



THE AGA KHAN UNIVERSITY

eCommons@AKU

Book Chapters

February 2006

Health curriculum and school quality: AKU-IED's

Shabnam Ahmed

Aga Khan University, Institute for Educational Development, Karachi

Follow this and additional works at: http://ecommons.aku.edu/book_chapters



Part of the [Elementary Education and Teaching Commons](#)

Recommended Citation

Ahmed, S. (2006). Health curriculum and school quality: AKU-IED's. *Quality in education: Teaching and leadership in challenging times*, 1, 42-50.

Available at: http://ecommons.aku.edu/book_chapters/61

Health Curriculum and School Quality: AKU-IED's Perspectives

Shabnam Ahmed, AKU-IED, Pakistan

Abstract

This paper is based on the experiences of the Health Action Schools project at AKU-IED and looks at issues surrounding the definition, choice and implementation of planned content of health education for primary schools in Pakistan. The paper argues that health education is a vital component to achieving quality because it links home with school; 'needs now' with 'needs later'. Yet it proves exceptionally difficult to plan and deliver such content effectively because curriculum planning bodies are geared to work with separate subjects rather than across the curriculum, with classroom content rather than wider learning experiences in and from school, and with textbooks and examinations rather than the physical and human environment of the school community.

The paper asserts that there is confusion about the definition and purpose of health education and that a wide gap exists between what is planned centrally and what is actually delivered in a school. The paper also asserts the need to rethink approaches aimed at improving content, methodology, materials and evaluation strategies and raises issues of wide relevance to the planning of health education and other themes such as environmental education and inclusive education.

Introduction

Strengthening the quality of education has become a global agenda at all educational levels and more so at the primary level. Various international forums and declarations have pledged improvements in quality of education.

The Jomtien Declaration of 'Education for All' (1990) recognizes that education must be measured in terms of actual learning outcomes rather than on the basis of enrolment.

The Dakar Framework of Action (2000) emphasizes the importance of "Improving all aspects of the quality of education, and ensuring the excellence of all so that recognized and measurable learning outcomes are achieved by all especially in literacy, numeracy and essential life skills" (Article 7:vi).

The emphasis of these international initiatives on quality education has led to an increase in national commitments towards quality education especially in developing countries where most educational activities at the national level are dependent on donations from international agencies.

Defining Quality

Quality influences what students learn, how well they learn and what benefits they draw from their education. Quality of education is usually defined in terms of the learning outcomes of students and this is usually the primary concern of all stakeholders. However, Adams (1993) points out that quality should be defined in terms of efficiency, effectiveness, excellence, and social justice.

Definition of Quality in the Context of EFA

The Dakar Framework of Action (2000) defines quality of education in terms of recognized and measurable learning outcomes. Suggested key measures to attain quality outcomes include:

- healthy, well-nourished and motivated students;
- adequate facilities and learning materials;
- a relevant curriculum;
- an environment that encourages learning; and,
- engagement of local communities.

This definition seeks to identify important attributes of education. Thus, it sets out four desirable characteristics of quality: *learners, processes, content* and *systems*.

Health Education within the Concept of School Quality

It is now recognized globally that good health is one of the most basic features of quality education. The expanded commentary on the goals of the Dakar Framework of Action (2000) links health and education explicitly by stating that successful education programmes require healthy, well-nourished and motivated students, and healthy, safe and secure school environments that can help protect children from health hazards, abuse and exclusion.

Programmes that provide the information and skills needed to protect them from drug abuse and HIV-AIDS must be made available to the youth.

Thus, school quality does not mean the mere advancement of a student from one class to another. Stephen and Hawes (1990) define quality as:

- relevance to context, to needs and to humanity;
- efficiency in setting standards, in meeting standards set and in improving standards; and,
- something special...which goes beyond normal expectations of school.

They argue that the ‘something special’ is a programme of health promotion in the school.

Integrating Health Education for Quality Education

National Context

The state of basic education in Pakistan portrays a dismal picture, characterized by a high illiteracy rate, low primary and secondary school enrolment, high dropout rates (the percentage of students who drop out from school before reaching class five) and the poor quality of education delivered. Due to the persistent low level of primary enrolment, of a total of 22.33 million children in the 5-9 age group, 5.8 million children are out of school and over half of those out of school are girls. The net primary enrolment rate, which is a better measure of educational attainment, depicts an even poorer outcome. Although the primary school gross enrolment ratio is 84:100 only 50% reach grade five. One of the recognized factors for early dropout rate is the poor health of children (World Bank, 2003).

