Child-to-Child:
A Review of the Literature
(1995 – 2007)

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Child-to-Child: A Review of the Literature (1995 – 2007)

1.0 Introduction

The purpose of this literature review is to not only share learning about the successes of programmes using the Child-to-Child (CtC) approach around the world, but to raise critical questions about the challenges that continue to hinder Child-to-Child programmes from delivering quality. This is the fifth in a series of literature reviews (Feuerstein 1981, Somerset (op cit), Child-to-Child,1991, Lansdown, 1995) focusing on Child-to-Child approaches and their impact. Since 1995, the global expansion of Child-to-Child activities, the emergence of new thematic priorities, and the evolution of Child-to-Child approaches based on lessons learned from the field, have led to the development of new Child-to-Child publications and more evaluations and surveys on the impact of Child-to-Child approaches.

Child-to-Child

The Child-to-Child approach has been successfully implemented since 1978. Education, Health Promotion and Community Development Programmes using the approach are active in over 70 countries and directly and indirectly impact an estimated 1.5 million children annually. Since 2003, the network has been strengthened by resource groups based in India, Kenya, Lebanon, Pakistan and the United Kingdom (London), who have come together to contribute their thematic expertise and experience of capacity building in training, materials development, research and advocacy.

Child-to-Child is a rights-based approach to children's participation in health promotion and development, grounded in the *United Nations Convention on the Rights of the Child (CRC).*Through participating in *Child-to-Child* activities the personal, physical, social, emotional, moral and intellectual development of children is enhanced. The *Child-to-Child Approach* is an educational process that links children's learning with taking action to promote the health, wellbeing and development of themselves, their families and their communities (Child-to-Child Publicity Document, 2004)

Review

This review includes the following:

- 2 quantitative studies highlighting the impact of CtC activities
- 5 qualitative evaluation reports about the impact of CtC activities
- 3 surveys about Child-to-Child activities worldwide
- 2 advocacy meeting reports
- 2 published and peer reviewed articles about Child-to-Child approaches
- 4 unpublished theses
- 5 Child-to-Child publications.

The selection criterion for determining sources is as follows:

- the account should be more than anecdotal
- the source of the publication should be from either a university or library borrowing system or documents from the Child-to-Child Trust office.
- training reports and trip reports have been excluded.
- all literature published before 1995 is excluded from this literature. Please see Lansdown's review (1995) for a review of earlier literature.

Finally, it is only through critical reflection and documenting lessons learned that we can improve practice and truly achieve the mission of Child-to-Child which is to promote and improve the health and well-being of children, their families and their communities worldwide.

2.0 Evaluations and Studies on the Impact of Child-to-Child

2.1 Quantitative Evaluations on the Impact of Child-to-Child

This section reviews some of the main findings from two quantitative studies on the impact of Child-to-Child approaches.

2.1.1 Health Education Practice in Primary Classrooms: A Study from Pakistan (Muzaffar Bhutta, 2006) This is one of the few studies exploring the impact of Child-to-Child approaches in the classroom using quantitative and qualitative research tools. It aims to describe and compare the classroom practices of teachers (n=67) who had been trained in Child-to-Child health education pedagogy and had been teaching in urban and rural primary school settings in the Sindh province of Pakistan.

What is unique about Muzaffar Bhutta's study is the newly developed observational measure – the health education Child-to-Child classroom profile – used as a major tool for data collection in classrooms. The profile consists of 32 items for the description of classroom practice in primary schools. A structured questionnaire was also developed for the study to examine the characteristics of the participating schools (e.g. school system); classrooms (e.g. class size, children's age and gender); teachers (e.g. teachers' age, gender, qualifications); and 'history' of health education (e.g. health education training, use of the health manual, regularity of health teaching) in each school.

Results

- The overall results show that health education practices, drawn from Child-to-Child approaches, were more 'participatory' in rural classrooms than in their urban counterparts.
- Although rural teachers have been more motivated about health education than their urban counterparts, they still have to achieve what Muzaffar Bhutta refers to as the 'balance between active teaching and active learning in their classrooms'.
- Muzaffar Bhutta's findings show a strong link between the three elements of the HEALTH aggregate (i.e. a score of intensity of health education training, use of a health manual and regularity of health teaching). She therefore recommends that policy makers and practitioners consider the impact of groups of factors on quality health education, rather than try to assess the impact of individual factors (i.e. the need for training pedagogy of the use of CtC, current health education materials, practicing CtC approaches regularly).

2.1.2 Impact Evaluation of the Child-to-Child Health Education Project in Zanzibar (Komba 1996)

The Aga Khan Foundation Tanzania in partnership with the Zanzibar Ministry of Education implemented a five year project from 1990 – 1995, which involved 10 schools in the first phase (1990 – 1991) and then extended to 44 primary schools in the second and final phase (1992-1995). The evaluation assessed the impact of CtC approaches on the community's knowledge, attitudes and practices and to assess the CtC approach's effectiveness in impacting knowledge, attitudes and practices. The evaluator thoughtfully describes the methodology, research instruments, and pilot testing and data analysis procedures in the beginning of the report. Although the strength of this evaluation lies in the fact that more quantitative methods were used (e.g. KAP questionnaires), the main constraint of this evaluation report is that there was no baseline data collected at the beginning of the project against which impact could be measured.

