Prototype Action-oriented
School Health Curriculum
for Primary Schools

National Guidelines

National Guidelines

Prototype Action-oriented School Health Curriculum

for Primary Schools

National Guidelines

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

UNITED NATIONS CHILDREN'S FUND
MIDDLE EAST AND NORTH AFRICA REGIONAL OFFICE

THE UNITED NATIONS EDUCATIONAL SCIENTIFIC
AND CULTURAL ORGANIZATION

ISLAMIC EDUCATIONAL SCIENTIFIC
AND CULTURAL ORGANIZATION

Alexandria
1990

The main objective of this Programme is to promote the movement of "Health for All by the Year 2000" (HFA/2000) through endeavours to bridge the gap between the individual and the most peripheral health services. Even with the availability of all social needs, including advanced health services, a satisfactory health condition cannot be achieved as long as people maintain acquiescent or even passive attitudes in their approach to health, in their habits and in their life-styles. Our present attempt is the first step towards the creation of the proper contributor to social development and its proper beneficiary, that is the individual. It is an investment for the benefit of man, which would eventually lead to the improvement of his health condition; as a result, man would give health its proper human dimension.

Although this curriculum constitutes one phase in the process of demystification of health information, through the provision of such information and making them accessible to everybody, it should not be viewed as a mere endeavour in the field of health education or health information. The proposed educational method, if not more important than the information it contains, is at least equally important. The purpose of these information is not only to incorporate them in the various school materials and activities, but also to turn them into projects closely related to growth and development, and jointly implemented by pupils, teachers, parents, members of the community and peripheral workers, staff or non-staff. The foreseen outcome is that members of the future generations would develop positive attributes, and self-reliance in identifying their needs, and would develop their ability to work and deal with others in order to meet those needs, let alone developing management and research skills at an early age. In brief, this programme is an attempt to improve the quality of life by improving the quality of the human being, having as its target the children of an age-group where they can be easily influenced, and using health in its broadest sense as an entry permit to reach their minds.

O.S.

Reprint 1990
ISBN 92-9021-013-3

Printed by APTC in Alexandria

ACKNOWLEDGEMENTS

The Action-Oriented School Health Education Project has been under taken by the Eastern Mediterranean Regional Office (EMRO) of the World Health Organization (WHO) 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). Originator and supervisor of the project was Dr Omer Sulieman of WHO. Many organizations and individuals have contributed to this effort; but they are too numerous to list here.

Ministries of Education and Health of WHO EMR Member States were sent the first draft of the prototype curriculum material; many sent in their useful comments. The draft was also reviewed by the Institutes of Education and Child Health of the University of London, Centre of Education Development of Sudan, Health Science Centre of the University of Colorado in the United States, and the International Child Health Department of Paediatrics, University Hospitals in Upsala, Sweden.

Special thanks are due to Dr David Morley, who pioneered the CHILD-to-child programme and chaired the EMRO workshop on the subject, and to Mr David Werner, whose books **Where There's no Doctor,** and **Helping Health Workers Learn** have provided very practical guidance as well as inspiration for primary health workers everywhere.

Apart from individuals mentioned in the text, acknowledgement is due to the work done by Mr Isam Ahmed Hassoun, former Under-Secretary of Education of Sudan, and Dr Kamal Islam, pubiic health specialist and Assistant Director of CARE in Bangladesh, who conducted the situation analysis, compiled the material and prepared the first draft; and Mr Jack C.S. Ling, Visiting Professor of Communication, University of Southwestern Louisiana and former Director of Information and Education for both WHO and UNICEF, who was editor and leader of the working group that finalized prototype curriculum.

Members of the working group were Mr Hassoun, Ms Naema Maheimid of Sudan's Centre of Educational Development, and Dr Colin Yarham, Head of

Health Education Department of Kuring-gai College in Australia and Chairman of the School Health Education Committee of the International Union of Health Education.

Dr Yasser Daghistani, Professor of English, University of Damascus, and Dr Keith Rothwell, formerly of Hull and London Universities and currently consultant in epidemiology and science writer, edited the final test. Mrs Anne Homfray, consultant designer, prepared the cover and provided layout assistance, and Mr Mustafa Kenawy, Egyptian artist, residing in Alexandria, furnished many of the graphics in the text.

CONTENTS

FOREWORD

As we approach the new millenium, the noble goal of Health for All (HFA) by the Year 2000, adopted unanimously by the world community as the premier development objective, seems uncomfortably distant. There has indeed been progress in the application of the primary health care approach since the Alma Ata Declaration of 1978, but in a majority of the developing countries progress has been slow.

Health for All, above all else, calls for changes in attitudes and health habits; even among health care professionals themselves the change has been slow. In fact, some consider the failure to recognize the need to tackle behavioural changes, and the difficulties inherent therein, as one of the major impediments to Health for All.

Children have long been identified as the prime target beneficiaries of primary health care in the HFA strategy. What has been missing is the strategic significance of reaching and educating children about health and the corollary consideration that children, properly guided, can and should be contributors to HFA. After all, in a decade they will be the adults and the inheritors of Spaceship Earth.

Under the circumstances, educating children for health through the growing network of primary schools should receive the highest priority, not only from the point of view of health, but also from the perspective of education. For, in the final analysis, one of the most important developmental reasons for education is to prepare the child to be self-reliant and to become a healthy and productive citizen. The Action-oriented Integrated School Health Education Project, jointly sponsored by WHO and UNICEF, with active participation of UNESCO and ISESCO, attempts to initiate action in this vital area.