Education systems in Pakistan lack quality in service provision such as lack of access, non-functioning schools and low quality. The poor state of government schools is reflected by the fact that 15 % of them are without a building, 52% without a boundary wall, 40% without water, 71% without electricity and 57 % without a latrine (NEMIS, 2001).

In 1973, the Government of Pakistan produced a Physical Education and Health curriculum, which covered a large number of topics. In 1995, the Federal Government agreed that health education training should be included in the programmes offered by all the Teacher Training colleges. In practice, neither the

curriculum nor the training was enforced. As the subject of ‘health education’ was not to be examined, its importance was lost to the curriculum planners. Nevertheless, the Education Policy (1998-2010) assigns top priority to basic education, and within this, it does mention, although briefly, that health education is an emerging key issue that will be introduced and integrated in the school curricula. In the ten-year perspective, the development plan 2001-11, includes health and nutrition as an important aspect of poverty reduction and human development.

Despite this acknowledgement of the importance of health and health education, the present school curriculum in Pakistan makes a very limited attempt at integration of health education. An analysis of the existing Sindh primary curriculum shows that some health components, particularly personal hygiene, are covered in subjects such as Science, Social Studies, and to a lesser extent, in Islamiyat, Urdu and English; but, the focus is not on health as such. Whilst there is some emphasis in the Science and Social Studies curricula on hygiene, the environment, food, and nutrition, very little is included on safety, disease prevention, disability and mental health. The topics are focused on the individual rather than on communities. Health topics, as with other subjects, appeared to be taught in a very passive way.

The HAS Project: A Whole School Improvement Initiative of AKU-IED

In 1997, AKU-IED and the Child-to-Child Trust, UK, developed an area of school health promotion within AKU-IED’s broader focus on school improvement and quality education. The Health Action Schools (HAS) initiative aims to develop schools that foster children’s holistic development, fulfilling their right to education.

The HAS project was implemented in five pilot schools to:

- develop prototypes of health-promoting schools in Pakistan;
- share lessons learned;
- introduce school health education into AKU-IED’s programmes; and,
- advocate the importance of health education in schools.

Key findings of the four-year action research project indicate that health education:

- is a ‘way-in’ to quality improvement;
- has the greatest impact on low-resourced government schools;
- leads to improved learning environments;
- improves children’s self-esteem and communication skills;
- as a model of school-based trainings for teachers, benefits the teaching of other subject areas across the curriculum; and,
- requires appropriate teaching materials.

A health-promoting school as described by the World Health Organization has three important components or branches: pupils, teachers and parents. AKU-IED attempts to include all three branches within the school through its school health initiatives. It is essential for a health-promoting school to foster good relationships amongst pupils, teachers and parents, not only within the school, but outside as well. One strategy used to achieve this has been through the development of a contextually appropriate health curriculum using the Child-to-Child approach for developing health-promoting schools in Pakistan. The HAS study has also identified the need for the development of appropriate teaching materials for the teaching of health in schools. As a result of the HAS study, AKU-IED initiated the development of a health curriculum for primary classes 1-5. However, this was not an easy task; there were many barriers to overcome.

Barriers to Planning and Delivering Effective Health Education in Schools in Pakistan

The two main barriers to planning and delivering effective health education in schools in Pakistan, identified during the course of implementation of the HAS project, were conceptual barriers and operational barriers (Hawes 2000).

Our understanding and perceptions about curriculum, school, and especially health, affect our planning and delivery of effective health content. Taking health as an example, we can see that there are narrower and wider definitions of health and according to Hawes (2000), the planning of the task varies according to the definition one adopts. A school which takes a *narrow* view of health, as being about good hygiene habits, has an easier planning role than one that views

health broadly, taking into account the development of physical, emotional and social skills as different aspects of health. Therefore if a school health programme concentrates only on the health of the children in school, it poses far fewer challenges than one which also takes into account the health needs of families and communities outside it. Hawes (2000) rightly points out that a school can either *focus inward*, viewing its role as largely academic and self-contained, teaching and testing a prescribed syllabus, using textbooks and emphasizing rote learning of their content or, in addition to these, take steps to *focus outwards*, interacting with its community and seeking to become aware of the socio-economic issues within it. It is quite obvious that the latter option puts more responsibility on the head and the teachers.

Finally, the *curriculum* can be defined either, as ‘a content with attainment targets, measured by monthly tests and term exams’ (Hawes, 2000) or, as ‘all the learning planned and provided by the school, whether it takes place in a group or individually inside or outside the school’ (Kerr, 1968).

Pakistani schools, or, for that matter, most schools in developing countries, are inward looking and are hard pressed to complete the planned curriculum in time. The external life of the school is very limited. The HAS experience has also shown that including health education in the school curriculum was the most challenging task.