Key successes of the programme:

1. Pupils demonstrated that they had acquired health knowledge and proper health habits, although there was not sufficient evidence about attitude changes.
2. Teachers reported an increase in pupils' attendance and decline in the drop-out rate.
3. Communities showed high health knowledge and practice scores although the evaluator was cautious in attributing this to the CtC programme directly and exclusively.
4. Schools using CtC had higher KAP scores than those that did not.
5. Female students excelled in health practices while male pupils excelled in health knowledge and attitudes.
6. A majority of pupils involved with CtC reported to have spread messages to their parents and siblings.
7. Teachers rated drama as being the most popular form of delivering health messages.

Key challenges and recommendations:

1. Health knowledge levels for communities and schools using CtC could still be improved.
2. CtC co-ordinators could only devote two days a week to the programme and this was a challenge in some of the schools. In addition, transport issues plagued the ability of CtC co-ordinators to effectively complete their work.
3. CtC should become an examinable subject.
4. The project should be designed to appeal more to teachers.

Sadly, although the evaluation report suggested that the programme be formally integrated into the school system with support from the government ministries, lack of funding for the programme prevented it from continuing.

2.2 Qualitative Evaluations on the Impact of Child-to-Child

This section reviews some of the main findings from qualitative evaluations on the impact of Child-to-Child approaches.

2.2.1 Child-Centred Approaches to HIV and AIDS or CCATH (Carnegie 2004)

This project was implemented in Kenyan and Ugandan towns and poor urban areas where HIV and AIDS was prevalent and participating organisations included KANCO, NACWOLA, ACET, Child-to-Child Uganda, Health Link Worldwide UK and the CtC Trust UK. It was funded by Comic Relief and lasted from 2000 – 2004. The aim was to work with community-based organisations to strengthen community strategies and mechanisms to support orphans and vulnerable children affected by HIV and AIDS. The following are the five main areas the project focussed on and in which Child-to-Child approaches and activities were used:

1. Enabling older children to strengthen their coping skills to deal with the illness or loss of a parent.

2. Supporting older children and parents/guardians to provide care and emotional support to younger children.

3. Breaking down the culture of silence surrounding HIV and AIDS.

4. Promoting social inclusion of children affected by and living with HIV and AIDS to reduce stigma and discrimination.

5. Enabling families to develop coping strategies for managing the severe economic impact of HIV and AIDS (e.g. planning for future death, inheritance issues, sexual and labour exploitation, income generation and access to education).

The methodology used to evaluate the project was a combination of external evaluation and internal participatory evaluation (e.g. child-centred qualitative research tools) which involved all stakeholders, particularly the vulnerable groups.

Key conclusions specific to the impact on children are as follows:

1. One of the key successes was the range of innovative methods used for promoting children's participation in all stages of project planning, implementation and evaluation (e.g. needs assessment).

2. Interventions such as the memory project work and Child-to-Child activities to promote communication amongst children and their teachers were successful in breaking the silence around HIV and AIDS.

3. Peer relationships were improved through the Child-to-Child activities used. CtC practitioners can help children in child-headed households to overcome their problems of lack of support and to ease their burden by joining children together or twinning for emotional support through shared activities such as games.

4. CCATH interventions have achieved a wide-ranging impact with children over eight years of age. Through participating in Child-to-Child activities, children's ability to express their emotions and sense of self worth improved. They also had a positive reason to live.

5. CCATH activities have successfully supported institutions for children with disabilities, particularly impacting deaf children's self-esteem, on teachers and parents attitudes towards these children's capacity to communicate about HIV and AIDS has also been compared. More research should be carried out in this area.

Key challenges and recommendations:

1. One of the least successful objectives of the project was improving community-based organisations (CBOs) capacity to communicate with their constituents and involvement of more CBOs in other regions of Kenya and Uganda was suggested.

2. A weakness of the project was lack of baseline data on the beneficiary communities which would have allowed for quantitative impact measurement. The evaluator recommended the collection of baseline data for future studies.

3. A challenge and area of improvement is in developing schemes to provide economic help to families impacted by HIV and AIDS such as micro-financing schemes.

4. Areas of further research include the impact of HIV and AIDS on children younger than eight years of age, children with disabilities, children affected by armed conflict, men and elderly guardians. The issue of gender was flagged in the evaluation.

5. Quality control, follow-up training, chid protection, building links with service providers and outreach were areas of further improvements suggested.

2.2.2 Quest for Quality An Evaluation of the Health Action Schools Project (Carnegie and Khamis, 2002)

This was an evaluation of a four-year action research project that involved five pilot schools chosen from different educational contexts (e.g. government, private, community-based) in Karachi, Pakistan. Carnegie's approach to the evaluation was not only to assess the outcomes of the programme on the children, communities, families and teachers involved but to take the evaluation one step further and reflect on the process by which the outcomes were achieved.