Education here should be viewed in its fullest sense. It is important that educational efforts include activities. The project thus emphasizes "actions" by the pupils themselves, and in relation to their families and communities.

Time is ticking away. If the right steps are taken now by leaders in education and health, today's children will be tomorrow's productive citizens. As Gabriela Mistral, the Chilean poet said:

"Many things can wait. The child cannot. Right now his bones are being formed. His senses are being developed. To him we cannot say tomorrow. His name is TODAY".

Hussein A. Gezairy
WHO Regional Director for
the Eastern Mediterranean Region

Richard Reid
UNICEF Regional Director for
the Middle East & North Africa

Mohamed I. Kazem
UNESCO Representative and
Director UNEDBAS

Abdel Hadi Bou Taleb
ISESCO Director-General

I. INTRODUCTION

In 1987, with the population of the world estimated at 5,000 million, some 950 million persons were enrolled in schools. Of these, about 625 million are at the primary or elementary level.

Together with those children who are not receiving any formalized education, they form a vast section of a young population rapidly growing towards adulthood. In addition to their formal schooling, children are subject to multiple influences that affect their attitudes and behaviour. The sources of influence include their parents, other family members, their peers, communities and the media. Their attitudes and values, which are shaping their lifestyles today will determine the world's health tomorrow – as these young people become the parents and leaders of the future.

In the context of social justice and as an important means of achieving health for all through the primary health care strategy, the health learning of the school-age child should be enhanced in every possible way so as to promote self-reliance and social responsibility and a better way of life for today's children and tomorrow's adults.

Many millions of children are enrolled in primary schools in the EMR and MENA Region. On the shoulders of these children rests, for the most part, the future of their countries. How they respond to this challenge, is being determined today. The present is the most opportune time to initiate action directed at improving the health of these children, so that they are physically healthy, mentally alert and able to play a constructive role, socially and economically in the development of their society.

Although the original intention of this effort was to work out a health curriculum for primary, intermediate and secondary stages, it was subsequently decided to postpone dealing with the intermediate and secondary stages and concentrate, for the time being, on the primary level.

The decision to focus on the primary school in the preparation of this curriculum is based on several factors:

(a) Primary schools including Koranic schools are widespread. A great number of pupils, families and community members can be reached through the schools; because of the school networks, remote and rural villages can be covered and more teachers may be drawn into working for health.

(b) About half the children in this Region never receive any type of formal education beyond the primary school stage.

(c) Drop-out rates in the fifth and sixth grades are high (10 – 60%), especially among girls. Of the balance only 30 – 50% continue studies at the intermediate level. Most of those who drop out are poor, they come from the least privileged sectors, and belong to groups with high mortality rates. One reason for children to drop out may be poor health; and health education can be expected to improve their health.

(d) Children of this age-group are impressionable, receptive and eager to learn.

(e) Primary school children have great potential for carrying health messages home.

(f) Limited resources make it necessary to give priority to the question of which age level should be taught first; starting from the first level of education is a logical way to introduce health education.

(g) The primary school can be used as a spearhead for community-health projects.

II. RECENT ACTION

As early as 1983, EMRO started to take action in developing a School Health Curriculum. The intention was to inform and educate children, teachers about health. However, it was realized that the methodology of teaching should have a positive return on the attributes and qualities of the children. Furthermore, a new role should be identified for the school to act as a spearhead for development. The school will open its doors for community members to benefit from and the teaching ground will expand into the community. This way everybody will benefit, the school will have a developmental role and an economic return, the community will be supported by teachers and pupils in its development endeavours, the pupils will develop positive attitudes and the education system will have relevance to the needs of the people and the overall cost of education system will be reduced indirectly. A four-phase plan of action began late in 1985 for an Action-oriented Integrated School Health Education Curriculum for Primary Schools.

By "action-oriented" is meant that as a part of their learning experience at school, pupils not only gain new knowledge and skills, but also apply them in their homes and the community simultaneously. Thus the newly-acquired knowledge and skills are immediately transformed into action. The process is therefore gaining knowledge through discovering and doing.

By "Health" we mean a state of physical, mental and social well-being and not merely the absence of disease or infirmity.

By "integration" we mean incorporating health information as an integrated part of the school curriculum and, where necessary and practicable, integrating the various components into appropriate existing school subjects and activities. The activities include:

(a) school health services;
(b) the physical, mental and social environment of the school;
(c) the involvement of the school in community services and activities to improve the total social status of the community.

By "curriculum" we mean the following set of materials:

(a) A TEACHER'S GUIDE, including sample lesson plans.
(b) A TEACHER'S RESOURCE BOOK (with suggested learning activities).

PHASE I: SITUATION ANALYSIS OF SELECTED COUNTRIES OF THE REGION

A situation analysis of the Region was needed. Two consultants, one sponsored by WHO and one by UNICEF, were dispatched to seven countries and a detailed questionnaire was sent to the other countries of the Region. In addition, the consultants discussed the problems with officials of the International Bureau of Education in Geneva and the Arab League Educational, Scientific, and Cultural Organization in Tunis.

The main findings were as follows:

1. While all countries agreed on the importance of health education in schools, scarcely any of them appeared satisfied with the content and methods currently used in teaching health.

2. Health is not taught as a separate subject and there are no specialist teachers or separate examinations for school health teaching in most countries.

