum provides an action-oriented approach that focuses on a pupil's own habits and involves the pupil's physical and social environment, as well as that of parents and the community.

Justification for AOSHC

Over the years there has been a lot of investment in providing health services and developing appropriate means for health provision. However, there has been no investment in developing the qualities and attributes of the recipients of health services. As a result people in many situations are negative and unsupportive towards their health development and do not necessarily utilize fully the services available to them. Conversely, in rich countries where services are free, people have developed dependency on the health services provided.

Health development has faced problems relating to management, resource mobiliza-

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tion, poor intersectorality and weak community role. In spite of appreciable investment made to solve these problems, successes are below expectations because the education methodologies have not created the right culture at an early age for later skills development to be easy and successful.

These factors call for action to improve the qualities and attributes of people, to make them lead positive lifestyles and solve those problems which are facing health development through developing the right scientific approaches and a mentality of self-reliance at an early age.

The AOSHC is designed to address these issues and to help bridge the gaps which exist between providers and beneficiaries on a partnership basis, and through the creation of development ideology among future generations. It also establishes mechanisms to enable more intersectoral collaboration between education, health and other sectors, encouraging shared responsibility for health promotion. Since schoolchildren are easy to reach and schoolteachers are community opinion leaders in their own right, schools can be used as a spearhead for health and social development. This way the education system can educate the whole community with ideas that strengthen social development.

Evolution of AOSHC—historical milestones

The programme is jointly sponsored by the WHO Regional Office for the Eastern Mediterranean (EMRO) and the Middle East and North Africa Regional Office of the United Nations Children's Fund (UNICEF) in cooperation with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the Islamic Educational, Scientific and Cultural Organization (ISESCO).

Dr Jack C.S. Ling, formerly Chief of Health Education, WHO, Geneva, Mr I. Hassoun, a senior educationist from Sudan and Dr Kamal Islam from Aga Khan University in Pakistan collected and analysed school health curricula from about 35 countries from all around the world. This team then developed the AOSHC material, which consists of national guidelines, a teachers handbook and six booklets of teachers' reference material covering various health issues.

The AOSHC material was later used to develop a teacher's guide for formal adult education programmes, a guide for institutions providing non-formal adult education, and the Family Health Directory. The AOSHC was then further developed into what is known as the community school.

AOSHC implementation in the Region is shown in Table 1.

Objectives

- To promote action on the Global Strategy of Health for All by the Year 2000 through bridging the gap between the individual and the most peripheral health services.
- To improve quality of life by improving the qualities and attributes of human beings, leading to self-reliance and the ability to adopt healthy lifestyles.
- To use schools as a spearhead for health and social development.
- To build development of ideology and a culture based on the scientific approach among future generations.

Strategical methodology

The methods used to deliver the curriculum are more important than the content. They are based on the discover, do and use princi-

Table 1 **AOSHC implementation status in EMR countries**

Country	First implemented	National coordinator	National committee	Workshops to educate supervisors	Project implemented in grades 1–3	Teachers' guide available	Evaluation of the project
Afghanistan	1995	×	–	–	–	–	–
Bahrain	1988	×	×	×	–	×	1994
Cyprus	1992	–	×	×	×	×	–
Egypt	1988	×	×	×	×	×	1992
Iran, Islamic Republic of	1995	×	×	×	×	×	–
Iraq	1995	×	×	×	–	–	–
Jordan	1988	×	×	×	×	×	1992 by UNICEF
Kuwait	1998	×	–	–	–	–	–
Lebanon	1996	×	×	×	×	×	–
Libyan Arab Jamahirya	1996	×	–	–	–	–	–
Morocco	1988	×	×	×	×	×	1993
Oman	1996	×	×	–	–	–	–
Pakistan	1991	–	×	×	–	–	–
Palestine	1995	×	–	–	–	–	–
Saudi Arabia	1996	×	–	–	–	–	–
Sudan	1988	×	×	×	×	×	–
Syrian Arab Republic	1991	×	–	×	–	–	–
Yemen, Republic of	1992	×	×	×	–	×	–

× = *implemented*
– = *not implemented*

ple. It is through a dynamic collective approach that the objectives of the AOSHC can be attained.

The strategy emphasizes the community role of the school through opening its doors to the community and broadening the classroom to encompass the whole environment. The strategy creates not only interaction but also partnership and a mutual benefits exchange process between the community and the school. It aims to make the education system repay society for some of the investment made into schooling.

