IMPROVING PUPILS QUALITY THROUGH COMMUNITY ADVOCACY: THE ROLE OF SCHOOL – BASED MANAGEMENT COMMITTEE (SBMC)

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Abstract

Hitherto, quality in education has always been measured on quality of content in curriculum and how well such fits present and future needs of learners. The new concept of dimensions in quality relates to "quality learners" among other dimensions. Quality learners according to UNESCO are learners who are healthy and supported in learning by their families and communities. This paper looks at the health of the school child as a major management concern and therefore advocates for a role to be played by the School Base Management Committee (SBMC), in sensitizing the community on the role of parents and community members in ensuring quality learners. Two major health issues are identified in this paper, these are HIV/AIDS and Malaria which incidentally have been identified by World Health Organisation (WHO) as killer diseases particularly in the Sub-Saharan Africa. The paper concluded by drawing up an advocacy strategy to be used by SBMC in partnership with the school authority to at least minimize the challenges posed by these major health issues.

Key Words: School Base Management Committee, , improving pupils quality.

Introduction

Quality has always been measured by financial and other inputs. With time, the term quality relates to educational output. As education faces new challenges, new concept of quality develops. Although the universal concept of quality relates to what is being taught and how well it fits present and future needs of the learners but in line with UNESCO concept, another way of looking at quality is in relation to its input and one of such inputs is the learners. Specifically, UNESCO views quality in six dimensions that is: learners, environment, content, processes, outcomes and responsiveness, (UNESCO, 2000).

School systems work with the children who come into them. Many elements go into making a quality learner, these include health, early childhood experiences and home support. Adequate nutrition is also critical for normal brain development. Prevention of infectious diseases and injury prior to school enrolment are critical to the early development of a quality learner (UNICEF, 2000).

Poor health is one of the factors that contribute to absenteeism and irregular attendance in schools. When children reach school age, research demonstrates that to achieve academically, a child's exposure to curriculum, his or her opportunity to learn; significantly influences achievement, and exposure to curriculum comes from being in school (Fuller et al, 1999).

The need to inspire quality consciousness in school operators and managers for the attainment of total quality assurance in schools, and a turn around in educational effectiveness gave birth to the concept of community participation in school management. Policy makers believe that to improve education quality, it is

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vital to advance from classroom teaching level to school organization level and reform the structural system and management style of school (Abu-Duhou, 1999). This is the basis for school-based management committee.

In Nigeria, the School-Based Management Committee was set up to increase citizen participation in school management, this is part of the efforts of school reform in Nigeria. According to Dakar Framework of Action (2000), the experience of the past decade has underscored the need for better governance of education systems in terms of efficiency, accountability, transparency and flexibility, so that they can respond more effectively to the diverse and continuously changing needs of learners. Reform of educational management is urgently needed to move from highly centralized, standardized and command-driven forms of management to more decentralized and participatory decision-making, implementation and monitoring at lower levels of accountability.

Although observation has shown albeit erroneously, that some school managers particularly head teachers see the role of SBMC as a relegation of schools autonomy, whereas SBMC is to promote the autonomy of schools. SBMC has been defined in different ways by different writers and authors, for example Cheng (1996) sees school based management (SBM) as tasks that are set according to the characteristics and needs of the school itself and therefore school members have a much greater autonomy and responsibility for the use of resources to solve problems and carry out effective education activities, for the long-term development of the school. Caldwell & Spinks (1988) see school based management as a school system of education to which there has been decentralized a significant amount of authority and responsibility to make decisions related to the allocation of resources within centrally determined framework of goals, policies, standards and accountabilities.

The definitions show that in schools which practice SBMC policy, transfer of authority takes place, giving schools some degree of decision making.

The goals of School Based Management Committee programmes vary according to each country but they typically include:

(i) increasing the participation of parents and communities in schools,

(ii) empowering principals and teachers

(iii) building local level capacity, and perhaps the most importantly,

(iv) improving quality and efficiency of schooling, thus raising student achievement levels.

The objectives are:

(i) engender community's interest in school in their localities with a view to their assuming ownership of their schools

(ii) provide mechanisms for more effective management at school level.

(iii) provide a platform on which the community and schools pool resource together to enrich schools management.

