David Morley

The very young as agents of change

Children in primary schools should be encouraged by their teachers to adopt healthy life-styles and become advocates of healthy living in their families and communities.

Much can be achieved in the health field through collaboration between child health planners and people involved in primary school education. It is worth noting that there is a school in almost every village or peri-urban squatter area, and that teachers are highly respected members of their communities. If a school has good health practices, the local community is quite likely to adopt them.

The importance of primary school education to girls has been amply demonstrated. In every country where research on this subject has been conducted, health in terms of infant mortality, nutrition and birth-spacing is more strongly correlated with the primary school education of the mother than with the level of health services or with any other factor so far identified. Basic education should provide the skills and attitudes necessary to enable people to function in society and should give them the confidence and ability to undertake further study.

The aim should be not only to prepare children for life after they have left school, but also to enable them to cope with immediate health problems. Of course, primary school curricula are heavily congested in all countries, and it would not be feasible to introduce a new subject. Instead, health education should be an element in all established subjects.

The principal publications of the Child-to-Child Trust are activity sheets that examine common problems. For example, one gives basic information on diarrhoea and why it develops. When children have absorbed this they may go to their families and communities to learn how frequently diarrhoea occurs in bottle-fed and breast-fed babies. They then return to school and analyse their findings, possibly in the mathematics class. Having discovered how much more frequent diarrhoea is in bottle-fed babies, they may calculate the cost of bottle-feeding a baby for a year. They may plan some action, perhaps involving the preparation of posters or the production of a simple play about a bottle-fed and a breast-fed infant. After the action has been undertaken in the community the children return to school and discuss the changes they have achieved.

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The Trust has started to rewrite primary school textbooks so as to provide a background in primary health care. Thus in Health into mathematics, teaching on fractions, percentages and graphs is combined with messages about immunization and oral rehydration therapy.

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Messages should always be practical. For example, if it is desired to teach children the importance of rapid breathing as a sign of pneumonia in babies, one can use a pendulum consisting of a piece of string with a stone attached to one end. At a length of two metres it swings at the rate adults and older children breathe; at one metre it does so 30 times a minute, the rate at which a baby normally breathes; and at 35 cm it swings at the rate of breathing of a baby with pneumonia.

In London the Trust offers ideas to those interested in creating child-to-child programmes, which vary greatly with local circumstances: those developed in Bombay, Botswana, Uganda and Liverpool differ considerably from one another. Child-to-child programmes were introduced in the United Kingdom after their value had been demonstrated in East Africa.

Children invariably respond positively but it may be difficult to persuade the adults responsible for health and education to work harmoniously together. In the interest of the general well-being of society, health and education ministries should collaborate in trying to harness children's boundless natural energy and enthusiasm for life. Children can be the conscience of the family; for instance, they may point out that medicines should be kept beyond the reach of toddlers, or that smoking is a dirty and dangerous habit. Their potential for bringing about beneficial change is enormous.