CHAPTER I

INTRODUCTION
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The present topic of research is "Curriculum designing in Health Education for Adults in Rural Areas of Chittoor District, Andhra Pradesh". To provide background to the topic, certain important issues relating to health education and curriculum are presented in this chapter. The issues presented include:

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1.18 Place of Health in Adult Education
1.1 **Health - Meaning and Importance:**

Health is not a condition of matter, but of mind, nor can the material senses bear reliable testimony on the subject of Health (Science and Health).

As predicted by René Dubos and Others, the very technology that makes human life more comfortable and solves most of the age-old problems of health also creates a new and varied sophisticated problems of health. A new drug may serve as an effective and new treatment or as an agent of death, if abused.

Modern medical science is often accused for its preoccupation with the study of disease, and neglect of the study of health. It has encouraged people to rely on drugs and tonics for the maintenance of health than teach them the rational way to health.

Health has been viewed by different people from different angles:

i) **Bio-Medical Concept:** Health has been traditionally defined as "absence of disease" and disease has deviation from a biochemical norm. This concept is known as the bio-medical concept. For all its spectacular success, the bio-medical model was found inadequate to solve some of the major health problems.
of mankind such as, the population problem, problems of malnutrition, chronic diseases accidents, mental illness, drug abuse, insecticide and bacterial resistance, etc.

ii) **Ecological Concept:** Ecologists viewed health as a harmonious equilibrium between man and his environment and disease as a maladjustment of the human organism to the environment.

iii) **Biosocial and Biocultural Concepts:** Developments in social sciences revealed that disease is both a biological and social phenomenon. There are not only biological factors but also social, cultural and psychological factors (non-medical dimensions) which must be taken into consideration in defining health and illness.

iv) **Holistic View:** The holistic view is a synthesis of all the above concepts. According to this concept, health is viewed as a multidimensional process involving the well-being of the whole person in the context of his environment. This view corresponds to the view held by the ancients that health implies a sound mind, in a sound body, in a sound family, in sound environment.
The definition of health is a broad-based one. Health encompasses all phases of living comprising the psychological, sociological, biological and spiritual fields. Even though, these characteristics are listed separately, in reality, they exist together and are intermingled in order to result in a state of health.

Health is a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity (WHO).

The above definition goes beyond the mere absence of disease. It envisages three dimensions or components of health-physical, mental and social, all closely related. A fourth dimension has also been suggested namely 'spiritual' health. A person who enjoys health at these three planes is said to be in a state of "Positive Health".

In many rural areas, the people are suffered by a low standard of living which is caused by low levels of productivity and income. Health is affected by the poor and low standard of living and in turn affects all other conditions. The development of rural communities which constitute about 70 per cent of the
Indian population is one of the thrusts of the country to-day. It is considered that health and education are the two most important inputs for human development and insisted that health must be an important component of education not only in the formal educational system but also in the non-formal educational system, reaching vast majority of the Indian population which are not covered by the formal education system.

Life is not just living, but living in good health. Without health, life is no life. There is no enjoying this world without sound health. There is an urgent need to develop healthy citizens who will consider health as an asset so that they can live most and serve best.

1.2 Health Education - Concept:

Health education is a process of imparting information about health in such a way that the recipient is motivated to use the information for the protection and promotion of the health of individuals, their family and communities.

Ruth E. Grout (1968) defines, health education as "translation of what is known about health into
desirable individual and community behaviour patterns by means of educational processes."

According to Ramakrishna, V. and Krishna Swamy, K.S. (1958) "Health education is a process .......... leading to programme planning, utilising available resources, modifying health behaviour, breaking down barriers of ignorance, prejudice and misconception after an intelligent and thoughtful consideration of relevant health-knowledge." This means that Health education is a process involving a series of steps and efforts by people and is not a single procedure.

From the above definition, it is clear that Health Education aims at bringing scientific knowledge to people so that they can use such scientific knowledge for betterment of their own health and health of community in which they live.

Wood explained that Health Education represents, "The sum of experiences in school and elsewhere that favourably influence habits, attitudes and knowledge relating to individual, community and racial health."

The above statement defines health education in terms of the life experiences of individual affecting what he knows, how he feels and what he does.
Health Education can be defined as the process of providing or utilizing experiences for favourably influencing understandings, attitudes and practices relating to individual, family or community health. It is the process by which persons become aware of their own initiative in establishing practices to meet these needs. Health education is also concerned with the changes in knowledge, feeling and behaviour of people. It is concerned with thinking and feeling as well as with bodily strength and fitness. It also includes the way in which people behave towards each other. Health education must teach the knowledge a person needs to protect his own health and the health of the people he lives with. He must know how to use this knowledge. The lessons in the health programme teach facts, ideals and practical use of these facts and ideals in real life. Health education includes living or cultivating a lifestyle which is promotive of health. For instance, the health conscious individual has to take physical exercise, cultivate the right dietary habits, avoid excess and observe self discipline in certain matters. Health Education deals with specific facts and not with generalities. These facts are the results of experimentation,
research and well founded conclusions of health-education, medicine, public health, nutrition and pharmacy etc.

Health Education is a professional field, an academic discipline and is selective in nature for its scientific base. This means that health education can be considered to be the field of study for people desiring to work within it. It also means that Health education is an academic discipline within the school curriculum just like any other subject. It is an applied science and not a pure science. Because of the involvement of all categories of people, it is necessary to have bits of knowledge from a variety of other disciplines such as biology, psychology, sociology and physiology. The strategies of health education provide the approaches needed to bridge the gap between scientific discovery and its application for everyday healthful purposes. Health education utilises this information and through appropriate teaching strategies, attempts are made to integrate this knowledge into people's daily living patterns. Health education is needed at every level of education. Health education contributes to the total education
of individual by providing meaningful experience which can prospectively influence his health behaviour. The proof of the success of health education lies with the health practices of people throughout the years.

Health Education facilitates primary prevention of health problems. Primary prevention means providing opportunities for the person to learn and practice healthful living to such an extent that fewer problems of health occur. Learning scientific information dealing with diseases, digestion and growth and development is fine, but more basic is learning to live to promote optimal well-being. The knowledge of large variety of subjects found within the total scope of health education will all contribute to healthier daily-living patterns.

Health is soundness, wholeness and vigour of body and mind. Our country is facing many health problems like mal-nutrition, diarrhoea, measles and blindness etc. Poverty, illiteracy and ignorance are stated to be primary causes of this state of affairs in the developing and underdeveloped countries. Most of the people are not aware of the available health-facilities. They are resorting to the indigenous medicines with out
knowing their nature and action. They are not informed about the nutritious values of the locally available food-stuffs. This ignorance prevents them from easily acquiring the valuable food-stuffs. Individual behaviour and reaction to health-promotion and care during illness, health-status of an individual or community are the result of many forces within oneself and in the society. Education for health prepares people to recognize what they must do to maintain their health and care for themselves when they fall ill.

In a rural based society like ours, medical knowledge should reach the interior areas. There should be a constant flow of information from teacher to the policy-maker. This is a feedback method for involving community in the health care programme. A meaningful dialogue and good rapport between the people and the profession will help enrich both. The improvement of understanding is for two ends; firstly, to increase our own knowledge and secondly, to enable to deliver that knowledge to others.

1.3 Scope of Health Education:

Health education is not confined to any situation in particular, nor it is restricted to any specific time but it is a continuous process. It is a process which
affects changes in the health practices of people and in the knowledge and attitudes related to such changes. It begins with early life with the mother's concern for child's health and observation of adult's behaviour and practices. It continuous through life, in school, at home and at the place of work and play ground. Man's life being dynamic and adaptable in many situations; there is scope for Health education. Education can be imparted with the help of communication through different methods and media.

Health not only depends upon the material resources available for healthy living viz., environmental sanitation, personal health services etc. but also an individual factors such as attitude towards health, healthy habits etc., which play an important part for maintenance of health. Thus by proper health education, the public may be benefited.

1.4 Objectives of Health Education:

i) Health education is given to make the people as individuals and members of groups to value health as a community asset.

ii) Health education helps people to develop the knowledge and skills to undertake, the activities which will enable them to help themselves
iii) Health education helps people to understand the nature and purpose of health services and facilities.