3. Health subjects, where taught, are integrated into other subjects, but this is done inadequately. Factual information on health is taught with an emphasis on passing examinations, without any apparent attempt to influence the student's behaviour and attitude.

4. There is little evidence that school activities include health education except in sporadic instances, and teaching methodologies are primitive and inadequate.

5. There is a lack of intersectoral collaboration in existing health teaching.

6. Little attention is given by the media, i.e. radio, television, press, etc.., to health education for school pupils.

7. No separate budget provision is made for school health education in any country.

8. Aims of school health teaching are not clearly stated by the school systems. There is scarcely any attempt to influence the family or community through school health education.

9. There is no separate, official syllabus for school health education in many countries. The countries which have such a syllabus have not been able to implement it in an effective way.

10. Teaching aids and materials are meagre and inadequate.

11. Pupils are seldom called upon to participate in community health activities.

12. There is no evidence that schools involve parents in health matters.

13. Most of the teachers involved in school health teaching are not specifically trained to undertake such responsibility.

14. There are no specialist inspectors to supervise health teaching in schools. The present inspecting authorities either are not prepared for supervising the teaching of health or do not have the time or inclination to do this work.

15. No techniques have been evolved in any country for monitoring or evaluating school health education, and none of the countries have performed and evaluation of its impact.

16. Plans of action for school health education are not available in many countries of the Region.

17. Only one Gulf country, Bahrain, heeded the 1980/1981 call for action by the Council of Arab States of the Gulf, which produced a working paper on the subject promising a curriculum with a comprehensive approach geared to

generating appropiate behaviour and attitudes among pupils. Even in Bahrain, however, the textbooks and methodologies adopted are of a predominantly factual and didactic nature.

PHASE II: WORKSHOP ON AN ACTION – ORIENTED HEALTH CURRICULUM

A workshop sponsored by the WHO Regional Office on an action-oriented school curriculum was convened in Alexandria from 23 to 27 February 1986, and was attended by participants from Member States. Other participants included resource persons with special experience in school health, child health and education. This workshop represented the second phase of the WHO Eastern Mediterranean Regional plan for the development of an action-oriented school health education curriculum.

Principal recommendations of the workshop

The following recommendations were made by participants in the workshop:

1. An action-oriented school health education plan of action, with national guidelines and prototype curriculum, should be prepared and implemented, as soon as possible, by the Regional Office.

2. A working group should be formed to collaborate in the actual development of a school health education prototype curriculum and materials. This group is to involve representatives from educational, child health and material design institutes.

3. An inter-regional and interagency action-oriented school health education workshop should be held, sponsored by WHO Headquarters, to coordinate efforts of various WHO regions and other agencies in this area, so that other WHO regions can also benefit from the progress so far achieved in the Eastern Mediterranean Region.

4. The necessary steps should be taken to ensure governments' commitment to this project.

5. An effective international coordinating mechanism should be established, including not only UNESCO, UNFPA, UNICEF and WHO but also the

International Red Crescent/Cross and other Regional Organizations with interests and activities in the school health area.

6. The action-oriented school health education efforts should begin at the primary level and Koranic schools. Although it is recommended that the project should concentrate on primary level schools to begin with, the possibilities of going into intermediate, and later secondary, schools should be explored.

7. At the national and international levels a series of workshops for doctors, educationalists and policy-makers should be organized to gain support for action-oriented school health education.

PHASE III: PREPARATION OF AN ACTION-ORIENTED SCHOOL HEALTH EDUCATION PROTOTYPE CURRICULUM

Following this workshop, the Regional Office, in collaboration with, UNICEF, embarked on the preparation of an action-oriented school health education prototype curriculum for primary schools.

The preparation of the prototype curriculum was undertaken with the following considerations in mind:

1. The countries in the Region present a wide variety of physical, social, cultural, economic and political conditions. Their environments and infrastructures reflect, and sometimes intensify, these differences. Differences are encountered not only among governorates and districts within the same country but also among rural, urban and nomadic communities. In order to be effective, school education, especially health teaching, must be planned and closely geared to the immediate conditions and needs of the people to whom it is addressed. This principle applies to the primary much more than to the intermediate and secondary stages of education.

2. One example of the problems created by this heterogeneity of conditions concerns school teachers. No curriculum can be properly conceived and planned without first having a clear idea of the kind of teacher who will be entrusted with the teaching task. Schools in the Region, even within the same country, are staffed by teachers who have received various types and degrees of education and training. In some countries, there is a heavy reliance on untrained and/or expatriate teachers. The conditions under which these teachers are expected to practise their profession also impose variable stresses and limitations. Some teachers are called upon to

manage classes of more than a hundred children, or teach in classrooms without windows or even a blackboard.

The question, therefore, arises as to the kind of teacher whose needs are to be met in preparing this prototype. There seemed to be no other way but to formulate the curriculum in a generalized and flexible manner, leaving adaptation and adjustments, as well as the designing of an appropriate training course, to be made at the country level, because it is only here that an accurate evaluation of local conditions, needs and facilities can be made.

The inclusion in the primary school curriculum of such topics as alcohol abuse, drug addiction and sex education is controversial on account of the young age of the pupils and/or socio-cultural objections. However, in the interest of the large number of pupils who will not continue their school education after primary school, it has been thought best to include those topics in the prototype curriculum leaving the decision for inclusion or deletion to the national level.