(iv) provide communities and Local Government Education Authority (LGEAs) with a new mechanism to demand accountability from school managers (i.e. Head-teachers).

(v) help the school in the formation of its mission statement and articulation of its vision.

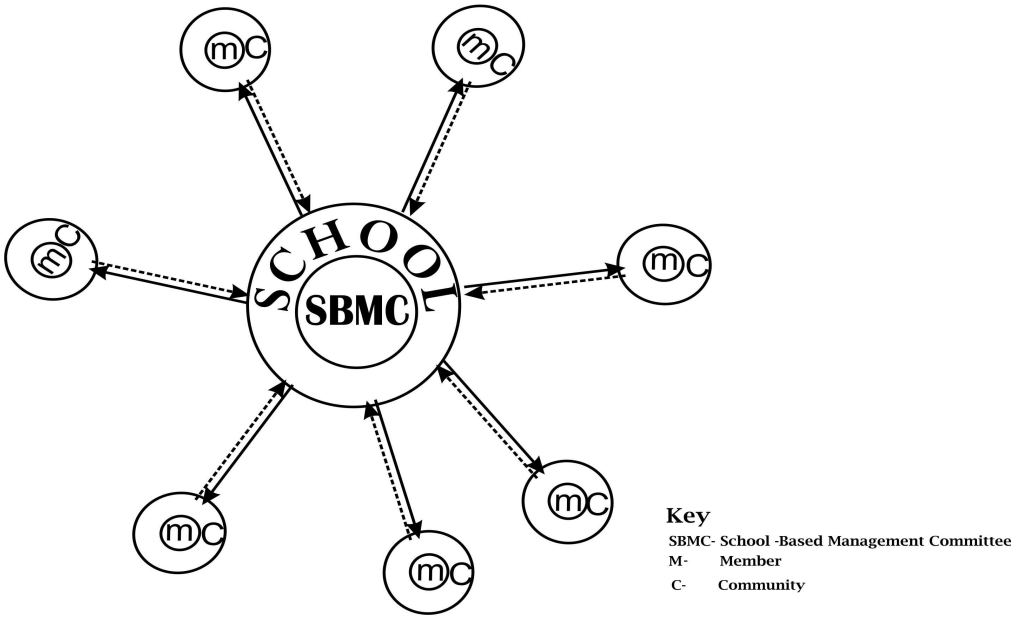
(vi) provide legal framework involving stakeholder in planning, monitoring and evaluation of education at the school level.

(vii) provide and update a school development plan on an annual and longer term basis. (Akinsolu & Onibon, 2008).

The school belongs to the community, which forms the grassroots stakeholders in management. Decentralization will make it possible for the community to participate in the decision making of the school. Murphy & Beck (1995) noted that a central feature of SBM is the SBM committee. While the committees

vary in composition and responsibilities, most writers agree that it is within the committee that school stakeholders such as headteachers, parents, community members and students do participate in decision making. SBMC features is depicted in Figure I below:

Figure 1- School -Based Management Committee Model



The figure indicates that SBMC is management organ of the school. The school itself is part of the community since both pupils and teachers are either products of the community or live in the community as shown by the arrows.

The members of the SBMC are in the same tone members of the community. All of them interact on daily basis therefore indicating that both the community and the school cannot live in isolation. From this one can also deduct that they impacted on each other. It therefore becomes easy for the SBMC to be like the "man in the middle" between the school and the community.

A school-based management committee in Nigeria is a form of community involvement in school governance, based on regulation with elected but voluntary membership. Certainly the intention behind school committee is to implement democratic participatory decision making.

It is argued that people know better and are able to be more responsive to their own needs. Locating authority locally seems more efficient, compared with decisions from central government which often miss their targets and take a longer time to implement. People who work in local schools or live locally, the argument goes, will efficiently gather information relevant for their own purposes, ranging from pedagogical to school infrastructural issues. This kind of information is more reliable and will lead to effective decision-making by school stakeholders in terms of public service delivery.

Undoubtedly, the SBMC is relevant at this time of Nigerian educational development. The function goes beyond resource management and its utilization as some observers view it. This is a narrow concept of

SBMC. The communities are to ensure quality both in educational inputs and outcomes and also quality in learning environment for schools. This can only be effective if we have learners who are of good quality.