1.5 Need of Health Education:

Recognition of the essential need for the health education of the public is reflected in two statements of principles in the preamble to the constitution of the WHO namely that the extension to all the people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health and further that informal opinion and active co-operation on the part of the public area of the utmost importance in the improvement of the health of the people. There are two angles of approach to health education. There is the health education necessary for the individual as an individual and the health education necessary for every individual as a member of the community, the personal and social angles.

1.6 Aims of Health Education:

It aims at bringing scientific knowledge to people so that they can use such knowledge for the betterment of their own health and the people or community in which
they live. Health education cannot be thrust on people, but must be acquired through their own efforts. Ignorance, prejudices and many social and cultural factors influence health. Hence education is necessary to replace ignorance by knowledge, remove prejudices and bring about changes in beliefs and attitudes in a direction of favourable to health. It has four definite aims. These are:

1) To make good health an asset valued by the community,
2) To encourage the full use and development of health services,
3) To teach people how to achieve good health,
4) To encourage them to achieve good health by their own action and effort.

1.7 Principles of Health Education:

According to Park and J.E. Park (1989) there are six principles.

1) Health education is concerned with everyday living as it affects the individual, his family, his community. Health education deals not only with health problems of the individual but also with those of the family and of the pupils within a
classroom and school and with those of community and the nation as well. These problems are not of the past but of the present and future.

ii) Health education deals in specific facts and not in generalities. These facts are the results of the experimentation, research and well founded conclusion of school health education, medicine, dentistry, public health; nursing, related biological and sociological sciences, engineering, nutrition, and pharmacy. The purpose of health education is to interpret experimentations, research and conclusions so that the facts can be easily understood and reach all students.

iii) Health education is positive in its approach. It does not moralize or coerce but provides reliable factful evidence so that the student can form positive opinion to guide his actions.

iv) Health education has a five pronged attack. It attempts to improve one's physical and mental health status, erase the pseudo-information, eliminate attitudes regarding improvement of the pupils' health status, promote health practices that benefit him and stimulate continuous interest
in health education. Specific and valid health facts are necessary. These facts applied to everybody living can strengthen the individual's health practices, attitudes and interests so that health becomes a "State of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

v) Health education depends upon the teacher's enthusiasm and interest. There are elementary and secondary school teachers who consider health education of no significant value; they believe it to be subservient to that traditional subjects and to physical education.

vi) Health education is based on objective information about the individual pupil's physical and mental health status and his health practices, attitudes, interests and knowledge. To be meaningful to the people, health education must satisfy their many health needs and interests. Objective information is found in statistical evidence of mental health problems of school-age children.
Health Education Process:

Health education does not start in a vacuum. The right health knowledge and practice has usually to displace at least part of what the patient already believes and practices. Therefore the first step must be study to the health relevant beliefs and practices of the local community in their true cultural setting.

From the practical point of view, health practices are what matter, and beliefs matter only in so far as they determine practice and make it difficult to change a harmful practice into a beneficial one. The health relevant practices are to be divided into the harmful, the harmful, the harmless and the beneficial.

When health education begins, it does so against a background of belief and practice that is at least partly incorrect. When finally it is complete, the individual is not only properly informed and carrying out the correct health practices, but he feels so strongly about matters of health that he is even prepared to initiate health action by the committee. According to the aims of health education -
i) it supplies a person with enough new and correct knowledge about a disease to make the preventive measure required by scientific medicine seem reasonable.

ii) it makes a person feel for sufficiently keenly about the importance of his own health to make him alter his behaviour and adopt these preventive measures.

iii) it makes him concerned for the health of others.

iv) it tries to make him feel so strongly about the first three that he supports and even initiates preventive action by the community.

The health education process is more complex and the successive changes it involves at various levels are summarized. Ex: Dysentry.

i) A change in knowledge - this is the first stage, such for instance as knowing dysentry is an infectious disease.

ii) A change in attitude follows this - the patient is not only able to repeat what he has been told, but now has a greater regard for the possible spread of the disease.
iii) A change in behaviour is seen next - the patient begins to act on his belief and no longer disposes of his excreta indiscriminately.

iv) A change in habit - the patient now dispose his excreta in a latrine as an unthinking habit that requires no conscious decision.

v) A change in custom - when care is disposal of excreta has become one of the cultural characteristics of the group to be handed on to the children of the next generation.

It is common for a person to believe in something which he does not practice, or for him to practice something in which he does not believe. This divorce of practice from belief - this cognitive dissonance as it is called - produces a certain psychological tension which is only relieved by the adjustment of practice to belief or vice-versa.

1.9 Content of Health Education:

According to Park and J.E. Park (1989) Health education is as wide as community health. The content of health education may be divided into eight main divisions.
i) **Human Biology**: It includes the structure and functions of the body, and how to keep physically fit. The need for exercise, rest and sleep are taught. The effects of alcohol, smoking, resuscitation and first-aid are also taught.

ii) **Nutrition**: The aim of health education in nutrition is to guide people to choose optimum and balanced diets which contain nutrients necessary for energy, growth and repair - but not to teach the familiar jargon of calories and bio-chemistry of nutrients. Education is given on the nutritive value of foods; about storage, preparation, cooking, serving and eating of food. Here, the primary aim is to help people to make the best use of the available resources.

iii) **Hygiene**: This has two aspects - personal and environmental.

**Personal Hygiene**: The aim of personal hygiene is to promote standards of personal cleanliness within the setting of the conditions where people live. It includes bathing, clothing, washing hands and toilet; care of feet, nails and teeth, spotting, coughing, sneezing, personal appearance and inculcation of clean habits in the young.
Environmental Hygiene: It has two aspects - domestic and community.

Domestic hygiene comprises that of the home, use of soap and water, need for fresh air, light and ventilation; hygienic storage of foods, hygienic disposal of wastes, need to avoid pests, rats, mice and insects.

Environmental health is a major concern of many governments and related agencies throughout the world. In the developing countries, the emphasis is on the improvement of basic sanitary services consisting of water supply, disposal of human excreta, other solid and liquid wastes, vector control, food sanitation and housing.

iv) Family Health Care: Family health care programmes include human growth and development, mother and child health care, human reproduction, family planning, population dynamics, immunization, nutrition and other related activities.

v) Control of Communicable and Non-communicable Diseases: There is a wide range of specific communicable and non-communicable diseases needing health education activity, to mention a few-malaria, sexually transmitted diseases, trachoma, leprosy, tuberculosis, mal-
nutrition, cardio-vascular disease, dental diseases, drug addiction, alcoholism etc. Lack of elementary knowledge about the nature of diseases and their prevention is widespread even in the most highly developed countries. Health education aims to bridge this gap. People are encouraged to participate in programmes of disease control, health protection and promotion.

vi) Mental Health: The aim of education in mental health is to help people to keep mentally healthy and to prevent a mental breakdown. People should enjoy their relationships with others and learn to live and work without mental breakdown. There are certain special situations when mental health is of great importance - mother after child birth; child at entry into school for the first time, school child entering the secondary school, decision about a future career, starting a new family and at the time of widowhood. These are the critical periods of life when external pressure tends to breakdown mental health.

vii) Prevention of Accidents: In the developed countries, they are taking an increasing toll of life and limb. Accidents occur in three main areas: the home, road and the place of work. Safety education should be
directed to these areas. Accidents occur in workshops, factories, railways and mines. Management must provide a safe environment and promote general order and cleanliness.

viii) Use of Health Services: One of the declared aims of health education is to inform the public about the health services that are available in the community and how to use them. They should not be misused or abused. Further, people should be encouraged to participate in the various national health programmes designed to prevent disease or promote health.