3. The prototype curriculum is therefore intended to be studied, reviewed, revised and rewritten for primary schools (children aged 6 – 13 years) in the countries of the WHO Eastern Mediterranean Region, although parts of it may be more appropriate for use in preparatory schools (children aged 12 and above).

4. It is hoped that, wherever possible, the prototype curriculum should be considered for teaching as a separate subject. However, education officials, curriculum specialists, teachers, pupils and even parents seem to agree that the primary school child is today overburdened, and that an extra load would not be welcome, no matter how many benefits it promises. Such realities, including the current personnel and financial constraints in the health and education sectors, call for a more sensible approach: designing the prototype material and its various components in such a way as to facilitate their integration into different school subjects, such as science, social studies, etc. It should be understood that introducing the subjects should not involve adding them to the current load but it does call for substituting or reshuffling some of the existing materials.

5. The process of integrating the various units into the existing curricula, which differ from country to country, requires an intimate knowledge, among other things, of the country's syllabi for each subject and each grade, as well as the approaches and methods employed in teaching. Without such knowledge, suitable points and means to introduce health messages cannot to be determined, and

smooth and effective integration cannot be achieved. For these reasons, the prototype gives only suggestions and examples to indicate how the integration can be done.

IT CANNOT BE OVEREMPHASIZED THAT PERSONNEL IN CHARGE OR CURRICULA AT THE NATIONAL LEVEL ARE THE BEST SUITED TO COMPLETE THE JOB IN EACH COUNTRY.

6. The curriculum in its present form has been designed so as to obviate any need to produce special textbooks for the pupils. One reason for this is that it is generally believed that governments and pupils in the Region already have too many textbooks to cope with, and the lack of resources in many countries limits any increase in the number of these books. The other, more important, reason is that the absence of textbooks may lead teachers to rely more on "action" – practical work and abundant use of teaching aids, which must, whenever possible, be low-cost and of the "do-it-yourself" type.

7. Finally, it is important to reiterate that the main feature of this prototype curriculum is its emphasis on "action". Each lesson should be followed by health-related activities of a developmental nature at the family and community levels.

The proposed prototype curriculum consists of two components:

A. A TEACHER'S GUIDE, incorporating the principles and methodologies recommended for teaching health in primary schools. It includes sample lesson plans, demonstrating how health material can be integrated into the various school subjects and activities. Of course, these are no than examples and **they are not intended for direct use in teaching.**

B. A TEACHER'S RESOURCE BOOK (two volumes), in which a number of health subjects are presented in the form of teaching units divided into topics, each with related activities to be learned or performed by pupils. For each unit the Book provides appropriate background information for the teacher. All this material is primarily intended to serve as examples. Each country will ultimately decide, in the light of its specific needs and facilities, what health units and activities it wishes to adapt and adopt. It will no doubt wish to rearrange them as needed.

The prototype follows the WHO/UNICEF guidelines set by the International Consulation held in Geneva in 1985 and the recommendations of the 1986 Regional

Workshop; it has taken into account the advice of UNESCO and the International Union of Health Education on this subject. The material reflects the spirit of self-reliance and personal responsibility, as well as the essential element of community involvement that underlies the primary health care approach to Health for All by the Year 2000, the noble goal adopted by the international health community. The presentation of the material begins with understanding the human machine, growth and development, and nutrition; then the various elements of personal health, social and mental health, community health, environmental health, first-aid skills are presented, and finally there is a dossier on common sicknesses, both communicable and non-communicable.

Though much thought was given to the order of presentation of the material, there is no expectation that the order will be followed by any education authority; indeed, principals and teachers will most probably tailor the material to fit their existing syllabus and curriculum. For the purpose of training teachers, it was thought that a rational grouping of subjects and order of presentation would be helpful.

The organization of the material is reflected in both the *Teacher's Guide* and the *Resource Book*. Both are available in Arabic and English, but they need to be translated into local languages of the countreis that wish to join the project.

It must be mentioned that much of the material, especially the *Teacher's Resource Book*, has been drawn from a wide range of source materials, books, papers, reports and documents, mostly published by WHO, UNESCO and UNICEF. Also very useful material has been drawn from, *Helping Health Workers Learn* by D. Werner and B. Bowers; and from Dr David Morely's "CHILD-to-Child Programme", which aims at educating school children who often care for their younger siblings at home. Other sources of material include the *MEDEX Primary Health Care* series, published by the School of Medicine of the University of Hawaii in Honolulu.

III. NATIONAL IMPLEMENTATION

PHASE IV: PROPOSED NATIONAL GUIDELINES

IV.1 Establishing a focal point

It is best to begin by nominating an institute or a national coordinator to take charge of all arrangements pertaining to the subsequent development and implementation of the new curriculum.

IV.2 Setting up an inter-sectoral board

The second step in the process of implementing the new school health curriculum would be the setting up of an intersectoral board of a calibre that can influence policies and practices in the country. It should include, besides representatives of the ministries of education and health, members from other ministries, non-governmental organizations and private enterprises, whose interest and cooperation can provide the board with vital expertise and support. These institutions may include, for example:

The ministry of agriculture
The ministry of information and broadcasting
Mass media
Teaching institutes
Universities
Teachers' and medical associations
The ministry of labour or manpower
The ministry of planning
The ministry of local government
International agencies and non-governmental organizations involved in health and in education

The goals set before this board is to enhance the health learning of school-children in every possible way, so as to promote the exercise of self-reliance and social responsibility and a better life quality for today's children and tomorrow's adults, and to establish a new role of schools to allow them act as spearheads for development and as a means of achieving Health for All through the primary health care strategy. The immediate objective of the board would be the development and implementation of the Action-oriented School Health Education Curriculum, using the prototype as a guide, adapting, deleting from, and adding to, its components in order to meet the conditions and needs of the country.

