13. THE CHILD-TO-CHILD CURRICULUM IN EAST AFRICA
(KENYA AND TANZANIA)

Strengths, Challenges, and Weaknesses

INTRODUCTION

According to Waljee and Hawes (2004), the child-to-child curriculum is a program that teaches and encourages children to concern themselves with the health and welfare of others in their communities. The program can target learners within a school and/or a community, and so involve family members, relatives, and neighbors in the place where the children live.

Under this program, children are encouraged to examine and reflect on their health and welfare and the health and welfare of their younger siblings and other children at school and in the community as a whole (Waljee & Hawes, 2004). The child-to-child curriculum encourages the holistic development of a child as a member of a school community as well as a member of the community in which his or her school is situated. The curriculum is a way of encouraging conscious development among learners not just as future scholars, but also as important participants in the affairs and activities of their communities (Freire, 1996).

In Kenya, public health workers train children in how to educate others to implement this curriculum. The Ministry of Public Health thus collaborates with the Ministry of Education and works through early childhood education structures. But this collaboration is not confined to the two ministries alone. It involves all stakeholders, including non-governmental organizations (NGOs) and community-based organizations (CBOs). In Tanzania, multilateral organizations, such as the United Nations Children’s Education Fund (UNICEF), are also involved.

The curriculum is currently being implemented in early childhood development education (ECDE) centers and primary schools in Kenya and Tanzania. The target group is mainly children 6 to 10 years of age. The children are taught about the most common diseases in their locality and how to detect the symptoms through observation of signs displayed or manifesting in a patient (Dan Andanje, personal communication, May 2010). Other lessons include how to avoid contracting diseases by, for example, washing hands after visiting a toilet and before and after eating food. This simple practice helps limit the contraction and spread of, for example, diarrhea, cholera, and typhoid, most of which are waterborne diseases. Children are also taught about the importance of sleeping under a net to avoid
mosquito bites, which can cause malaria. This teaching occurs mainly through the Malaria is Unacceptable (Malaria Haikubaliki) campaign presently taking place in our countries.

Teaching strategies include song, dance, drama, role-play and storytelling about the common diseases, and simulation games about the dangers associated with them. Those trained (peer educators) are encouraged to spread the message to others and to report signs of diseases identified in their locality to health workers, teachers, and community elders. The curriculum has been very effective where it is implemented. This success confirms what a number of educationists argue is one of the best ways of educating children to be productive members of the community (Freire, 1996; Gravett, 2004; Waljee & Hawes, 2004; Wanyama, 2009).

Although the child-to-child curriculum has shown much potential in preparing children to become more active participants in most community activities affecting them and others, it continues to encounter a number of challenges, which we consider in this chapter. But first, we want to discuss the strengths of the child-to-child curriculum in Kenya and Tanzania.

STRENGTHS OF THE CHILD-TO-CHILD CURRICULUM IN KENYA AND TANZANIA

One of the strengths of the child-to-child curriculum is the confidence that children develop as they undergo the learning process promoted through the program. The different strategies and skills that the children learn drive this confidence—confidence that facilitates a meaningful partnership between learners and educators (Takanishi & Bogard, 2007). Takanishi and Bogard (2007) also argue that when educators and learners collaborate in the learning process, learners are better able to draw meaning from what they are taught, which often relates to real-life situations. For example, in the Kitale district in the North Western Rift Valley, Kenya, public health workers and selected teachers in lower-primary school classes meet once a week to educate selected youth from local schools on the detection and prevention of diseases. These meetings are organized by district education officials and sponsored by a number of local NGOs as well as by the Kitale Anglican Diocese. The young people selected work with public health workers and teachers in camps, during which they experience a range of the methods referred to above. They support one another and are instrumental in spearheading campaigns that include, amongst others, Malaria Haikubaliki (mentioned earlier) and the campaign to combat measles.

Peer educators have thus become an integral part of education and public health activity implementation strategies in Kitale. Their role and the significance of their work recently received recognition from the local district administration, recognition that was perceived as a big honor for the individuals and groups working toward the betterment and wellbeing of the people of Kitale.

The collaborative process by which teachers and educators construe meaning from the child-to-child curriculum enables them to constructively reflect on and challenge lore that might otherwise be taken for granted as truth. Reflection allows