1.10 Health Programmes in India:

Since India became free, several measures have been undertaken by the government to improve the health of the people. Prominent among these measures are the National Health Programmes, which have been launched by the Central Government for the control of communicable diseases, improvement of environmental sanitation, nutrition, control of population and rural health. Various international agencies like WHO, UNICEF, UNFPA, World Bank, as also a number of foreign agencies like SIDA, DANIDA, NORAD and USAID have been providing technical and material assistance in the implementation of these
programmes. A brief account of these programmes which are currently in operation is given below:

1.10.1 National Malaria Eradication Programme:

In the 1950s malaria was India's number one health problem. The National government launched a programme known as National Malaria Control Programme (NMCP) in 1953 to reduce the incidence of malaria in the country. The initial success against malaria had been spectacular. From 75 million cases in 1952, it had been brought down to 2 million in 1958. In 1958, the programme was up-graded to National Malaria Eradication Programme (NMEP) in 1986, there were only 1.7 million cases.

India's commitment to the goal of 'Health for All' by 2000 A.D. necessitated the integration of anti-malaria activities with primary health care. Primary health centres are involved in the collection and examination of blood smears from fever cases through multi-purpose workers. The programme in the rural and remote areas relies considerably on community participation. Drug Distribution Centres are manned by Panchayat members, forest officials, village health guides and other community workers. Fever Treatment Depots are manned
by teachers, forest and revenue officials. Insecticide spraying operations in areas with AP 12 and above, being a specialized task, have been retained as a vertical programme, under supervision of District Malaria Officers.

1.10.2 National Filaria Control Programme:

The National Filaria Control Programme (NFCP) has been in operation since 1955. In June, 1978, the operational component of the NFCP was merged with the urban malaria scheme for maximum utilization of available resources. The training and research components, however, continue to be with the Director, National Institute of Communicable Diseases, Delhi. Under the NFCP, the following activities are being undertaken.

a) Delimitation of the problem in hitherto unsurveyed,

b) Control in urban areas through
   i) recurrent anti-larval measures, and
   ii) anti-parasitic measures.

As on 31 December, 1985, there were 197 filaria control units, 27 survey units, and 148 filaria clinics functioning in the endemic areas. The village health guides will have to be trained and involved in anti-
filarial activities with local community participation.

Training in filariology is being given at three Regional Filaria Training and Research Centres situated at Calicut (Kerala), Rajahmundry (A.P) and Varanasi (U.P) under the National Institute of Communicable Diseases, Delhi. Besides, 12 headquarters bureau are functioning at the state level.

1.10.3 National Tuberculosis Programme:

National Tuberculosis Programme (NTP) has been in operation since 1962. Its objectives are:

a) Long-term objectives - to reduce tuberculosis in the community to that level when it ceases to be a public health problem, i.e.,

i) one case infects less than one new person annually;

ii) the prevalence of infection in age group below 14 years is brought down to less than 1 per cent against about 30 per cent as at present.

b) Operational or short-term objectives -

i) to detect maximum number of TB cases among the out-patients attending any health institution with symptoms suggestive of tuberculosis and treat them effectively.
ii) to vaccinate new borns and infants with BCG.

iii) to undertake the above objectives in an integrated manner through all the existing health institutions in the country.

National Tuberculosis Programme operates through the District Tuberculosis Programme (DTP), which is the backbone of the NTP. Over 600 TB clinics have been set up in the country, of which 366 have been upgraded, as District TB Centres (DTC) to undertake district-wide TB control in association with general health and medical institutions. BCG vaccination is now taken up under the national immunization programme with the goal of protecting all children by 1990. To meet the demands of BCG vaccine, the Government of India had set up a BCG vaccine laboratory at Guindy, Madras in 1948. The BCG vaccine laboratory produces and supplies freeze-dried BCG vaccine and PPD tuberculin.

17 TB training and demonstration centres have been established in major states of the country. Two premier TB institutes, namely National Tuberculosis Institute, Bangalore established in 1959, and Tuberculosis Chemotherapy Centre, Chetput, Madras established
in 1956 conduct training and research activities. NTP is a centrally sponsored scheme. Anti TB drugs for free treatment are being supplied to the TB clinics run by State Governments on a 50:50 sharing basis between the centre and the state. For the Union Territories and voluntary organizations, the pattern of assistance is 100 per cent. Short-term chemotherapy has been introduced in selected districts all over the country and is being extended to more districts in a phased manner.

1.10.4 National Leprosy Control Programme:

The National Leprosy Control Programme (NLCP) has been in operation since 1955 as a centrally aided programme to achieve control of leprosy through early detection of cases. The NICP moved with a slow pace and later it gained momentum during Fourth Five Year Plan. In 1980, the Government of India declared its unscientific resolve to eradicate leprosy by the year 2000, and constituted a working group to advice accordingly. The working group submitted its report in 1982, and recommended a revised strategy based on multi-drug chemotherapy aimed at leprosy eradication through reduction in the quantum of infection in the population,
reduction in the sources of infection, and breaking the chain of transmission of disease in 1983, the control programme was redesignated National Leprosy Eradication Programme (NLEP) with the goal of eradicating the disease by the turn of the century.

NLEP operates a vertical programme in endemic areas. The revised strategy is based on early detection of cases (by populations surveys, school surveys, contact examination and voluntary referral), short-term multi-drug therapy, health education and rehabilitation activities.

The programme is implemented through the establishment of leprosy control units; Survey Education and Treatment (SET) centres; and Urban Leprosy Centres. By the end of March 1986, there existed 499 leprosy control units, 715 urban leprosy centres and 6985 SET centres, 45 leprosy training centres and 253 temporary hospitalization wards in the country extending coverage currently to about 400 million of the 430 million population in endemic areas. About 150 voluntary organizations in the country are actively engaged in anti-leprosy activities.
1.10.5 Diarrhoeal Diseases Control Programme:

National Diarrhoeal Diseases Control Programme was started during the Sixth Five Year Plan to bring down diarrhoea-related mortality (this includes cholera) through promotion of oral rehydration therapy. The programme was intensified during the Seventh Plan to reduce diarrhoea mortality by 50 per cent by the year 1990. This programme is integrated with primary health care at the village/sub-centre/PHC levels, and at the District hospital level. Private practitioners are also involved in the programme. Every village health guide is supplied with 100 packets of oral rehydration salts per year. In addition 200 such packets are supplied to subcentres. Health education materials like "Home treatment of Diarrhoea" in regional languages is supplied to all PHCs for free distribution.

1.10.6 STD Control Programme:

The programme began in 1949 as a pilot project for control of venereal diseases. In 1955, the Planning Commission recommended the establishment of at least one VD Clinic in every district, and one head quarter's clinic and laboratory in every State. A central VD Organization was set up in the Directorate General of
Health Services in 1957 for implementing and coordinating the programme in the country. A free supply of penicillin (PAM) and VDRL antigen were made available to the VD Clinics. The strategy has now been focused on training, teaching and research in the various aspects of STD.

To provide training facilities to the in-service medical and paramedical personnel in venereology, the Government is running two training centres, namely the Institute for the study of STD, MMC, Madras and the STD Training and Demonstration Centre, Safdarjang Hospital, New Delhi. A regional training centre is being established at Calcutta for the eastern zone and another at Nagpur, for western zone.

1.10.7 National Programme for Control of Blindness:

This programme was launched in 1976. The ultimate goal of the national programme is to reduce blindness in the country from 1.4 per cent to 0.3 per cent by 2000 A.D., and to provide comprehensive eye care through primary health care. National Institute of Ophthalmology has been established for manpower development, research and referral services. About 900
ophthalmic assistants are expected to be trained annually. Each PHC and District Hospital are to be provided with one Ophthalmic assistant each.

Targets have been laid down for each state for cataract operation. The voluntary organizations are encouraged to organize eye camps in remote rural and urban areas as per guidelines, with permission from state authorities. Community health education is a built in component at all levels of implementation. The programme also includes regular check-up and precision of Vitamin A prophylaxis and service facilities in rural areas.

1.10.8 Iodine Deficiency Disorders (IDO) Programme:

India commenced a goitre control programme in 1962, based on iodized salt. Even to this date, the disease still remained high. The reason is the production of iodized salt did not keep pace with requirements. The iodine-deficiency manifestations were not limited to endemic goitre and cretinism but to a wider spectrum of disability including deaf-mutism, mental retardation, and various degrees of impairment of intellectual and motor functions. As a result, a
major national programme - the IOD Control Programme has been initiated in which nation-wide, rather than area-specific use of iodized salt is being promoted. It has now been decided as a national policy to fortify all edible salt in the country in a phased manner by 1992. The essential components of a national IOD pro-
gramme are iodized salt, monitoring and surveillance, manpower training and mass-communication. It has become necessary to fortify salt with both iodine and iron to combat IOD and anaemia.