The challenges faced by the HAS programme and recommendations for improvements are captured below:

1. The action research process and model should be continued because it was a vehicle to the development of materials and training.
2. Whilst positive impact was measured on the health education and school environment elements of the model, less success was achieved in the area of health services.
3. Partnerships need to be further developed and nurtured with schools, communities, government and non-government agencies.
4. Staff needed to be recruited and developed as high staff turnover, both in the schools and the HAS project team, was a threat.
5. Children and parents should be more closely involved in monitoring activities.
6. For its future sustainability and expansion of its successful model, HAS should evolve from being an implementing agency to a facilitator of capacity building. It was suggested HAS influence policy and practice about school health education at the wider level both nationally in Pakistan and abroad.

Key Successes: Processes and Outcomes in HAS Schools numbered formatting below is uneven

1. Context-specific materials, adaptations of the CtC step approach (e.g. four as opposed to six steps) and models of training were developed to improve the quality of the teaching-learning process in the classroom.
2. The action research component of the programme was a strength.
3. Quantitative assessments of the health knowledge and self-esteem of pupils demonstrate outstanding achievements, with greatest change surprisingly noted among the poorly-resourced, semi-rural government schools as impact was statistically significant in these settings.
4. There was some evidence of improved health behaviours, examples of which include a lice-free campaign, bringing boiled water to school and fewer students buying snacks from hawkers.
5. Improved relations between teachers and children and a reduction in gender discrimination against girls was noted, especially in government schools.
6. Teaching methods in health education (e.g. drama, surveys) were being transferred to the teaching of other subjects.
7. Self-esteem and health knowledge were increased among teachers.
8. Stronger links between parents and schools were reported.
9. Some activities involving pre-school children were successful.
10. Overall, one surprising outcome Carnegie reported was that the greatest gains of the programme were experienced by the smaller, less resourced schools as opposed to well-resourced private schools.

2.2.3 Child-to-Child in South London Evaluation Report (Kirby , 2002)

This is an evaluation of a three-year Child-to-Child programme initiated by the Community Health South London (CHSL) Trust in Lewisham in 2001. The overall aim of the programme was to support 9-12 year olds to identify and take action on key health issues in their communities.

The evaluation primarily focussed on the following:

- Children's participation
- Children's self-efficacy
- Children's relationships with adults
- Adult support for children's participation
- Adult and organisational learning

Information was collected from a sample which included two classroom teachers, 36 children, three parents, two school nurses, two school heads, the CtC worker and three youth workers. Participatory methods ranging from interviews and focus group discussions to observation and self-evaluation were used.

The findings about the outcomes of the programme are as follows:

1. Children decided on issues of priority in their communities and were observed to make more decisions in CtC than during other classroom activities.
2. Both adults and children learned a lot about health issues by taking action on them (e.g. supporting the elderly and racism).
3. Children felt more listened to and valued by their teachers, peers and parents.
4. Children in the CtC programme became more active members of the school community.
5. Children developed group work skills.

6. Parent volunteers were successfully involved and were provided with good support by the school to overcome initial anxieties of working with children. Parents involved improved relations with their own children and developed more positive attitudes to the school and teachers.
7. Adults (both teachers and parents) enhanced their appreciation of children's competencies.
8. The role of a dedicated, paid CtC worker who conducted sessions was considered a key factor in determining the success of the programme.
9. Involvement of the school nurse helped to link the education and health services at the school.
10. Commitment and support from the School Head was a key success factor.

Challenges:

1. Some barriers preventing children from sharing their ideas and feeling involved in decision-making included not having their ideas agreed to by other children and adults influencing the topics chosen.
2. Children were asked to identify problems rather than positives in their communities which the evaluator felt reinforced negative stereotypes.
3. Adults had to work hard to keep children engaged and interested in CtC sessions in the school because children did not volunteer to take part. In the After School club, the children were more interested because they volunteered and chose to be involved.
4. Children were most motivated when they took action and participated in fun activates that did not involve doing much work. Their motivation dipped when there was too much written work and few games.
5. The CtC approach was considered unstructured for schools but flexible and useful. It was difficult to conduct enough sessions to cover each step of the CtC step approach and to ensure that the topic did not take too long to cover that student's motivation would be lost. It was found that two hours was the right duration for sessions.
6. The project required high staff ratios to work with children and staff cover was needed when children took action in the community.
7. CtC sessions did not fulfil National Curriculum objectives but could do so in the future.
8. The After School club faced challenges due to the drop-in nature of the programme. It was problematic when children did not attend sessions about a topic and some children felt sessions were like school in being too formal and structured.

The evaluation ends with the following recommendations for programmes using CtC approaches:

1. Guidance is needed on how to link CtC with the National Curriculum.
2. School nurses may require more training or on-going support to effectively get involved in the CtC programme.
3. CtC projects need to focus on achieving community health outcomes.
4. More work should be done to explain the benefits of CtC to key stakeholders such as community organisations, parents and decision makers and sell the importance of the programme and children's participation.
5. Adults need to more effectively involve children in activities.
6. Training needs to focus on different facilitation roles.
7. Activities should emphasise fun and not school type work. Also, ground rules of student behaviour should be decided by children and adults.

One of the strengths of this evaluation report is that the evaluator clearly demonstrates a strong understanding about CtC approaches, children's participation, and adult facilitation. A refreshing observation is that a generous section of the report is dedicated to the ethics of evaluating children's programmes including consent, access, confidentiality and protection issues.