In order to achieve its objectives, the board may adopt the following strategies and guidelines:

IV.2.1 Develop a political commitment

Unless policy-makers at the highest level give their public support to the Programme in an active and sustained fashion, collaboration among the sectors will not occur, and the needed resources will not be forthcoming.

This political will, however, is often dependent on public sympathies and enthusiasm which the board must seek to activate through the mass media, religious bodies, civic and professional groups, and other channels.

IV.2.2 Develop functional collaboration among institutions that can contribute to the promotion of school health education

Cooperation and coordination among ministries of education and health must be exercised from the national to the local level, on the basis of shared responsibility for both the health education of school-children. This linkage between the two ministries must be reinforced and enriched by the all-important collaboration with other sectors and institutions, especially the mass media whose essential role in arousing awareness and advocacy among all sectors of the society is indispensable.

With the financial constraints facing many countries, intersectoral collaboration may be the only way (apart from community donations) to meet the costs of improving school health facilities.

IV.2.3 Carry out a situation analysis

A clear knowledge of the state of school health and school health teaching, and their inter-relationship with prevailing socio-cultural and economic conditions is essential for the determination of needs and work plans. This is why a thorough situation analysis at country, district and school level should be conducted from the very start. The methodology for conducting such an analysis can best be decided in the light of facilities available in each country, but the analysis must involve:

(a) The identification of major health problems and needs of school-children, as well as those of the communities to which the schools belong.

(b) An assessment of existing health teaching programmes and other channels of health learning, their impact on the problems and needs identified, and the extent to which they can be strengthened.

(c) A review of the content and methods of health teaching through school curricula and extra-curricular activities showing how they fit into the timetable of examinations, evaluation, and supervision, as well as into the scheme of priorities as seen by teachers, pupils, parents, etc.

(d) An assessment of the content of the education and training of teachers and supervisors, and their ultimate impact on health learning.

(e) A review of the extent and nature of pupil participation in community activities, and how far pupils are motivated by communities to participate.

(f) An assessment of the existing state of school health environment and school health services.

(g) An assessment of the degree and impact of existing or achievable inter-sectoral cooperation.

(h) An assessment of actual, or potential resources, and priorities for the use of these resources.

(i) A reasoned statement of regional or local differences.

(j) Taking into consideration the ideas of field workers in education and health, and of community leaders, and parents.

IV.2.4 Provide the curriculum guidelines

Based on the findings of the situation analysis, the board may lay down guidelines for the ministry of education curriculum department (or an education institute or a special task force) to develop the curriculum using the protoype curriculum as a guide.

IV.3 Establish a national health education committee

A national committee should be established to oversee the health education development under the Ministry of Education with the active participation of the Ministry of Health. Some functions should be carried out by the committee, others can be done through the established units within the Ministry of Education or by sub-committees established for specific purposes by the committee.

IV.3.1. Promote the other components of the school health education programme

A school health programme cannot be successful by teaching health alone; the three other components of the programme, namely, school environment, health services and school-community relations, must be simultaneously attended to. Furthermore the teaching should cover health related areas of the basic needs of life.

None of these components can be effectively dealt with in isolation from the others, and it is imperative that the efforts of the committee should cover all four areas. The other three areas provide the teacher with excellent educational opportunities, with appropriate situations for demonstration and practice that

facilitate the vital elements of reality and effectiveness in the learning process. On the other hand, it is easy to see the futility of teaching a health curriculum when school health services, school environment and home and community support are adverse or indifferent to the education provided. A teacher cannot ask his pupils to wash their hands after going to the toilet or before eating, if the school has neither water nor toilets, or if the parents are not willing to direct the child to do the same when he is at home. Children and parents cannot be asked to seek medical help where medical services are inaccessible or medicines unavailable.

It has already been indicated that with the difficulties many governments are now facing in providing for a rapidly increasing number of schools, only community donations and self-help efforts, together with intersectoral cooperation, can be resorted to for help. However, since self-reliance is one of the main objectives of school education, both pupils and teachers, given guidance and encouragement by the committee, may have much to contribute.

IV.3.2 Curriculum

Here are some special considerations which need to be observed:

(a) The curriculum for each country should be based on its current health problems.

(b) Generally, two different methods are adopted in the preparation of a curriculum. In the first method, detailed outlines covering the content to be taught to each grade are prepared at the national or state level, and teachers follow these outlines closely. In the second method, teachers are given the educational objectives for each subject of instruction and a wide latitude in developing their own lesson plans and teaching methods. The adoption of the latter system presupposes that the teachers are well prepared for this type of function. While either system could be adopted, depending upon local capabilities, it is advantageous to adopt the first method of a planned programme where teachers lack orientation to health and the proper motivation. But, even in a planned programme, the involvement of teachers in curriculum preparation has many advantages. Their experience with the various grades of students provides a good judgement of what can be undertaken and what methods should be used with respect to each level. Another advantage is the deeper commitment of the teacher to the curriculum.