1.10.9 Expanded Programme on Immunization:

In 1974, the WHO launched its "Expanded Pro-
gramme on Immunization" (EPI) against six, most common, preventable childhood diseases, viz., diptheria, per-
tusis (whooping cough), tetanus, polio, tuberculosis and measles. The primary health care concept as enunci-
ated in the 1978 Alma Ata Declaration included immuni-
ization as one of the strategies for reaching the goal of Health for All by the year 2000, while the WHO's programme is called EPI, the UNICEF in 1985 renamed it as Universal Child Immunization (UCI).

Universal immunization programme which was started in 1985 has two vital components: Immunization of pregnant women against tetanus and immunization of
children in their first year of life against the six EPI target diseases. The aim is to achieve 100 per cent coverage of pregnant women with 2 doses of tetanus toxoid (or a booster dose), and at least 95 per cent coverage of infants with 3 doses each of DPT and TOPv and one dose of BCG and one dose of measles vaccine by 1990. More recently, a "Technology Mission on Vaccination and Immunization of Vulnerable population, specially children" was set up to cover all aspects of the immunization activity from research and development to actual delivery of services to the target population. The immunization services are being provided through the existing health care delivery system (i.e., MCH centres, PHCs and sub-centres, hospitals, dispensaries and ICD units).

1.10.10 National Family Welfare Programme:

India launched a nation-wide family planning programme in 1952, making it first country in the world to do so. During the Fourth Five Year Plan (1969-74), the Government of India gave 'top priority' to the programme. The programme was made an integral part of MCH activities of PHCs and their subcentres. In 1970, an All India Hospital Post-partum Programme and in 1972,
the Medical Termination of Pregnancy (MTP) were introduced. In 1977, the Ministry of Family Planning was renamed 'Family Welfare'. The launching of the Rural Health Scheme in 1977 and the involvement of the local people (e.g., Health Guides, Trained Dais, Opinion leaders) in the family welfare programme at the grass- root level were aimed at accelerating the pace of progress of the programme. The National Health Policy laid down the long-term demographic goal of NRR = 1 by the year 2000 - which implies a 2-child family norm through the attainment of a birth rate of 21 and a death rate of 9 per thousand population and a couple protection rate of 60 per cent by the year 2000.

1.10.1 National Water Supply and Sanitation Programme:

The national water supply and sanitation programme was initiated in 1954 with the object of providing safe water supply and adequate drainage facilities for the entire urban and rural population of the country. As a supplement to this programme, Accelerated Rural Water Supply Programme was started in 1972. During the Fifth Plan, rural water supply was included in the Minimum Needs Programme of the State plans. The Central Government is supporting the efforts of the States in identifying 'Problem villages'. A problem village has
been defined as one where no source of safe water is available within a distance of 1.6 km. or where water is available at a depth of more than 15 metres or where water source has excess salinity, iron, fluorides and other toxic elements or where water is exposed to the risk of cholera and guinea worm.

During the Sixth Five Year Plan (1980-85), 1.92 lakh villages out of 2.31 lakh 'problem villages' were provided with at least one safe source of drinking water. The latest assessment indicates that safe water is available to 80 per cent of the urban and 47 per cent of the rural population and adequate facilities for waste disposal available to 30 per cent of the urban and 1.0 per cent of the rural population. The Government of India launched the International Drinking Water Supply and Sanitation Decade Programme in 1981. Targets have been set on coverage and are 100 per cent for water, both urban and rural; and 80 per cent for urban sanitation and 25 per cent for rural sanitation.

11.0.12. Guinea-worm Eradication Programme:

This programme was launched in 1983-84 during the Sixth Five Year Plan. As on January, 1986, six states in India were endemic affecting 7114 villages in
481 primary health centres and 66 districts.

The eradication strategies have been spelt out in detail in the operation manual on guinea worm eradication. The main approaches being used are: provision of drinking water sources on a priority basis to villages with endemic disease; vector control with abate (temephos) giving a concentration of 1 mg per litre (1 ppm); health education, including personal prophylaxis, i.e., boiling of drinking water, sieving of unprotected water. A recent innovation is nylon mesh filters; and active surveillance.

1.10.13 Minimum Needs Programme:

The minimum needs programme was introduced in the first year of the Fifth Five Year Plan. The objective of the programme is to provide certain basic minimum needs and thereby improve the living standards of the people. The programme includes the following components:

a) rural health,
b) rural water supply,
c) rural electrification,
d) elementary education,
e) adult education
f) nutrition
g) environmental improvement of slum, and
h) houses for landless labourers.

In the field of rural health, the objectives to be achieved by the end of the Seventh Five Year Plan, under the minimum needs programme are: The establishment of PHCs, sub-centres, upgradation of PHCs.

In the field of nutrition, the objectives are -
a) to extend nutrition support to 11 million eligible persons,
b) to expand 'special nutrition programme' to all the ICDS projects, and
c) to consolidate the mid-day meal programme and link it to health, potable water and sanitation.

1.10.14 National Diabetes Control Programme:
The main objectives of the programme are -
i) identification of high risk subjects at an early stage and imparting appropriate health education,
ii) early diagnosis and management of cases,
iii) prevention, arrest or slowing of acute metabolic as well as chronic cardiovascular-renal complications of the disease.
The central focus of the National Diabetes Control Programme would be on a District Diabetes Control Programme. The programme will function at three levels of the sub-centre, primary health centre and district hospital level. It has been stipulated that the programme during the Seventh Plan be undertaken in 5 districts in different states. An outlay of ₹25 lakhs has been provided during the Seventh Plan.

National AIDS control Programme:

With the spread of AIDS from one country to another it became necessary to initiate a national control programme. The Government of India in 1985 constituted a taskforce to look into this matter. An AIDS Cell was established in the Directorate General of Health Services, New Delhi to coordinate all activities pertaining to AIDS in the country.

The national strategy has the following important components: establishment of surveillance centres to cover the whole country; identification of high risk groups and their screening; issuing specific guidelines for management of detected cases and their follow-up; formulating guidelines for blood banks, blood product manufacturers, blood donors, and dialysis units;
information, education and communication activities by involving mass-media; research etc.

1.11 **Curriculum-Definitions:**

An adequate definition of Curriculum is yet to be found. There is no agreement among curriculum planners about the concept of curriculum. A few definitions given by curriculum experts are given below:

i) According to Donald F Cay (1978), the term curriculum covers school experiences like an umbrella - educational design - (the) reflection of political, religious, social and ethical values of any given society - experiences involving interaction between those who teach and those who learn - the master plan, devised by educators and other adults in a community, state or nation that will best serve their needs and as they see it, the needs of their children.

ii) According to Harold Spears (1963), Curriculum is an even a more nebulous thing, not described by its outward features but rather by the point of view of the thinking from which it springs. A curriculum is something to be felt rather than something to be seen.

iii) To Thornton and Wright (1974), Curriculum embraces, "all of the learning experiences of students under the
direction of the school".

iv) To Smith, Stanley and Shores (1969) Curriculum is a perpetuator of the status quo. A sequence of potential children and youth in group ways of thinking and acting. This set of experiences is referred to as the curriculum.

v) To Beauchamp (1968) "A curriculum is a document designed to be used as a point of departure for the instructional planning.

vi) The Gail M. Inlow (1973) a curriculum is that body of value-goal-oriented learning content, existing as a written document or in the minds of teachers, that, when energized by instruction, results in change in pupil behaviour.

1.12 Curriculum - Need and Importance:

The concept of education and learning has undergone great evolution over the years. There is a growing awareness that education is not coterminus with schooling; that education transcends mere transmitting of knowledge and experience; that learning is not a passive, but an active process; that learning, working and living have to be more closely integrated; and that the learners themselves have to play a much more active role in the
learning process.