2.2.4 Health Education Project of the Aga Khan Foundation Gorno-Badakshan, Tajikistan (Smith, 2001)

This is an evaluation of the Health Education Project (HEP) that started in 1999 and aimed to enable schools to provide relevant health education in the Ishkashim and Roshtkala districts.

The two key findings from the evaluation were as follows:

1. The Health Education Project successfully motivated teachers to teach health.
2. In both districts, the project had a positive impact on the children's knowledge, attitudes and behaviours related to personal hygiene.

Key recommendations suggested in the report on how to improve the use of CtC approaches were as follows:

1. More work needs to be done with teachers, individual schools and communities to ensure better success in implementing CtC approaches.
2. The evaluator felt more needed to be done to enhance children's active participation and to maximise the potential of children as health messengers. She suggests three phases of children's participation which include *Children as Messengers of Health Information, Children as Active Health Promoters*, and *Children as Fully Active Participants*.
3. The training sessions (six days) lacked content about the principles of children's participation and could have been improved with the addition of a training manual.
4. Monitoring and evaluation expertise was lacking and capacity building was needed in this area.

2.2.5 Learning from Children A Review of CtC Activities of Save the Children Fund (UK) in Nepal (Zaveri et al 1997)

This is a qualitative evaluation assessing the successes and challenges of Child-to-Child approaches in 25 schools in the Sindhupalchowk and Surkhet Districts of Nepal. The report begins with a situation analysis and profile of the schools involved and the research methodology that influenced various aspects of the study from sampling to the tools selected.

This report has served as a model for subsequent evaluation reports for two reasons. The first is the range of child-centred tools used in the evaluation such as communication mapping, time trend changes, health mapping and others. The second is the introduction of qualitative indicators to assess programmes involving children, which are summarized below:

- Indicators for children's participation
- Indicators for children's communication

- Indicators for Child-to-Child content
- Indicators for gender equity
- Indicators for linkages and co-ordinator of CtC programmes
- Indicators for CtC material
- Indicators for training of teachers
- Indicators for planning and organisation
- Indicators for overall impact

Key successes of the Sindhupalchowk District programme were as follows:

1. CtC activities had made a clear impact on children's health knowledge and there was some evidence of changes in children's attitudes and behaviour. Children, including girls, took on leadership roles to carry out health checks and clean the school environment.
2. There was some evidence that cases of infections related to poor hygiene had decreased in CtC schools but this conclusion needed further supporting evidence. One school in Sindhupalchowk could not find a single case of scabies among its 300 students.
3. Overall school attendance and punctuality improved among children and teachers were more motivated because of improvements to the school environment (e.g. water and sanitation provision).
4. Children were also more confident about discussing health issues with their families at home, take greater care of siblings and showed better communication with adults. At the same time, teachers and parents perceptions about the children's abilities was improved.
5. Strengthened links between schools and community groups have been built to support children's action and women's groups encouraged girls to attend school.
6. Schools were managed better with time tabling, well organised assemblies, improved student behaviour and starting on time.
7. The school environment had improved, with particular improvement in toilet and classroom hygiene.

Key Challenges and Recommendations:

1. Surket District teachers who were trained in CtC approaches showed little or no evidence of implementing CtC approaches because they felt it was too time consuming and did not find the step approach relevant to their environment. The evaluation revealed that post-training, teachers 'remained unconvinced of children's capabilities.' (Zaveri et al 1997).

2. The evaluator suggests the need to adopt a 'phasal' approach to implementing CtC activities that is in line with how fast teachers and parents views on children's capabilities can change and how quickly children's confidence to take action is built (e.g. Phase 1 – Children as Messengers, Phase 2 – Children as Fully Active Participants) The evaluator emphasises the risk in moving too fast and failing to build the supportive environment for **sustainable** CtC activities to flourish in.

3.The following factors are suggested as crucial in creating a supportive environment for CtC activities:

- Teacher training and follow-up
- Resource materials
- Sanitation and water supply

- Linkages with the community
- Linkages with government services
- Recognition of the school

3.0 Surveys about Child-to-Child Activities Worldwide

3.1 The Effectiveness of the Resource Group Model and future direction for the Child-to-Child International Network (Babul, 2006)

This qualitative small-scale survey was carried out for two reasons. The first was to learn about the effectiveness and impact of a model in which regional resource groups (RGs) supported the international CtC network locally and regionally. The second was to obtain feedback and suggestions on other models to make the international network more inclusive and about the future roles of the resource groups, the CtC Trust and other non-resource groups in the network. An e-mail questionnaire was completed by a diverse and representative sample of 23 organisations/practitioners located in different countries, who had varying numbers of years of experience with CtC.

Key Findings:

1. Babul concludes that the poor response from Latin America points to the need for the CtC Trust to be more proactive in networking and relationship building in this region, even though language seems to be a barrier.
2. Outside of the countries in which RGs operate, awareness about them and their thematic expertise is limited. Only half of the organizations have contacted an RG, of which 3 respondents complained about the experience and only 1 respondent had a positive experience. Instead, it was found that the majority of respondents contacted the CtC Trust for support rather than the RGs.
3. Partners were unanimous in their view that the CtC Trust should continue to exist with training and networking as its main functions. While it satisfies most of the organizations who have contacted it, the Trust needs to improve on following up on enquiries and communication with organisations.