In some parts of the world where the school based management is effectively used, it is used to promote self budgeting reforms, school based curriculum development, school based staff development and school based student's counselling but not much is heard of health improvement. The SBMC can be used to guarantee quality of learners particularly quality of the health of learners if they are used as instruments or agents of community advocacy. Education is likely to be more successful if educators view community participation in education not as a necessary evil but as potentially powerful partners in the community of learners. The thrust of this paper therefore, is that reforms for quality and quantity in the health of pupils in particular need to be an important part of the functions of the SBMC. The major health problems facing Nigerians school could be zeroed in into two: HIV/AIDS and Malaria

The emergence of HIV/AIDS is one of the most devastating occurrences in human history. HIV/AIDS is affecting all regions in the world but in different degrees with sub-Saharan Africa being the worst hit. HIV/AIDS is said to be the leading cause of death in sub-Saharan African while worldwide it is the fourth biggest killer (IIEP, 2003). The impact of HIV/AIDS is particularly severe on school and education. Two-thirds of all adults and children with HIV globally live in Sub-Saharan African. Almost three quarters (72%) of all adult and children deaths due to AIDS in 2006 occurred in Sub-Saharan Africa (FME, 2005). A lot of focus on HIV/AIDS has been on the population above 15 years while ignoring the younger generations which unfortunately are very vulnerable to infection either through their parents or sex abuse by adults. The UNGASS Declaration of Commitments in HIV/AIDS (2001) agreed that their targets among others include reducing HIV infection among 15-24 year-olds by 25 per cent in the most affected countries by 2005 and globally, by 2010. It is obvious from this declaration that the primary school age or paedriatic age bracket is often ignored (IIEP, 2003). The high prevalence of HIV/AIDs in Nigeria led the Federal Government into formulating an HIV/AIDS policy for the education sector.

To achieve this objectives, the SBMC can play a role through the community, teachers and pupils sensitization on the possible prevalence in primary school towards finding a solution.

Malaria is another disease that can impact negatively in Education for All (EFA) goals and the Millennium Development Goals (MDGs) for education. Education and other stakeholders have a key role to play in preventing and in mitigating its effects in school. Like HIV/AIDS, malaria has contributed immensely to pupils' absenteeism and even death among primary school children. This situation severely threatens the achievement of EFA goals.

Adeleke (2007:39) explains that:

> Malaria presents enormous health problems in Africa and about 300-400 million acute attacks per year are estimated to occur world wide with about 80% of the cases and deaths in the world occurring in Tropical Africa (WHO, 1998). It is estimated that about 250 million people in Africa are carriers of malaria parasites (UNICEF, 2006; Benzengog and Elom, 1999). This may be due to the fact that the malaria vectorial system in Africa South of Sahara is probably the most powerful available anywhere to human population (Benzengog and Elom, 1999) Malaria is a major public health problem in the tropics and accounted for between 5% and 15% of deaths of children in endemic areas (WHO, 2006).

The Table 1 below shows the number of admitted malaria cases and deaths reported from 1998 to 2000.

Table 1: Malaria cases and deaths reported in thousand between 1998 and 2000.

	Age Group	1998	1999	2000
Malaria Cases	< 5 years	220	2038	1177
	> 5 years	4033	3659	949
Malaria Deaths	< 5 years	18	14	28
	> 5 years	33	26	28

Source: Federal Ministry of Health

In the Table 1 above, the number of malaria cases reported increased from 220,000 in 1998 to 2,038,000 in 1999 (826.4% increment) but reduced to 1,177,000 in 2000 from 2,038,000 in 1999 (42.2% reduction) among under five years. In the age group of five years and above, the number of malaria cases reported continued to decrease from 4,033,000 in 1998 to 3,659,000 in 1999 to 949,000 in 2000. This is 9.3% reduction from 1998 to 1999 and 74.1% reduction from 1999 to 2000.

Moreso, the number of malaria deaths reported among under 5 years age group reduced from 18,000 in 1998 to 14,000 (22.2% reduction) but increased to 28,000 in 2000 from 14,000 in 1999 (50% increment). In the age group of five years and above, the number of malaria deaths reported decreased from 33,000 in 1998 to 26,000 in 1999 (21.2% reduction) but increased to 28,000 in 2000 from 26,000 in 1999 (7.1% increment).