It is clear that an educated person is one who has learnt how to learn, how to adapt and how to change his surroundings, through purposeful intervention in his environment. As a part of the process of education he gains the understanding that no knowledge is terminal and that learning the process of seeking knowledge is the only guarantee against obsolescence. This why out-of-school learning practices, which were once upon a time highly valued in our country, are now receiving renewed and growing interest.

Formulation of an appropriate curriculum and strategy of learning is crucial to the success of adult education programmes. The curriculum formulation for adult education has to be an innovative process. The temptation must be overcome to design curriculum in terms of the existing models, with which we have been familiar.

Many non-formal educational and adult literacy programmes have suffered from deficiencies both in curriculum content and teaching methods.

The common deficiencies in the nature of the curriculum are: (a) predominance of the traditional literacy
approach, emphasising the acquisition of only 3 R's; (b) uniformity of subject-matter and its not being related to learners' needs; (c) dysfunctionality of the content in regard to the objectives to be attained and requirements of a given community; (d) irrelevance to the problems of the immediate environment and of the nation.

With reference to the strategy of learning, it is noticed that (a) the educational process is predominantly teacher-centred; (b) teacher's professional authority had been confused with the authority of knowledge; (c) learners are mostly considered as a listeners' group; (d) there is excessive dependence on verbal ways of transmitting knowledge; (e) learners were not sufficiently active participants in the learning process; (f) audio-visual means are underestimated; (g) the inter-relation between individual learning and group action is generally neglected.

For all these reasons it has became necessary to put much greater emphasis on the content and methodology as major pre-requisites of achieving the goals of adult education.
As mentioned in the Summary of the Report of the Working group on Adult Education for Medium Term Plan 1978-83: "In the context of NAEP, resource development is intended to mean the instrumentality for transforming the concept and the objectives of the programme into a learning system. Its elements include curriculum development, preparation of teaching/learning materials, training and evaluation. Resource methodology has to be based on the principles of: (a) flexibility and openness; (b) devolution, and (c) efficiency".

The curriculum in the NAEP has to be related to the identifiable needs of the groups of learners, and, therefore, would ordinarily be preceded by a survey of such needs. The curriculum

- should enable the learners to get a basic understanding of the social and physical environment in which they live;
- should develop an attitude of self-reliance and initiative;
- should encourage them to constructive action;
- should prepare them for parenthood and family life;
should enable them to realise their rights and responsibilities, and

should impart skills in literacy and numeracy so that self-reliant learning may take place. The duration of the adult education programme, including literacy, should be of 300 to 350 hours.

Based on these objectives, the curriculum diversified, functional, problem-solving, inter-disciplinary and environment-based - should aim at enabling the learners to take concrete and definite action for improving the quality of their life and their ability to work. It is, therefore, fundamental to try to relate learning to the environment of the learners, to their social, economic and cultural milieu and to the developmental goals of the country. It, thus, follows that basically the foundation of the adult education curriculum should be the everyday concerns of both the learners and educators.

The learning activity should be organised around the basic needs, expressed or unexpressed, immediate and felt problems, and interests of the learners.

Hence, the emphasis in adult education is not on accumulating knowledge and providing skills, but on promoting the process of critical thinking, analysis and
consequent remedial action on encouraging the rational and scientific attitudes. The test of learning achievement in adult education lies in enabling the learners to improve their life situations, to overcome the constraints under which they live, to enrich their life and work, and to participate in and contribute to social and national progress.

Such an approach has to be built on an unconventional teacher-learner relationship characterised by equality between them and sharing of experience and knowledge. Learners, even if illiterate and deprived of many physical and cultural assets are not ignorant: (a) they possess definite social and personal values which need only adaptation to changing times; (b) they possess skills which need modernisation; (c) they possess a logical mind, which is suppressed by poverty, clouded over by superstitions and blind adherence to traditions consequently they are unable to function and identify their own interests, because they have got used to accepting their state of subjugation; (d) this logical mind will function more fully when education contributes to its liberation through discussion, dialogue and encouraging action.
To suit the requirements given above, the curriculum of adult education has to be designed with ingenuity. No one can prepare a curriculum of adult education which will serve the purpose of all categories and groups of learners for all time to come; it must be related to the identifiable needs of different groups of learners. For homogeneous groups living in diverse environmental situations, however curricula should be appropriately diversified. With the appearance of new problems and concerns, curricula have to be redesigned or adapted. When developmental objectives change, the learning contents should also change.

1.13 Curriculum Planning Arenas:

Naturally, any work on content/curriculum design presumes the identification of educational objectives. Unlike most of the previous out-of-school adult education programmes based on general, abstract, narrowly fixed, uniformly devised objectives the new programme of adult education is based on:

(1) broad objectives linked with concrete national developmental goals;

(2) particular objectives, derived from the broad ones, to bring them closer to different
environments and various categories of learners;

(3) change in learners' behaviour expected in the process of learning and its outcome.

The broad and general objectives of the programme of Adult Education for the Youth in the 15-35 have been indicated in the Scheme of Non-formal Education.

The concrete and particular objectives have to be specifically worked out at and local levels, where ecological entities require differentiated learning contents. In other words, using broad general objectives as guiding principles, the local organisers, non-formal programmers and learners themselves should feel free to accept, modify, amend and change the suggested objectives and curriculum framework, to make them more relevant to the learners' professional needs and environmental requirements. Evidently this can be done only on a scrutiny of and knowledge about the local situation.

Instead of mere information and transmission of formal knowledge, the learners may expect a much wider content.

From the learners' perspective, they may - instead of mere information and transmission of formal knowledge - expect from non-formal education a much wider impact. For
these purposes, a clear conception of the learners perceptions, aspirations and basic needs becomes an essential precondition for any curriculum design.

Discussing the modalities and criteria for curricula designing, somebody said rightly: "Though it is all right to include such words as "enable", "understand", "appreciate" and "prepare" in a statement of learning objectives, the statement is not explicit enough to be useful until it indicates how you intend to sample the "understanding", "preparing", "enabling" and "appreciating". Until you identify and describe what the learner will be DOING when demonstrating that he "understands" and "appreciates". You have described very little at all. In other words, what is the most important is not the accumulation of abstract (or even concrete) knowledge and understanding, but the real behaviour and readiness for overt action. Such criteria are even more distinct in non-formal learning by younger and elder people, than in formal schooling of children and adolescents.

There are, in fact three levels where learning objectives have to be identified:

First, the national perspective. There are various political, social, economic, cultural and other
global goals and objectives, which influence people's attitudes and aspirations as much as they promote needs for them to get prepared to contribute to or take advantage of these objectives. As in many countries, our national plans and long-term goals are formulated by governmental bodies on assessment of the country's needs and broad objectives are reflected in our educational programmes.

Second, the local perspective. Community conditions and environmental circumstances do interact with national objectives. In other words, common goals are reflected in various environments in a different way. The objectives like national integration, removal of caste prejudices, or increase of industrial productivity although common and national objectives have some particular local colour and learning has to be related not to goals as such but to their specific circumstantial expressions. In a complex and heterogenous society, various groups have different interests and problems diversified learning contents may help the learners more adequately to solve them. In view of the emphasis on help to those who are poor, deprived and under-privileged, adult education may play a particular role. But to do this, learning contents, while mirroring national
objectives, should also have to be appropriately diversified to fit specific learners' concerns.

Third, the learners' perspective. Very often educational programmes are carried on without taking into account the psychological, sociological, cognitive, cultural, professional and other differences between learners. They are made for the abstract, "average" learner, instead of for the concrete and typical. Learners belonging to various social groups with diverse backgrounds and needs, and placed on different levels of the social hierarchy have not only their own learning requirements, but also react differently to the same learning contents.

This is why the formulation of educational/learning contents/curricula must begin with the identification of broader national objectives, the environmental requirements and the investigation of the learners' profile.

A systematic investigation should be the basis of collecting information and knowledge useful in deciding about the objectives at the local level. Unless we exactly know the pressing problems or concerns of the learners, the constraints or obstacles in the way of solving the problems and the possible educational remedial
measures, we will not be able to formulate realistic objectives.