The strategy is based on a clear philosophy, clear aims for the programme and role identification based on the creation of an appropriate organization within the school population. The programme is built in phases, implemented using an easy methodology and according to the needs, abilities and ages of pupils. Training of teachers and peripheral health workers is carried out in the schools by master trainers who receive training at district level. Schools are provided with the materials and guidelines needed. Each teacher is given a special role to perform and there is one programme coordinator at each school level.

Expansion of the programme among neighbouring schools is fulfilled through a process of technical cooperation among community schools whereby a school which has adopted the AOSHC will assist a neighbouring school, and pupils from one school will train pupils in another.

While implementing the programme, school communities employ three levels of objectives and strategies relating to what is happening within the school, in the neighbouring environment and at home. Approaches can include drama, games, songs, health education activities, wellness weeks, special health days, exhibitions and competitions.

Close working with peripheral development workers is an important parameter of the strategy. These workers will include not only health workers but also peripheral agricultural extension workers and veterinary, water, traffic and municipality workers. There will also be close working relations with local community leaders and associations.

Many activities will be performed during spare time such as weekends and holidays in order to avoid overloading an already congested school curriculum. A main principal of the strategy is to meet the objectives with little or no cost.

AOSHC implementation methods

There are about 12 tested methodologies for implementing the AOSHC. These are described as follows with anticipated benefits to show how set objectives can be met.

1. Health projects developed from AOSHC material

Mini-projects are developed addressing locally important health issues, e.g. environment, personal hygiene, safety, disease prevention and dental care. Each project has in-school, outside and at home objectives and activities. Projects are managed by a pupil programme manager, assisted by a committee of students and about 20–50 pupil workers. School teachers and peripheral workers will be the project's advisers and supporters. Roles are clearly identified and a check list of activities is developed. The expected outcomes are:

- Pupils will develop the following skills: team work, management skills, planning skills, healthy lifestyle, communication skills and work related skills;
- Schools will become more healthy;
- The community will benefit from health returns and society will save on health expenditure.

2. Field teams

After theoretical orientation small teams of pupils are assigned to an area to discover, analyse and discuss developments in the community related to health issues, e.g. environment. A team in its first assignment will list and later discuss situations in the area which have a positive impact on the environment, e.g. a green area or public garden. In their group discussion they will learn about the sectors involved in developing the park, how useful it is, how it can be protected and promoted, and then they will work as a team to perform the promotional intervention. The expected outcomes are:

- Children will learn the following skills: team work, communication, planning and analysis. They will also gain research and work-related skills;
- The community will benefit from their work input;
- Environment will improve;
- Children will develop positive attitudes.

3. Home assignments

Each child, once per week or as appropriate, is asked to look in its house for positive things which, for example, can prevent a health risk such as diarrhoea. The child will discuss the issue with its parents and look for good practices such as washing hands before eating, eating hot food, safe keeping of toxic substances, etc. The expected outcomes are:

- Children, by looking for good things first, develop positive attitudes;
- Good communication and harmony is fostered in the family;
- The home health situation will improve;
- Parents become involved in school activities.

4. Joint school and community projects

Projects similar to those developed in schools are set up but are jointly managed by pupils, school drop-outs and community members. Such projects also have broader community implications. They may include projects like anti-illiteracy programmes, village census, tree planting, cleaning campaigns, numbering houses, naming streets and safety promotion. The expected outcomes are:

- Better use of spare time;
- Skills and attitudes are developed;
- More benefits for the community;
- Better use of resources;
- Involvement of school drop-outs in school activities.

5. Special clubs and associations

Pupils and school drop-outs can form clubs or associations around common issues such as sports, friends for traffic safety, care of the elderly, friends of the environment, lovers of animals etc. Such clubs can run campaigns and have joint interventions, organize special days or exhibitions, etc. The expected outcomes are:

- Positive skills and attitudes are developed;
- Increased social harmony;
- Protection of groups at high risk;
- More development gains.

6. Integration within school subjects and activities

The AOSHC material is integrated within general school subjects such as mathematics, geography, religion, social sciences and within school activities such as drama and sports. The AOSHC method of teaching can also be used for other subjects where appropriate. The expected outcomes are:

- Health education for children without the need for extra text books or time;
- Making the education system relevant to every day life.