(c) Careful consideration should be given to the findings of the situation analysis, as well as to the need for a balanced programme for the education of children in all

facets of health. Continuity from year to year, and building on previous knowledge are essential to make a chart showing the scopes of subjects and the sequential programmes to be developed. Each health education lesson should be restricted to a simple concept and one teaching idea, so that pupils may have time to develop understanding attitudes and practical health skills.

IV.3.3 Teaching/learning materials

In the past, teaching in schools has always been subject-centred and teacher-based. The pupils were passive participants in the learning process. Experiences have shown that this may not be the best way to teach. The current shift favours teaching which is activity-oriented, problem-centred and pupil-based, where the class becomes an active partner in the learning process and the teacher becomes a facilitator.

It is necessary to have proper planning and production of teaching/learning material to support activity-oriented learning. A common question is whether teaching material is the same as learning material. The following two examples will clarify the situation.

Example 1

A set of slides used by a teacher in support of his presentation may be considered teaching material. However, when the same set of slides is accompanied by a text recorded on tape, which can be used individually or by a group of pupils on their own, it becomes learning material.

Example 2

A set of flash cards used by the teacher to explain or clarify some issues is teaching material; but when the same material is used by the pupils to investigate and find out the message in the poster it becomes learning material.

The answer therefore lies in visualizing not only how the material has been designed but also how it is used. Most teaching material can be used as learning resource material provided the teacher knows?

The training/learning resource materials to be developed within a country would include the following:

1. A trainer's manual for those who will be responsible for training teachers. This manual will enable a trainer to identify well in advance:

(a) the reading he/she must do,
(b) the resources he/she must acquire,
(c) the material he/she needs and the methodology he/she will follow.

The manual will help the trainer to establish a training/learning environment to conduct a problem-centred and activity-oriented, student training programme in which the lecture forms only a small segment of the teaching session.

2. A trainee's manual for those teachers who will be receiving the training. This manual will contain directions on how to use all the resources included in the training module. It will have a course outline, instructions on what to do during the course and required assignment. Besides this, it will also contain pre-test practical exercises and post-test material. The overall objective of the trainee's manual is to initiate activities that will bring about a shift from passive learning to active learning.

3. Development of learning resource material for training – material for teachers and pupils. The development of learning resource materials should be designed and structured to provide a greater emphasis on learning rather than teaching. These learning materials may be in the form of printed documents, slide tapes, flannel-graphs, slide monographs, video-tapes, audio-tapes and any other materials that will facilitate learning.

The *Resource Book* and the *Teacher's Guide* for action-oriented school health curriculum produced by the Regional Office may be used as a guide for initiating the preparation of the above materials.

The overall steps in planning the development of learning resource materials should include:

(a) Defining the programme objectives

Well-defined programme objectives with clear goals should be established. These goals should refer to the intended changes that are expected to occur after the training takes place.

(b) Defining the appropriate learning materials required

Once the goals are set, the appropriate learning suited to the needs of those who are being trained (teachers and pupils) could then be developed. The choice of the materials will depend on:

- How soon the material is required?
- How simple is the message?
- What is expected to be achieved; does the learning material aim at developing skill, knowledge or attitude?
- What teaching/learning materials already exist in the country; can some of these be modified to meet current needs?
- Whether guidelines on how to use the existing teaching/learning material are available or not?
- What types of expertise are available within the country?

(c) Allocating adequate funds

One important consideration would be the amount of money available for the preparation of the learning material. Very often it is found that the budget for training activities does not provide adequate money for the production of such materials.

(d) Identifying resource centres/institutes

Institutes or groups have to be identified for the actual production and pre-testing of the materials in conditions which are similar to the actual situation where they are going to be used. Effective design and production of material often calls for the participation of the audience concerned through a representative group. The materials so produced, properly tested, should contain not only scientifically accurate information but also take account of cultural values of the people, thus facilitating the learning process and leading to changes in attitudes and behaviour.

IV.3.4 Training programmes

The proper training and motivation of teachers to involve the pupils in learning about health is perhaps the most important component of this programme. Without the willing efforts of well-trained and motivated teachers all inputs may be wasted and the entire impact of the programme lost. In fact, all education and health

personnel who are expected to be connected with the implementation and functioning of the new curriculum will need to receive some instruction and training related to health and to school curricula. The content, nature and duration of this training will depend on their professional background and on the nature and extent of their involvement. The training may be effected through basic courses for would-be teachers, in-service courses for current teachers, workshops and seminars for headmasters, supervisors, administrators, etc.

Orientation and skill development in education and communication, especially two-way communication, should be incorporated in the professional preparation of physicians, nurses and all other health workers involved in school health services.

Provision should be made for refresher courses for teachers in charge of health education at fairly short intervals, especially during the first few years of implementation.

Inter-disciplinary workshops and seminars, e.g. involving health/education and mass media personnel can make a significant contribution to mutual understanding and cooperation.

All programmes designed to prepare individuals for participation in health education activities of any kind should emphasize motivation as well as content.

IV.3.4.1 Developing programmes

Some general objectives that may apply to all types of training are:

(i) to create awareness and understanding of the role of health education in the field of general education;

(ii) to develop an interest in, and a favourable attitude towards, health teaching;

(iii) to develop the ability to recognize opportunities to incorporate effective health teaching into everyday work;

(iv) to develop the ability to plan, implement and evaluate health teaching as an integral part of the school health programme;

(v) to increase the ability of teachers and pupils to communicate with individuals, families and community groups to enlist their participation in the school health

programme, and to identify health development roles for pupils and teachers in support of community health programmes;

(vi) to promote team work for health education, as found appropriate;

(vii) to encourage recognition of the role of specialists in related fields and of the advantage of drawing on their resources as and when necessary.