To do that, it is necessary (i) to identify the sources for deriving objectives; (ii) to develop procedures for collecting and analysing information; and (iii) to translate such information into an appropriate curriculum. The three main sources are suggested for obtaining information for the formulation of objectives. These are: (a) National Development Policies, (b) Study of the Environment, and (c) Survey of Learners.

The initial survey is an indispensable part of the preparatory work for a programme of adult education. It is necessary not only for the formulation of objectives, but also for identifying the educational inputs needed to help learners to solve their own problems and the local resources which could be mobilised for the purpose. It becomes particularly valid for the establishment of the link between development objectives and learning contents, if such a linkage is to take a concrete and practical shape.

1.14 Characteristics of Curriculum:

Founded on conceptual and operational assumptions, as mentioned earlier, the curriculum content for adult education has to be:
Relevant to the learners' interests and needs, to the ecological setting in which they live and work, as well as to broader environmental requirements; it must take cognizance of the nature of the learners' mental growth and the nature of their perceptions; close to the aspirations of the deprived populations, of those who are poor, marginalised, under-privileged, often oppressed and lacking opportunities for satisfying their life requirements. Since schooling facilities do not reach people living in poverty and do not help in eradicating the social and financial disparities, the non-formal learning facilities are expected to decrease the disparities. In that sense, the programme is the primary measure to bring about a society with less disparities and more social justice; flexible with respect to the needs of the learners, duration of learning process, timing, location, resources, resource persons, learning facilities, to make the programme suitable and profitable to different groups of learners, a wide range of practices and solutions will have to be made available.

The formulation of objectives and the collection of data will provide an idea of the issues or concerns of the learners in various places. This will permit
identification of content areas and various components of a utilitarian and comprehensive curriculum.

The next step would be to inter-relate the content areas and decide upon a tentative sequence keeping in view the inter-disciplinary relationship of concepts, problems and the learning package.

Following all these conceptual assumptions and operational predicaments, the suggested curriculum has the following six characteristics:

(1) It is based on the ecological approach. In other words, the fundamental criteria for its formulation are lying in the characteristics of the local environment and the people living there. As a matter of fact, the curriculum attempts to give answers to environmental requirements and learning needs, as much as to help people to get ready and able to improve their own lot and the surrounding life situations.

The environment is here taken in its wide connotations: with physical, geographical, natural, social, technical, cultural, ecological and human components.

The emphasis on the local bias does not mean at all that national objectives and global parameters could be neglected. Each local environment is part of a larger
community; in every locality the overall trends are reflected, and this inter-relationship between the general and the particular has to be carefully taken into account.

In more practical terms, we should be less interested in land reforms as such, than in concrete ways to implement it in a given area and to help landless farmers improve their standard of living; we should devote less attention to learning about communicable diseases in abstract, rather than to diseases affecting children and women in a particular village and to existing superstitions preventing efficient curative measures; we may be less keen to discuss constitutional rights as a general subject, rather than to analyse deeply how particular rights are going to influence the farmers' life in that area and how some of these rights are concretely violated or neglected; we should avoid scholastic lecturing about poverty or hunger, but rather put all the emphasis on understanding the causes of poverty and hunger in the immediate surrounding, as well as on knowledge and skills necessary to abolish or decrease them.

Thus, the ecological approach does not mean isolation from general concerns or parcelisation of a
wider national body, but more relevance in learning contents and a closer relationship between the individual and his immediate and larger community.

(2) Diversification is its second characteristic. Unlike in the past when uniform curricula had to be used, today there is a need to diversify them as far as possible. If a learning programme has to equip people to understand and deal with particular working and living situations, uniform patterns of learning contents and "packages" will be neither efficient for nor attractive to learners belonging to various categories.

Depending on local circumstances, naturally, those in charge of curriculum preparation should see if various programmes, or at least large portions of them, need not be adapted to particular interests and needs of particular groups, such as, younger groups, landless labourers, marginal farmers, expectant mothers, groups freed from bonded labour, slum dwellers, tribal groups, etc.

This should not be interpreted as if existential problems as well as problems relating to work, social environment, general orientation, personal and social development, have no common elements for various groups
of learners. The objectives, content, methodology, and evaluation procedures of programmes for different groups of learners, therefore, may be similar in certain respects and different in certain others. For every group the 'mix' of learning activities, including both the common or constant elements and the specific or related elements, will have to be worked out. Carrying the diversification of contents/curricula too far and splitting the groups of learners to the extreme would adversely affect the learners' performance and the efficiency of programme organisers.

(3) It leads the learners from awareness to action, from consciousness about the reality to some active and constructive steps to change that reality. However, this process includes several components: from awareness through understanding and knowledge, skill acquisition and attitudinal change to readiness for social and individual action and action itself.

The curriculum is thus presented unit-wise, rather than according to the usual pattern of subject-matters. Each learning unit is a composite entity of various components, linked together and placed around a concrete, practical concern of the learners. Some similar attempts
have already been made in the past, linking agro-techni-
cal knowledge with professional skills, literacy and
numeracy. A step further is attempted here: to include
social and economic aspects into learning subjects
dealing with technical skills or literacy skills; to see
food production related to psychological barriers and
superstitions; to bring closer the removal of poverty
and social obstacles; to discuss nutritional issues in
relation to cultural habits and prejudices; to overcome
the usual hiatus between technical problems and the
existing socio-political and socio-cultural reality, or
between quantitative and qualitative aspects; and so on.
This is the result of the observation that the "func-
tionality" of literacy programmes has in the past been con-
ceived in a rather narrow way, serving the major objec-
tives from their social, cultural, political and human
aspects. The suggested curriculum is an attempt in the
direction of widening the concept of functionality in
adult education.

(4) It is based on the Problem-solving approach. The
focus is thus (i) on the "problem" which has to be
solved, and (ii) on knowledge and skills necessary to
be acquired by people who have to solve it. The "problem"
in the sense used here is not a negative phenomena or a
defect, but may be an objective to be reached, an
obstacle to be removed, a constraint to be eliminated,
on a decision to be implemented. The same applies if
the objectives of the programme are seen as "concerns"
of the learners.

In any case, such a learning programme must put
emphasis on preparing people to be able to search solu-
tions in various life and work situations, rather than
to get prepared to solve one problem for once at a unique
occasion. True education means more than that; real
learning leads further than that. This is why cognitive
aspects (understanding and knowledge, apprehension and
perception), along with practical skills, have got a
prominent place in this curriculum.

(5) The Inter-disciplinarity is its next characte-
ristic. It is not only a multi-disciplinary programme,
in the sense that it includes various disciplines (learn-
ing about nature and society, acquiring literacy, train-
ing in technical skills, etc.) but it should be an inter-
disciplinary programme, in the sense that mutual relation-
ship and reciprocal concern are established among various
disciplines.
The curriculum itself and the Curriculum Guide more particularly give some indications about the expected interdisciplinarity in its implementation. But the lack of actual experiences in that respect would be an obstacle for the time being and may remain so for quite sometime to come.

(6) Acquisition of Literacy: As a matter of fact, literacy is neither the dominant subject, nor a neglected component. This corresponds (i) to the fact that this programme aims to serve the needs of the deprived sections of the population, which are largely illiterate; and (ii) to the fact that mere literacy is basically insufficient in today's world and for people's actual participation in development.

Concerns about illiterate adult populations and their needs have been occasionally polarised in the past: on one hand, the generous and zealous attempts to impart literacy solely as a remedy and a substitute for the real, liberating education; on the other, the elitist attempts to console illiterates regarding their status and discourage them from acquiring an "alienating" and sometimes useless tool. The future of the world and of our society has to be built on quite a different plane.
1.15 Partners in Developing Curriculum:

Curriculum construction is not an easy task. No individual can prepare a perfect curriculum. A combined, concerted and co-ordinated effort of several experts is essential.