3.2 Survey of Child-to-Child Activities Worldwide (Hawes, 2005) is perhaps the most comprehensive and complete survey of Child-to-Child activities worldwide, which is available on the website (www.child-to-child.org). The criteria used to determine which programmes would be included in the survey was 'programmes not necessarily called 'Child-to-Child' but they subscribe to the same broad aim to encourage and enable children and young people to promote the holistic health, well-being and development of themselves, their families and their communities worldwide.'

An English questionnaire was sent to approximately 198 projects using Child-to-Child approaches, 119 of which were on the website directory (1996) and the remainder of which were discovered to be conducting CtC activities based on internet searches. A total of 90 completed questionnaires were returned with adequate information. The low response rate was due to outdated contact information, the fact that some programmes had become inactive, lack of e-mail access by some projects, and language issues for non-English speaking people.

An analysis of the questionnaires revealed the following trends:

1. Approximately two-thirds of programmes are based in and from schools and the majority of these serve between 1,000 and 20,000 children.

2. Over 25 programmes serve more than 20,000 children.

3. In order of priority most programmes focus on water and sanitation. Other priorities listed in order of importance include landmines, refugee children, children's rights, ECCD, inclusive education and HIV and AIDS.

4. The internet search revealed at least twenty countries with smaller programmes not in the directory, some of which are listed below. It is suspected that there is much more activity in China than is credited at present.

- Mozambique
- Mongolia
- Madagascar
- Swaziland

5. The Aga Khan Foundation and UNICEF are major agencies that are stressing the approach less widely than in the past, though they still maintain considerable interest and commitment.

6. Plan International, Water4People and USAID are emphasising Child-to-Child approaches more than in the past.

7. Agencies and NGOs maintaining a steady commitment to the approach include Save the Children, Water Aid, Bernard Van Leer, Health Link, Cafod, Comic Relief.

8. The following emphases are now less apparent than formerly:

- Separate Child-to-Child programmes
- Medical Programmes emphasising Child-to-Child.
- Programmes involving teachers colleges
- Programmes to write new materials

9. There are several areas where there has been a sharp growth in interest.

- HIV AIDS related programmes
- Water and Sanitation Programmes
- Mines awareness programmes

3.3 The Future of Child-to-Child: The Partners' Perspective (Khamis, T (2003).

As a part of the development grant awarded by Comic Relief, the Child-to-Child Trust was asked to carry out a review to understand how partners in the CtC international network would feel about the decentralised model of Child-to-Child (CtC). The main research question was how could a more decentralised model of the Child-to-Child network work better for the partners. A qualitative approach

was used with telephone interviews conducted with a sample of 20 practitioners, representing diversity in both countries and organisations.

Key findings:

1. The majority of partners agreed that a more decentralised model of the CtC network was an exciting prospect and one they support and like to be part of.

2. Partners felt that regional resource groups could take over from the CtC Trust the important roles of materials development, production and dissemination as well as training, particularly of short courses, .

3. Partners felt strongly that the Trust in London needed to continue to exist as a coordinating body. Quality assurance, distillation of learning across the network and advocacy were cited as roles that the Trust needed to continue taking the lead on.

4. There was some debate on the 'name' of "Child-to-Child", with most agreeing that the current name was credible and 'known'. Some argued that the name was often limiting and needed a qualifier. When questioned, most liked: ***Child-to-Child: (an international network) promoting children's participation in health and development.***

4.0 Publications by and about Child-to-Child

4.1 Teaching/training materials

Two key factors have influenced the development of Child-to-Child publications in recent years. The first is about the lessons learned from the experiences of practitioners and programmes using CtC approaches around the world. The second is the growing international concern about issues such as HIV and AIDS, early childhood, gender, school health, inclusive education and the environment.

4.1.1 **Monitoring and Evaluating Children's Participation in Health and Development** (Hanbury, 2007) is designed for project managers to assess the quality, impact and outcomes of children's participation programme that has been field tested by Child-to-Child programmes in Asia, Africa and the Middle East. It is a reader-friendly tool that presents a range of indicators that monitor progress at different levels of experience and includes a workbook for users to reflect on the 30 steps to monitor and evaluate children's participation programmes.

4.1.2 The ***Child-to-Child Resource Book*** (2007, 1994), considered one of the most useful CtC materials for practitioners, has been recently revised to include updated health content based on the World Health Organisation's *Facts for Life*. Bird flu, safe motherhood, HIV and AIDS and diabetes are examples of new health topics for which additional Activity Sheets have been written in the simple format and structure of the previous Activity Sheets (See Appendix 2 for a list of topics).