Strategies Used to Overcome Barriers in Planning and Delivering Health

Curriculum

Once such analysis is done, it becomes obvious that health education just does not fit into the narrower categories of the curriculum. For AKU-IED, planning and teaching a health curriculum was an uphill task. Schools and communities were open to ideas where a child’s individual hygiene and health practices were concerned but they were not ready to accept children’s role as health promoters especially when their own children questioned their health practices and challenged their traditional beliefs and practices.

It was found during the project period that children who gain knowledge in schools can pass that knowledge on to those who have been denied education. It also became quite evident that by focusing children’s attention on the needs of others rather than merely on their own, there is an immense improvement in the development of attitudes and values.

Intensive trainings and workshops on the Child-to-Child approach to health promotion were conducted in order to help pilot schools to understand and incorporate the broader definitions of health. Schools either allotted separate health classes within the school timetable or took up 'spare time' from unused subject allocations, or worked outside the classroom, forming health clubs. In rural areas where communities were more integrated, it was easier for schools, supported by communities, to focus outwards and include health curriculum within their school timetable.

The integration of health into the curriculum was more difficult in urban schools since communities saw the school's role as helping children pass exams with good grades and any diversion from the regular school routine was not acceptable. Teachers also found themselves hard pressed for time and were not very willing to take on any extra responsibility. Under such circumstances, the willingness of the head was seen as a point of entry because when the head appointed a health coordinator, the person took his or her responsibility more seriously and took responsibility for the effective implementation of health education in the school (HAS Yearly Report 2000).

Development of a Health Curriculum

It was realized that in order to make AKU-IED's health activities sustainable and in order to expand the number of health-promoting schools, it would be important to develop a health curriculum that included contextually appropriate health issues and incorporated broader definitions of health, school and curriculum. Therefore, a health curriculum was developed based on health issues identified by the teachers, children and community. It was developed over a period of three years in order to:

- help stakeholders develop an understanding of broader definitions of health, curriculum and school;
- enhance the skills of teachers in using the Child-to-Child approach;
- help teachers acquire correct knowledge about contextually appropriate and common health issues;
- provide health materials that are simple and easy to use to help teachers promote effective methods that encourage active learning; and,
- develop materials on relevant health issues in schools in urban and rural areas of Pakistan.

The curriculum that was developed includes contextually appropriate health topics on three health themes for class 1-5:

- Hygiene and Disease Prevention.
- Environmental and Community Health.
- Family and Social Health.

Some Key Findings from Field Testing of the Health Curriculum

After field testing of the material during 2003–2005, it was found that:

- Relevant health curriculum is a vehicle for health promotion in schools and school improvement.
- Planned content helps teachers in implementing new initiatives in their busy timetables.
- The Child-to-Child methodology enhanced the pedagogical skills of teachers in other subject areas too.
- A health curriculum helps in sustainability of health promotion interventions in schools, which leads to whole school improvement.
- Health curriculum contributes to holistic development of children (HAS reports, 2003–2005)

Recommendations

There is a need for effective coordination of efforts between health and educational sectors at the national, provincial, district and local levels in:

- Curriculum planning.
- Development of contextually appropriate instructional material.
- Preparation of educational personnel through pre-service and in-service education.
- Improvement of school environments.

- Monitoring and evaluation.
- Research on impact of health curriculum on the quality of the school.

References

Global School Health Initiative (GSHI) (n.d.) Retrieved September 24, 2003 from <http://www.who.int/hpr/archive/gshi/strategies.html>

Hawes, H. (2003). Health Curriculum and School Planning. *Compare*, 33(1).

Hawes, H. (2003). *Skill Based Health Education*. London: London University.

Ministry of Education. (2001). *National Education Management Information System (NEMIS)*. Pakistan: Author.

Moodie, R. & Hulme, A. (Eds.). (2004). *Hands-on Health Promotion*. Melbourne: IP Communications.

UNESCO. (2005). *Education for All Global Monitoring Report - The Quality Imperative*. Retrieved January 24, 2006 from <http://portal.unesco.org/education/en/ev.php>

UNESCO. (2000). *World Education Forum: The Dakar Framework for Action*. Paris: Author.

World Bank. (2003). *Poverty in Pakistan: Vulnerabilities, Social Gaps, and Rural Dynamics*. Washington, DC: Author.

World Bank. (1993). *World Development Report: Investing in Health*. Retrieved April 10, 2004 from <http://econ.worldbank.org/wdr/wdr2003/>

Contact

shabnam.ahmed@aku.edu