IV.3.4.2 Planning health education in a teacher training programme

Before detailed planning is undertaken, information on topics that would provide answers to the following questions should be gathered.

(a) To what extent do health topics form part of the existing curriculum? Do they reflect the health needs and special problems and solutions appropriate to the country?

(b) To what extent do the environmental conditions of the teacher training institutions satisfy the standards prescribed by the appropriate authority?

(c) Who teaches health and what teaching methods are adopted?

(d) What constraints – political, administrative, or sociopsychological – are involved in the promotion of health education in teacher training institutions?

An outline of the new curriculum, along with a statement of need for revision, must then be prepared in collaboration with those concerned with teaching.

The next stage is the creation of a proper climate for curriculum change. Attention will again be needed at three levels: top policy-makers in the fields of school health, education, and administration; curriculum committees for teacher preparation; and teacher training institutions.

It is necessary for every teacher training institution to develop the capacity for teaching health. An increasing number of larger teacher training institutions are placing the responsibility for coordinating and teaching health and health education in the hands of an instructor for the subject. Where this is not possible, an existing instructor with previous training and experience in a related field can be trained to assume responsibility.

Among many learning experiences, provision should be made for practice in teaching health. It is commonly stated that improvements in educational methods are slow because "teachers teach as they were taught and not as they were taught to teach". Student teachers should be invloved fully, and should participate in the health services and education programme of the school.

The success of school health activities depends on the quality and motivation of teachers. It is unrealistic to expect teachers to give training in habits to which they themselves are not accustomed. Priority attention must be given to training in health education during the basic preparation and in-service training of teachers for the successful implementation of health teaching programmes.

IV.3.4.3 In-service programmes

In-service training should receive attention. There are many ways in which this could be done.

1. Existing teacher training institutes could organize short seminars, workshops, summer courses, etc., for teachers already in service.

2. Some health education offices have a teacher training unit that undertakes the training of staff in relevant institutions on a priority basis. The activities of this unit could be extended to include short orientation courses for those in service in the school system.

3. A mobile team of trainers could conduct demonstration health-teaching activities in selected schools in the region concerned.

4. Wherever environmental sanitation projects are initiated, the staff of the project could (a) include teachers in the committee formed for health education, (b) utilize their services for community health education, and (c) arrange orientation training for teachers in environmental health projects.

IV.3.5 Functions of teachers in health teaching for school pupils

The functions of school teachers embrace all aspects of the school health programme:

IV.3.5.1 Healthy school environment

(a) Identify the deficiencies in environmental health standards in the school and its immediate surroundings.

(b) Seek and obtain help from competent authorities, the community, or voluntary agencies to develop a sanitary environment in the school.

(c) Maintain the sanitary conditions in the school with regard to housekeeping, water supply, and the disposal of liquid and solid wastes.

(d) Maintain sanitary and hygienic conditions in the conduct of school meals.

IV.3.5.2 School health services

(a) Understand the functions of the school health services.

(b) Cooperate effectively with personnel such as sanitarians, school nurses, public health engineers and physicians in the health services they render to the school.

(c) Participate in the follow-up programme for correcting the deficiencies of environmental health.

(d) Work effectively with the school health council or such other committees formed to strengthen the school health services programme.

IV.3.5.3 Health teaching and education

(a) Carry out health education according to the needs and interests of pupils of various grades.

(b) Develop and use a variety of learning experiences adapted to the development level of pupils. Experience which can be of particular use includes:

- sickness in the school, home, or the community;
- participation of pupils in the maintenance of sanitary conditions in schools and immediate surroundings;
- participation in school meal programmes.

(c) Select and use a variety of teaching materials, and prepare simple ones locally.

(d) Evaluate health education in terms of knowledge, attitudes and behaviour.

(e) Develop suitable motivation (stressing the positive aspects) for healthy living.

(f) Keep abreast of new developments in health teaching.

(g) Furnish an example of healthy living for pupils to imitate.

IV.3.5.4 School, home and community relationship

(a) Interpret school health education to families and communities.

(b) Develop school – community relationships through parent – teacher associations or other suitable committee mechanisms.

(c) Participate in health education and improvement of health programmes in the community and involve pupils as well.

(d) Serve as a leader in the community in matters of health.

IV.3.6 Starting at the district level

The actual implementation of the new curriculum may initially be restricted to a district or to a selected number of schools in different districts. This may be the best way to test the curriculum before it is implemented on a broader scale. However, some countries may prefer to test the curriculum in another way that is more appropriate to their resources and needs.

IV.3.7 Establishing an effective supervision and monitoring system

Monitoring should start at an early stage both at the local and national levels. This should provide a useful mechanism for assessing the progress of the project and enabling any necessary modifications or improvements to be made in good time.

The success of health education activities depends, to a great extent, on the quality of supervision provided. Supervision means different things to different

people. It is essentially an educational process in which the supervisor takes responsibility for helping the supervisee to develop himself and become more competent in discharging his duties. Supervisory needs should thus gradually diminish with the passage of time.

Supervision in school health teaching should be perceived as continuing education. It should reinforce the initial training of the teacher and help him to meet new challenges that might arise in this field.