4.1.3 Another important publication is the recently revised ***Children for Health*** (ed. Hanbury, 2005). Like its predecessor ***Children for Health*** (Hawes, Scotchmer et al 1993), it has grown out of the UNICEF, WHO, UNESCO, UNFPA book **Facts for Life** (1989).Its wide-spread global popularity is evidenced by the estimated 25 languages it has been translated into. The second edition is organised in three parts. Part 1 includes chapters on what is health education, teaching health education, planning

for health education and evaluating health education, which would be useful to those planning and implementing health programmes in both school and out-of-school contexts. Parts 2 and 3 include 14 health issues written with specific 'know', 'do', and 'feel' objectives based on information from the latest edition of Facts for Life and the framework for FRESH Focusing Resources on Effective School Health (WHO/UNICEF/UNESCO/World Bank, 2000).

4.1.4 **Small is Healthy** (Pridmore and Kassam-Khamis (eds) 2006) has grown out of a manual that Hugh Hawes had written to support teachers in poorly resourced schools in Pakistan. It includes lesson plans written in a much simpler format than the Activity Sheets.

4.1.5 **Child-to-Child Approaches to HIV and AIDS : A Manual for teachers, health workers and facilitators of children and young people** (Hanbury-Leu and Carnegie, 2004) provides information and ideas for teaching children and young people about sexual health and HIV and AIDS. This resource can be used for training, planning lessons and curriculum development. It also includes six activity sheets that have been developed based on experiences from the Child-Centred Approaches to HIV and AIDS project (CCATH) piloted in Uganda and Kenya.

4.1.6 **Early Years Children Promote Health: Case Studies on Child-to-Child and Early Childhood Development (2003)** includes case studies from projects that use the Child-to-Child approach to work with children who are nought to five years old in a range of countries. It also includes activity sheets on six health topics (Playing with young children Parts 1 and 2, Understanding Children's Feelings, A Place to Play, Feeding Young Children) that can be used to work with children in their early years.

4.1.7 **Curriculum for Health Education: Primary School Planning and Practice (Hawes, 2003)** examines case studies of programmes using CtC approaches in India (Maharashtra State), Uganda and Zambia. The factors that influenced Hawes' choice of these three countries were his own experience working in them and the commonalities in their education systems due to their previous colonial histories.

The publication is divided in three sections: the context in which curriculum is planned and clarification of terms (e.g. health, curriculum school) and the changes and evolution of curriculum development in the last 25 years; a critical look at the successes and challenges of choosing and delivering health education in the three countries; and finally prospects of successful health promotion programmes.

Some of the key questions and issues raised by Hawes are summarised below:

1. Hawes debates the question of who (e.g. politicians, curriculum developers, school heads or teachers) makes decisions about what the curriculum should include.

2. The definition of curriculum is debated throughout the book. The tension between what the author refers to as the 'conventional curriculum statement' based on a set of textbooks versus the 'all-embracing curriculum' which may not be linked to examination subjects and makes learning based on the needs and realities of the learners lives.

3. Hawes presents the curriculum of health education in schools as a 'prescription of knowledge, skills and attitudes developed in class across the curriculum through activities in the school, community and though interaction with the home and the wider community outside the school.'

4. There is a growing demand for health education in the school curriculum but the two obstacles preventing its inclusion are a misunderstanding of the definitions and goals of curriculum and confusion about how health can fit into the curriculum. Hawes stresses the importance of building health issues that families and communities consider priorities into the curriculum so that children develop essential life skills.

5. There needs to be more inter-sectoral cooperation between the health and education sectors in all countries.

6. There are gaps in the expertise and skills of curriculum developers in all three countries. Furthermore, curriculum developers need to appreciate the importance of linking health education with the home and community.

7.Hawes introduces the concept of 'skills-based health education' which is not simply about the development of life skills. The difference between skills and skills'-based health education needs to be better understood.

8. The culture and language of the home and school need to be considered when planning skills'-based health education.

4.2 Publications about Child-to-Child by others

4.2.1 Children as Partners for Health (Pridmore and Stephens, 2000) is a critical review and analysis of Child-to-Child approaches based on case studies from programmes in India, Mexico, UK, Botswana, Uganda and Ghana. The first two chapters of the book describe the theories and concepts that underpin the CtC approach and the factors that facilitated the spread of the CtC movement, which Pridmore and Stephens attribute to the 'personalities and drive of the founding members' (Pridmore and Stephens, 2000). The chapters that follow highlight the successes, challenges and lessons learned from case studies of formal and non-formal programmes using CtC approaches.

The authors discuss the following questions about Child-to-Child theories:

1. The CtC approach is not clearly defined, leaving open debate about what CtC is and what it is not. The common view is that CtC is children teaching other children about health but the authors argue for the need to 'encourage and facilitate the use of CtC ideas and methods within existing programmes not owned by CtC.' (Pridmore, 2000).
2. They highlight the tension between traditional and cultural views of the role of children and their capabilities in the communities in which CtC is practiced.
3. There is a misconception that CtC is a fund of money rather than ideas. The authors argue this may impact the uptake of CtC principles at the field level.
4. Evidence for CtC's effectiveness is weak
5. The spread of the movement is far too dependant on the charisma and personalities of its founding fathers,
6. CtC approaches could lead to the exploitation of children rather than encourage their empowerment.

Critique of Materials

- The teaching-learning methods are teacher-centred and require training to be used effectively.
- The issue of how children learn and how that learning can be monitored and evaluated is not built into the materials.
- More support needs to be given to the production of local materials.