According to Vernon and Anderson (1956) the curriculum makers (partners) are

i. The teacher and a group of children
ii. The school as a social system
iii. Community and culture and
iv. Social agencies

According to Gail M. L. Nlow (1973) it is apparent that participants in curriculum development are of diverse interests and types. Collectively, they consist of learned scholars, government officials, school administrators, curriculum specialists, classroom teachers, students and selected lay personnel.

i. The Teacher and a Group of Children:

The teacher is the most important of the "Curriculum makers". He is the one who determines what the experiences of pupils will be. He determines what he shall do with the course of study, to some extent what content
is selected, to a greater extent how it is utilized, whether or not pupils shall play a part in determining their experiences, what approaches or activities will be developed in the class-room or in the extra class activity.

ii. The School as a Social System:

The school is in itself a community with a specific population working together, a series of life activities, a social structure, a pattern of values, and a system of rights and duties. This social system itself has a good deal of influence as a curriculum maker because of its influence on the teacher. The attitudes of the staff are affected by group participation and the ideas and ideals held by the group. The extent to which teachers and administrators co-operate in policy-making for the curriculum probably has a greater influence than has been realised.

iii. Community and Culture:

The ideals held by the society in which the teachers and pupil live are, of course, basic determinants of what the objectives of the curriculum will be. The policies and regulations of the board of education reflect the community attitudes. Parent teacher associations,
parent study groups, advisory councils, service clubs, and pressure groups of all types have their influence on the teacher and the curriculum. They are the organized groups that speak for attitudes of some community members, and they are a part of the community's power structure.

iv. Social Agencies: These agencies include:

The state legislature: Legislation on subjects to be taught presuppose that legislation have a peculiar capacity for knowing more about needs of the school communities and their children than the communities themselves under the leadership of their appointed teachers and administration.

v. State departments of education: These have to a large extent moved away from prescribing the content through state courses of study, state examinations, and courses required for graduation from high school.

vi. Schools or departments of education: These have had considerable influence on the curriculum through the education of the teacher, research in the curriculum, and now through programmes of in-service and graduate education for large numbers of teachers should delegate to the professional domain all other curriculum rights.
of decision. In this connection, any given school board should confine its recommendations on curriculum to the dimensions of urgent local needs and demands.

1.16 Steps in Designing Curriculum:

According to Saylor Alexander (1974) there are several steps in curriculum designing. The curriculum planning process involves four principal phases.

i. Setting major goals (and domains) through basic data analysis.

ii. Designing curriculum domains each related to one major set of goals.

iii. Anticipating curriculum implementation (instruction)

iv. Planning curriculum evaluation.

Step I considering basic factors relating to the domain

II identifying subgoals of the domain

III identifying possible types of learning opportunities

IV setting an appropriate curriculum design

V Preparing tentative design specifications, and

VI identifying implementation requirements
Step I - Considering Basic factors relating to the Domain:

Much as the curriculum planners may have consulted data about the social aims and needs, learners and the learning processes, and knowledge requirements, they will need to focus on specific data relevant to a domain and population when these are known.

Step II - Identifying subgoals of the Domain:

It involves moving from the broad goal of a domain to subgoals that are hypothesized as achievable for a particular population and within the potentials of the domain. Subgoals need not be narrowly stated; they may be open ended statements of desired outcomes broadly defined. For example within the learning skills domain, subgoals would be set relating to skills of reading, listening, organising, information and others. The more specific the data the faculty has consulted regarding the current status of student leaving skills, the more specific subgoals become.

Step III - Identifying Possible types of Learning Opportunities:

The third step in curriculum designing is a blend of visionary brainstorming and realistic appraisal of actual possibilities. In any domain this step involves
identification of a few organising centres or learning opportunities, a trial classification of these, usually according to the way in which they are provided, an extension of types that seem to persist in discussion and planning, and the ultimate development of agreed upon, possible opportunities classified tentatively as a basis for relating them to design principles.

Step IV - Setting on Appropriate Curriculum Design:

As their area of specialization, many students might choose the expressive arts, some might choose mathematics and some social studies and so on. Here, there is no specific design principle more applicable than the one we later describe as individual needs and interests. Thus, the specialization domain, embracing many types of specialized interests and related learning opportunities, also requires several curriculum designs.

Step V - Preparing Tentative Design Specifications:

Step V is a refinement of step four. At the latter point, the designing group makes a trial listing of types of learning opportunities study units, skills sequences, activity groupings, subjects, or courses, mini courses, community experiences, independent studies,
and so forth – as a basis for selecting design principles. Once the designs have been selected, learning opportunities are more deliberately planned. Thus, a plan for the domain of human relations might include at least two major designs, disciplines/subjects and social activities and problems. The tentative answers to these questions for each such opportunity are the basic ones in all design specification:

1. For what learners?
2. For which subgoals or objectives of the domain?
3. What types of learning experiences?
4. Roles of Participants: Learners, teachers, others?
5. What time and space dimensions?
6. Criteria for assessment?

Step VI - Identifying implementation Requirements:

With tentative decisions made regarding the questions just listed, the designers can identify requirements for implementation. Implementation requirements for some designs can be more demanding. For example, a design in the personal development domain might include systematic instruction in sex education, drug abuse, or other sensitive areas. For this, implementation may well require advance communication with
parents, approval of appropriate community groups and agencies, and the enlistment of special professional assistance in instruction.

1.17 Methods of Designing Curriculum Contents:

According to Saylor and Alexander (1954) there are five methods of designing curriculum contents and they are:

i. Designs focused on specific competencies

ii. Designs focused on disciplines/subjects

iii. Designs focused on process skills

iv. Designs focused on individual needs and interests

v. Designs focused on social activities and problems

i. Designs Focused on Specific Competencies:

All curriculum plans anticipate some type of eventual performance on the part of the learner. The design assumes a direct relation among objective, learning activity, and performance. In competency-based design, the desired performances are stipulated as behaviour or performance objectives or competencies, learning activities are planned to achieve each objective, and the learner's performance is checked as a basis for his moving from one objective to another. A design based on
specific competencies is characterized by specific, sequential, and demonstrable learning of the tasks, activities, or skills which constitute the acts to be learned and performed by students.

Bobbit (1918) and Charters (1923) who were early curriculum theorists substantially influenced processes of curriculum development by their emphasis on specific objectives and on analytical procedures, for defining them. They placed objectives before subject matter and called for a curriculum plan which would be built around specific life activities of adults. Their theories did not include a detailed plan for relating instruction to each activity or objective, although they clearly anticipated a close relation. This curriculum design contributes efficiently to the development of job competency. Motivation on the basis of job aspirations is high in this phase of curriculum, and it contributes to the development of talents and capabilities not fully provided for in other curriculum designs.

**Application and Limitation:**

A competency-based approach to curriculum development has been used at sometime in some way in virtually every curriculum area. Many specialized interests
require a type of competency or job analysis with specific designs of learning opportunities fashioned toward designed performance. But we do not see specific competencies as the basis of curriculum designs for most learning opportunities in the curriculum domains of personal development and human relations.

ii) Designs Focused on Disciplines/Subjects:

The dominant curriculum design is that of a curriculum framework of subjects, usually but not necessarily derived from the major disciplines of knowledge, with the framework reflecting design decisions as to specific subjects and their scope and sequence. The most characteristic and comprehensive features of the subject design is the relative orderliness of this pattern. The curriculum plan appears neatly divided into subjects, which themselves frequently are sub-divided into divisions corresponding to school grades and even marking and reporting periods.

With the subject design, there is a confusion as to what is a subject and what internal logic there is in the design. First, in the selection of a particular phase or a discipline, for school study such distortion can occur as to make invalid the usual structure of the discipline.
Second, the widespread practice, especially in the elementary school curriculum, of encompassing materials from more than one basic discipline. Third, in many cases the established disciplines do not offer students opportunities to learn to deal with problems of living, and new organisations of content that are basically extradisciplinary or perhaps interdisciplinary have been created and classified as subjects. The discipline/Subjects designers generally assume that there is a body of knowledge that constitutes the curriculum and that the task of designing involves decisions as to what phases and organizations of knowledge are to be taught to whom, and when and how.

Applications and Limitations:

The utilization of the disciplines/subjects design is well known and to summarize, there are two generalizations:

- Knowledge from the disciplines as reflected in the organization of school subjects has been and remains the dominant design of curriculum planning.