7. School meals

By arranging for equipment, ingredients and cooking to be donated by the community, school meals are arranged whenever possible. Children serve themselves, they are briefed about ingredients and best cooking practices and they clean the dishes. School meals can be linked with public or school occasions or the distribution of food supplements or donations given to pupils, e.g. milk or fruit. The expected outcomes are:

- Nutrition education for pupils and the community;
- Children will learn healthy cooking and eating habits;
- Social harmony;
- Personal skills and attitudes developed;
- People's nutrition improved.

8. School workshop or laboratory for skills development

Although this may be a resource for implementing the AOSHC programme, it is also a method by itself. Pupils, when deciding or implementing a plan, list the skills needed. Some skills possessed by pupils or community members may be useful to others who can be trained to acquire them. The school will define a site for this activity and the pupils then learn to teach each other. Suitable activities include the demonstration of health products or techniques, such as how to prepare milk products, how to kill flies, how to avoid accidents and how to purify water. The expected outcomes are:

- Teaching skills;
- Confidence-building;
- Promotion of individual skills.

9. Summer assignments

Clearly defined assignments with measurable products are given by the AOSHC coordinator to individuals and groups during school vacations. The expected outcomes are:

- Personal and community benefits as before.

10. Research (discovering) assignments and games

This method is associated and linked to Scouts activities, excursions or school trips during which pupils will try to list the health risks they may face and discover products and practices useful to health. This assignment will be preceded by a briefing relating to relevant subjects such as medicinal herbs, protection of the environment, breathing exercises and first aid. The expected outcomes are:

- Integration of health with entertainment;
- Team and individual positive skills;
- Safety precautions skills;
- Social harmony;
- Outdoor, healthy exercise.

11. Parent support teams

Selected parent groups are identified by the AOSHC coordinator and are provided with material and appropriate orientation and training to support pupils and establish with them joint clubs, associations and projects. The expected outcomes are:

- Increased parent/school interaction;
- Improved health and healthy behaviour;
- Confidence building amongst pupils and among the community towards the school system.

12. Health volunteers

Volunteers for health are appointed to work in areas individually selected and coordinat-

ed by the AOSHC coordinator. The expected outcomes are:

- Volunteering spirit created;
- Increased humanitarian attitude.

Community school

The community school represents an advanced stage of AOSHC. Besides health issues the curriculum includes agricultural, veterinary, income-generation and other issues relevant to overall community development. The community school is a component of and fully integrated within the healthy villages programme. The AOSHC becomes the action-oriented school *development* curriculum (AOSDC). The AOSDC is implemented in the same manner as the AOSHC with similar benefits, but a broader area is covered. By implementing the AOSDC a real development ideology will be implanted into the minds of future generations, replacing the now widespread, non-fulfilling educational system presently prevailing in many developing countries. The community school acts as a spearhead for community development, and its graduates will be useful citizens, well acquainted with the needs of their societies and capable of dealing with them.

Discussion

In many countries there is insufficient financial allocation for health services. The situation is worsened by the fact that the recipients of health services are not helping to improve their health either by their inability to realize their health needs or because they lead negative lifestyles harmful to their health. Furthermore, in spite of reasonable investment in developing their health managerial systems, efforts fail because the general education methodologies have not built the basic skills and attitudes that can develop leadership and managerial qualities among school graduates. In rich countries with generous allocations for health services, dependency, indifference and negative lifestyles create health problems with an appreciable negative outcome.

Negative lifestyles are now becoming a major cause of disease, disability and death, in both developing and developed countries. Negative lifestyles are also harming the environment, thus creating a vicious circle of continuing harmful effects. The individual thus remains a major factor in health development and health status. The lack of a sense of ownership of, and responsibility and accountability for, actions to improve people's health represents a common barrier that needs to be addressed at all levels.

As described earlier and as seen in the impact of its implementation in various countries it is evident that AOSHC is an effective intervention that should be invested in further. It addresses the issues discussed and contributes to the overall health and social development of the community.

Furthermore, by using schools in development we are encouraging the utilization of a previously untapped national potential. The work of the AOSHC programme can supplement the allocated resources and open avenues which use national resources in a fashion that will promote the intersectoral integration of development work.

The AOSHC approach places health in the right place, as part and parcel of overall socioeconomic development plans and efforts.