Lessons from Case Studies

1. It is challenging to provide long-term support to teachers. Teachers still grapple with the challenge of translating what they learn in training sessions into actual practice in the classroom.
2. Health education should be located within the curriculum so that it is given equal priority to other subject areas.
3. Funding and community support remain obstacles for the sustainability of CtC programmes.

Finally, the book concludes with implications for those policy makers and practitioners using CtC approaches and recommendations for future action and research. Some of these include:

1. A wider debate on what CtC and children participation is at the international level.
2. There is a great need for more research to evaluate CtC's effectiveness. The authors also suggest that strategies be developed for the dissemination of local research.
3. A call for stakeholders in communities to take on more ownership of CtC and to define what it means, identify constraints to children's participation and involve children in focus groups to given them ownership.

4.3 Publications with a Child-to-Child content

4.3.1 Partners in Planning: Information, participation and empowerment (Rifkin and Pridmore, 2001) includes a number of cases and examples which are based on the experiences of programmes using CtC approaches.

4.3.2 Life skills education toolkit for orphans and vulnerable children (Zaveri, 2007) focuses on issues facing a broad spectrum of vulnerable children including children of sex workers, street and working children, children living in poverty, orphans and children whose parents are infected by HIV, and children who themselves are infected by the virus. Dr Sonal Zaveri, an international adviser to the Child-to-Child Trust led the materials development process and the principles of Child-to-Child are embedded in the toolkit, thus providing evidence of how a programme using the principles of Child-to-Child, child participation and child rights is able to go to scale. The toolkit comprises a facilitator's guide and manual with 10 modules related to relationships, decision making, communication, problem solving, empathy, coping with emotions and goal setting; all within the context of prevention, care and support for HIV- infected and affected children.

4.4 Published Articles

4.4.1 Child-to-Child Helping Children in Emergencies and Affected By Conflict (Kassam-Khamis, 2006) In this article, Khamis demonstrates the benefits of using CtC approaches to help children affected by war, conflict and

disasters through sharing case studies of Child-to-Child programmes in Lebanon and Afghanistan. A useful feature of the article is that it gives an example of how Afghan refugee children learned to cope with their trauma through making low-cost toys to play with younger children in the camp, using the step-by-step approach.

4.4.2 Affecting Schools through A Health Education Initiative (Kassam-Khamis and Bhutta 2006). This is an account of the experiences and lessons learned from the four year Health Action Schools pilot study (1998 – 2001). It critically examines how health education can be a vehicle to school improvement and details the impact of the study on the children and teacher's knowledge and self-esteem. The authors conclude that health education is a key determinant for quality education that can improve the teaching-learning process if two facilitating factors are in place. The first is the support of the Head teacher and the second is that the language of instruction should be the child's mother tongue.

4.5 Detailed reports of activities

4.5.1 Learning Together in the Mpika Inclusive Education Project (Kangwa & Bonati, 2003) is a report about a project in Zambia that is still active in 2007 and involves children with disabilities studying in regular classrooms in 17 local primary schools. The report details how the MIEP programme started, key strategies that have helped it expand, and a useful section on lessons learned. Plenty of anecdotes and examples from children and teachers are included which makes this a useful document for those wanting to start community or school-based CtC programmes. A video accompanies the report and both are available from the CtC Trust Office.

4.6 Unpublished theses

Bhutta, S (2006) 'Health Education practice in primary classrooms in Pakistan' is an unpublished thesis which uses quantitative methods to compare the classroom practices of urban and rural primary school settings using Child-to-Child approaches in Sindh, Pakistan.

Nishihara, M (2000) 'School Health Education and Issues of going to scale ' is an unpublished PhD study focussing on the Child-to-Child approach in Zambia.

Pridmore (1996) 'Children as Health Educators: A Critical Review of the Child-to-Child approach' is an unpublished thesis, of which most of the material is found in Pridmore and Stephan's publication described above.

5.0 Reports of Advocacy Events

5.1 In March 2002, 25 individuals representing a range of experiences using CtC approaches attended a conference entitled '***New Directions for the Child-to-Child Trust',*** in Cambridge, UK. The two key aims of the conference were to share experiences and case studies of programmes using CtC approaches and to explore the idea of the CtC Trust in the UK devolving some of its responsibilities to field-based resource groups. Case studies from Pakistan, India, Mexico and other programmes were presented on five themes which included:

- Working with children in and through schools
- Helping children and young people affected by HIV and AIDS

- Promoting children's participation in health and development
- Improving early childhood care and development
- Working with children affected by conflict
- Reaching children who are out of school

The key issues that emerged from the conference are summarized below:

1. Advocacy and networking activities need to be increased to promote CtC as a vehicle to enhance children's participation in health and development, particularly in the area of non-formal education (e.g. outside of the formal school context)
2. The experiences of field-based programmes using CtC approaches can inform the development of new materials in thematic areas like ECCD, HIV and AIDS, and helping adults and grandparents development partnerships with children.
3. Partnerships with bilateral and international development agencies and religious organisations should be developed.
4. Research on children, childhood, the girl-child, child-rearing practices and traditional games should be carried out.
5. Child-to-Child training should focus on supporting the psychosocial needs of children and life skills development (e.g. leadership, team building).