IV.3.8 Plan for testing and evaluating the curriculum

School health education at the primary level is meant to contribute to the achievement of the following health goals for children, their families and communities:

(a) Improved health status (especially behaviour) of the pupils involved in the classroom health instruction.

(b) Improved health status of the family members of pupils involved in the health intruction. This change will occur as a result of the pupil's ability to transfer his/her learning to others.

(c) Improved health status at the community level as a result of the influence of the health instruction transferred within a community from many school children to their families, and the actual participation of these pupils in community health programme activities.

(d) Evaluation of the effects of health teaching in schools is difficult. There are so many things that affect people's life-style and health, which cannot be separated from each other and measured objectively. Nevertheless, such evaluation is important and must be carefully designed to avoid improper conclusions and bias.

It is recommended that the evaluation process address two basic questions at both national and local school level.

Evaluation question No. 1 : Is the health education curriculum being implemented as intended?

Evaluation question No. 2 : **Is the desired impact being achieved through the health education curriculum in terms of the child's (a) attitude, (b) knowledge, (c) behaviour; and is this, subsequently, also influencing the health of families and communities? (d) is the school (pupils, teachers and facilities) involved in the overall socio-economic development of the community?**

Evaluation question No. 1

At the national level the response to evaluation question No. 1 must include information about:

(i) the readiness of the health education curriculum for evaluation and whether behavioural objectives are clear and measurable;

(ii) the number of schools offering the curriculum;

(iii) the reasons why other schools are not offering the health curriculum;

(iv) the availability of teacher training for the health education curriculum, including instruction in evaluating the impact of health teaching on pupils;

(v) the assistance of an individual and/or agency recognized as the central authority responsible for the curriculum;

(vi) the nature of the supervisory mechanism for ensuring the quality of the curriculum.

At the local school level the responses to evaluation question No. 1 must include information about:

(i) the number of classes in which the curriculum is implemented;

(ii) the extent to which teachers and pupils are aware of, and understand, the expectations of the class, and the method of evaluation and testing;

(iii) the designation of a teacher within the school who is responsible for the curriculum;

(iv) the extent to which the curriculum is integrated into the overall curriculum;

(v) the presence of a local system for the implementation, monitoring and evaluation of the health curriculum.

Evaluation question No. 2

At the national level the response to evaluation question No. 2 requires additional research before any statement can be made regarding the specific information needed. Two areas of research are recommended:

(i) a descriptive comparison of the knowledge, attitudes and health practices of in-school and out-of school children before and after the pupils in schools have participated in the health curriculum;

(ii) a descriptive investigation into the impact of the pupil's knowledge, attitude and behaviour, after health education, on his/her family's life-style and health practices.

In dealing with the question of evaluation at the local level, the following points should be taken into consideration:

(i) evaluation should be more an ongoing than a sporadic activity;

(ii) if consideration is given to the addition of credit for the pupil's performance with regard to health habits, and hygiene inspection for grading purposes, then due consideration must be given to the socio-economic circumstances in which he lives;

(iii) apart from judging the performance of the individual child, the collective performance of the entire class should be considered as well.

IV.3.9 Utilization of external support

In most countries in the Region, external organizations are actively participating in ongoing projects related to health and or education. In some cases the work being done actually involves changes in school curricula, training programmes, or provision of teaching materials and equipment. Mention may be made specifically of UNFPA, UNESCO, UNICEF and WHO. UNFPA has been very much involved in several countries of the Region, in the introduction of population education in school curricula – an exercise quite similar to what we are trying to do with health

education. Obvious advantages can be gained by drawing on the experience of these organizations and projects as well as by coordinating activities with them in the process of implementing the new health curriculum.

It may also be possible to get external organizations that are not currently involved in programmes in a given country to be interested and to help with the implementation of the new health curriculum.

IV.3.10 Research

As the curriculum is developed and implemented, applied research should be undertaken in various areas to ensure the fulfilment of set objectives. Some of the areas that may need immediate attention include:

(a) Identifying the best age group for pupils to effectively carry health messages to others in the family and community.

(b) Approaches for integrating health curriculum not only within various school subjects and activities but also within a package covering various developmental areas.

(c) The health developmental role that can be played by school (teachers, pupils and facilities) in support of primary health care and as a spearhead for health programmes.

(d) Effectiveness of teachers and pupils as part-time health workers.

(e) Effect of indigenous habits and customs on the health education and health behaviour of school children.

(f) Effect of school health teaching on infant mortality rates and on drop-out and repetition rates.

(g) Knowledge, attitudes and practice (KAP) of pupils, families and teachers before and after receiving health education.

(h) Development of more appropriate teaching aids and teaching methods.

(i) Frequency and type of accidents affecting school children in school, at home, and elsewhere.

(j) In-depth situation analysis at national levels of health teaching in school.

(k) Ways of motivating teachers towards involvement in health teaching.

It is recommended that research work related to the school health education curriculum be regarded as an integral and ongoing component of the project.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

UNITED NATIONS CHILDREN'S FUND
MIDDLE EAST AND NORTH AFRICA REGIONAL OFFICE

THE UNITED NATIONS EDUCATIONAL SCIENTIFIC
AND CULTURAL ORGANIZATION

ISLAMIC EDUCATIONAL SCIENTIFIC
AND CULTURAL ORGANIZATION

Price:Sw.Fr.8.–

ISBN 92-9021-013-3

Special prices are available on application to the Regional Office for the Eastern Mediterranean for orders from Member States of the Region, from developing countries and for bulk purchases.