- Many curriculum elements called subjects have been created to meet curriculum needs that are not matched by disciplining content and have tended to confuse curriculum design with the programme of studies.
The limitations of the subject design will build upon these three points:

- Other limitations of the subjects due to the schools' tendency to fix them inflexibly and separately have occasioned many criticisms and limitations.

- The chief limitation of the subjects design, however well planned and implemented, is the lack of direct relation of the organized subject matter to the problems and interests of the learner.

- First, the tendency in curriculum development, to create "subjects' that have no real basis in organized disciplines reveals the inadequacy of the subject design used alone.

iii) Designs Focused on Process Skills:

The process focus is most frequently advocated in terms of learning processes, although some design theorists would use the process approach of inquiry and problems solving instead of fixed content for the entire curriculum plan or some major aspect of the plan. It is difficult to separate instructional process and curriculum centres for the curriculum plan.
Each of the curriculum design that focuses on process skills is based on one or more of the following arguments:

- Since the most significant goal of schooling is the development of lifelong learning skills and interests, curriculum plans should make these skills and interests central.

- The curriculum should be planned and organised so as to have maximum carry over into life processes and skills; greater carry over is likely what the curriculum design directly reflects these processes and skills.

- The process of valuing and other processes having a high affective element can be taught as well as essentially cognitive skills; the former should be as well represented in the curriculum as the latter

Applications and Limitations:

The theory of process skills is being applied in a variety of curriculum plans, usually not as a total design but embracing significant portions of the programme
The focus on process is also somewhat characteris-
tic of curriculum, instructional, and organizational
efforts to implement the continuum notion of education,
or continuous progress education.

iv) Designs Focussed on Individual Needs and Interests:

A curriculum design focussed on individual needs
and interests has these characteristic features:

- The curriculum plan is based on a knowledge of
  learner's needs and interests in general and
  involves diagnosis of the specific needs and
  interests of the population served by the plan.

- The curriculum plan is highly flexible, with
  built in provisions for development and modifi-
  cation to conform to the needs and interests of
  particular learners and with many option availa-
  ble to the learners. In fact, the learner may
  develop his own curriculum plan in some designs,
  but with guidance in selecting options and in
  planning.

- The learner is consulted and instructed individually
  at appropriate points in the curriculum and
  instructional process.
The predominant use of the needs and interests design in curriculum planning is in the provision of options for individual students.

- The learning opportunities based on needs and interests are more relevant to the learners.
- The needs and interests design involves a high degree of motivation and therefore success of the learners.
- Achievement of the individuals potential is facilitated by this design.

Applications and Limitations:

It is the needs and interests principle rather than a particular design which has most influence and applicability. Within each of the other designs including subjects/disciplines points arrive in planning curriculum and instruction at which decisions must be made regarding each student's programme and progress. To the extent, that consideration is given to the individual student's needs and interests in these decisions, the principle is utilized.

v) Designs Focussed on Social Activities and Problems

The socially focussed designs exhibit more diversity. Three design theories within this category are:
- The social functions or areas of social living
- The curriculum should be organized around aspects or problems of community life.
- The social action or reconstruction theories that hold the improvement of society.

Thus a curriculum design based on social activities or functions exhibits an organizational pattern derived from studies of group life.

There are two primary arguments for socially centered curriculum designs:

- They can directly contribute to the needs of the society for continuing improvement; and
- They are relevant to student needs and concerns and are therefore of great significance and interest to students.

Applications and Limitations:

The social-centered design has had wide application, although we know of no schools in which it is the sole focus of the curriculum. Instead, social centered designs affect the selection of subject matter in subject organized programmes or the choice of activities in less structured programmes. This design theory is highly
applicable to some curriculum domains, especially to the one we designate as human relations. The social centered design is also followed within the social studies as a basis for organizing units of work at all levels. In deed, entire courses in secondary and higher education are built around major social functions, particularly in the areas of economics, political science and sociology.

The limitations of the social-centered design are indicated by its use generally for only a portion of curriculum.

1.18 The Place of Health in Adult Education

The illiteracy in our country is of such a staggering magnitude that it would act as a counter-force on all the efforts that are being made by the governmental bodies and voluntary agencies to develop the nation. There is a need to remove social and economical inequalities between different sections of people. Adult education plays a vital role in arousing self-confidence and self-reliance in the masses. Indian society is predominantly a rural society and it is very difficult and time taking process to make the rural people aware of the problems they face in their daily
life. The primary aim of adult education is to help each man, woman and youth to make the best of his or her life.

One of the objectives of adult education programmes is to impart literacy skills. Another equally important objective is functional development and the third one is creation of aware. Hence the curriculum of adult education should include all three elements of i) Literacy which includes reading, writing and arithmetic skills.

ii) Development of functional skills connected to their trade, job or occupation which includes skills of communication for improving quality of life.

iii) Social, political and economic awareness which includes awareness of health measures and better way of life.

General awareness of various developmental activities which include health measures undertaken by government and other voluntary agencies is necessary to take advantage of the developmental programmes particularly launched for the welfare of the weaker sections of the society. Adult education programme gives a good weightage to health and family welfare as shown in the syllabus
provided for health in the training manual prepared for Adult Education Workers by the Adult Education Directorate, Ministry of Education and Social Welfare in 1978.

The knowledge and skills areas required for teaching and communication have been worked out on the following assumptions:

i) That one-fourth of the Adult education activity will relate to health and family welfare.

ii) That every villager in the age group 15-35 both male and female should be well versed in health aspects.

iii) Family welfare including health, nutrition, mother and child care should become part and parcel of adult education.

iv) The village community through its enlightened health consciousness should take care of village and environmental sanitation.

In the area of health and family welfare, the literate community is to be made aware of relationship between health and socio-economic development and their rights and responsibilities for healthful and productive living.
To enable the Adult education instructor to create the social awareness as spelt out above in relation to health and to enable the adult learners to discharge their responsibilities towards health care and promotion of health at individual and community levels, they have to be equipped with the knowledge and skills. Specific contents spelt out are as follows:

i) Environmental sanitation
ii) Personal hygiene
   iii) Common health problems in the area
iv) Health services in block, PHC services, etc.
v) Health laws relevant to public health
vi) Mother and Child Health Services
vii) School Health Programme
viii) Control of Communicable diseases
ix) Family welfare and Sex education
x) General suggestions for the uplift of health and sanitation

The detailed syllabus under family welfare is as follows:

i) Population education (population problem/growth as related to improving the quality of life)

ii) Sex education
iii) Contraception and contraceptive methods
iv) Medical termination of pregnancy (MTP) Act and service facilities (MTP Act)
v) Responsibilities of contraceptive depot holder
vi) Age of marriage
vii) Help for sterility
viii) Welfare of family members
ix) Family guidance for a better social and community relations.

Health education component is delivered through class-room instruction, demonstration, and field work. Printed materials are supplied and a number of audio-visual aids like charts, folders, films, slides etc. will be used for better exposure of aspects and understanding of the concepts. Audio-visual aids at village fairs may also have an informal effect on health and sex education. Also when there is an attack of chicken-pox, malaria etc. in the village, the teacher or instructor can touch on those aspects. He or she can take up an individual problem, generate discussion, ask the participants how best the problem can be solved and what action plans can be drawn to solve the problems. Thus an adult education instructor along with community
health worker should be alert to the situations and also help the villagers to take up family welfare measures including family planning drive, for all eligible couples. He can also instruct in regard to sex education and sex hygiene without touching the emotional aspects involved in it. It requires little more maturity and give guidance by asking the participants to see the doctor in Primary Health Centre. Even in evaluation of adult education programme, health education awareness should be touched.

There are many areas where adults need knowledge, skills and understandings. Health is one of the essential areas. Healthy citizens are the wealth of the nation. Small family norm is one of the national goals. People have to take care of their own health and promote community health. For this, good health education is necessary. The health education content should meet the felt needs of the people. Identification of suitable content is needed. Health is one of the core areas of curriculum for adult education programmes. Adult education functionaries need to be trained adequately. Problem-oriented and environment-based teaching-learning-training materials in health education need to be developed.

The research work done on health knowledge and needs of adults is presented in the next chapter.