The above issues were viewed as a road map for Child-to-Child's future direction, many of which have since been implemented.

5.2 In January 2001, a **Policy Dialogue on School Health Promotion** (Khamis, 2001) was held at the Aga Khan University's Institute of Educational Development in Karachi, Pakistan by the Health Action Schools team. The objective was to advocate health education as a key determinant of quality education, based on the outcomes of the Health Action Schools project. At the end of the Policy Dialogue the following outcomes were agreed:

- An agreed list of minimum health knowledge and skills for all Pakistani primary school children to have before leaving Class 5.

- An agreed entitlement for all primary schools in Pakistan, which both schools and those who provide and supervise them should strive to meet.

- A scope and sequence chart for Classes 1-5 to plan health education across a whole school programme.

- A published set of lessons around a priority of health themes.

- A published guide for schools to become 'Health Action Schools'.

6.0 Summary and Conclusions

Child-to-Child publications have been both shaped by and contributed to enhancing understanding about issues such as gender, conflict, effective school health, HIV and AIDS, and other themes in the fields of health and education. Perhaps the one factor that has enhanced the world-wide appeal and popularity of these materials is that they have constantly evolved based on the challenges and successes experienced by practitioners in the field. CtC publications have been and continue to be written and/or tested by a cadre of practitioners based in developing countries who are in

touch with the realities and challenges in the field. The only themes that stand out as not covered in the literature reviewed are child protection and monitoring and evaluation. However, the Trust is already focusing on these areas.

Reflecting on the more recent publications and accounts about Child-to-Child that have been reviewed, quantitative and ethnographic studies on the impact of CtC approaches still remain few in number. This is a trend that needs to be reversed to include a combination of quantitative and qualitative outcome measures about the impact of CtC approaches on children's knowledge, behaviours and attitudes. Muzaffar Bhutta's recent study is a pioneering piece of work which includes more quantitative tools to measure health outcomes and will hopefully be followed by similar impact studies.

Finally, there still remain only a handful of evaluation reports, theses and published articles about programmes using CtC approaches. These are a valuable source of learning for not only the Trust but other practitioners. Perhaps a more pro-active approach needs to be taken with programmes on the existing database to encourage them to engage in research activities and share reports and to offer training or expertise to assist them. The examples of literature reviewed here serve as examples about the importance and value in researching, documenting and critically reflecting on both the successes and challenges practitioners face in implementing quality CtC programmes. Whilst an assumption may be made of the benefits to children involved in CtC activities through the continued engagement of practitioners in over 70 countries world-wide and the translation of CtC copyright-free materials in over 33 languages in the last 30 years (since 1978), the legacy of literature on the impact of CtC is still a vital engine to the continued growth of the Child-to-Child movement in the future.

Appendix 1 Translations of Child-to-Child materials

As of 2007, translations of some Child-to-Child materials have been made in 33 languages, including some of the following: Arabic, Farsi, French, Gujurati, Hindi, Nepali, Portuguese, Spanish, Tamil and Urdu.

Appendix 2 Contents of Resource Books (Activity Sheets)

Children's Growth and Development
Playing with young children 1: Babies
Playing with young children 2: Pre-school children
Understanding children's feelings
Helping children who do not go to school
A place to play
Puberty, parenthood and sexual health

Nutrition
Feeding young children 1: aged 6 months to 2 years
Feeding young children 2: how do we know if they are eating enough?
Growing vegetables
Breast-feeding

Personal and Community Hygiene
Our teeth
Looking after our eyes
Children's faeces and hygiene
Clean, safe water
Our neighbourhood

Safety
Preventing accidents
Road safety
First aid

Recognising and Helping the Disabled
Children with disabilities
Helping children who do not see or hear well
Mental handicap and children

Disease Prevention
Caring for children with diarrhoea
Caring for children who are sick
Intestinal worms
Immunisation
Polio
Cholera
Coughs, colds, pneumonia (A.R.I.)
Malaria
Bird Flu
Diabetes

Safe Life Styles
Smoking and Drugs - Think for yourself
Medicines - when and how they can help us

HIV and AIDS

Children in Difficult Circumstances
Children who live or work on the streets
Children who live in an institution
Helping children whose friends or relatives die
Helping children who experience war, disaster or conflict

Living and Coping with HIV and AIDS
How HIV and AIDS Affect Children's Lives
No Child Should be Alone
Building Good Memories
Helping Each Other to Cope with Loss
Protecting Inheritance and Raising Funds
Planning for the Future

Making our own activity sheets

Appendix 3 Child-to-Child Readers

Level 1
Dirty Water
Uncle George Feeds His Baby
Accidents
Not Just A Cold
The Market Dentist and other Stories

Level 2
Diseases Defeated
I Can Do It Too
Teaching Thomas
A Simple Cure
Down with Fever
Flies
Two Girls and Their Dreams
Can Betsy Stay At School?

Level 3
Who Killed Danny?
The Cholera Crisis
Freda Doesn't Get Pregnant
Deadly Habits
Five Friends of the Sun
To Have A Son Like You
A Path of Peace

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