According to WHO (2008) report on malaria in Nigeria, there is about 35-80 million cases in 2006. This is shown in Table 2.

Table 2: Estimated and reported malaria cases and deaths in Nigeria

	Age Group	Number	Lower	Upper
Malaria Cases	All ages < 5years	57 506 430 34 096 000	35 481 000 5 710 000	80 297 000 65 825 000
Malaria deaths	All ages <5 years	225 424 219 000	116 000 110 000	354 000 337 000

Source: WHO (2008) report on malaria.

Adeleke (2007) also found that the prevalence of malaria is still in the paediatrics age group. Specifically, he reported that the age-specific parasites rate was highest in 1-5 years age group and the highest mean parasite density of 83,120 per microlitre of blood was recorded in 11-14 years age group. The detailed result of Adeleke's (2007) study is presented in Table 3.

Table 3: prevalence and Intensity of Malaria Parasitaemia according to the ages of the children

Age Group	No. Examined	No Positive	% Positive	Mean Parasite density per microlitre
0-5 months	40	14	35	4,450
6-11 months	45	15	33.3	6,218
1-5 years	107	48	44.9	23,180
6-10 years	51	6	11.8	52,160
11-14 years	37	9	24.3	83,120
Total	280	92		

Source: Adeleke (2007:41)

There are lots of focuses on HIV/AIDS but malaria is assumed to be more deadly than HIV/AIDS. The paediatrics age which is the school-going age, 1-5; 6-10; and 11-14 years as seen in the Table 3 are the age brackets for basic education. The malaria scourge is highest between 1-14 years it should therefore be a concern to the SBMC.

For better learning outcomes, health of the pupils is of vital importance therefore for effective teaching and learning, the SBMC is to act as a liaison between the school and the home and the community at large this can be done effectively through community advocacy.

The Need for Inclusion of School Health in SBMC Programme

There are several reasons why a school should push for a school health programme aside from the traditional teaching of grooming and eating the right foods. The most important is the fact that healthy minds are usually found in healthy bodies. Pupils cannot learn without good health- a sound mind is in a sound body. Also one needs to remember that determinants of health status in adulthood are formed very early and can be influenced by those who care about the health of the children. So, while the SBMC advocates for community participation in the management of schools for the achievement of effective learning outcomes, this can be achieved when the pupils in the school live in clean environments, eat healthy foods, develop positive behaviours and be educated on basic rules of hygiene and healthy living.

It has also been pointed out by (WHO 1997, p.13) that better health improves academic performance. The knowledge of health and the practice of positive health behaviour reduces school absenteeism and thus improves teaching and learning.

Furthermore, health problems can become a barrier to learning. Preparing a child to learn needs not only mental preparation but requires attention to his emotional, physical and psychological need. For children to learn effectively, they must be placed in an environment that is comfortable and where they feel well supported by parents, administrators, teachers and peers. Healthy learners are better learners (Almocera, 2002).

There is great evidence that school health programmes reach more people through their families and communities than any other form of health education approaches. The above makes it vitally important for SBMC to extend its activities into health habits in their school environments. The first step in doing this is effective community advocacy.

In developing countries, many schools are located in rural areas where clean water is always not available, but with the assistance of the SBMC of the schools, boreholes could be sunk or lessons on purification methods could be organized in the school community to create the necessary awareness of the dangers of drinking polluted water. An absolute requirement for school health is safe water and sanitation. The Guinea Worm eradication programme in Nigeria is a case in point. The SBMC could be well involved in this to take to the grassroots. Also malaria epidemic exists in many school environments. Lessons on preventive programmes that could eradicate mosquitoes by keeping surroundings clean and could be taken up by the members of SBMC under the supervision of the headteachers or school nurse where available. The SBMC in return is expected to sensitise the wider community. Good knowledge about HIV/AIDS is very necessary for growing children, they grow to learn the disadvantages of unprotected sex and clean environment. Since children may be too young for this in the primary school, their parents are to be sensitized with it and then be able to educate their children as they grow up. Whenever funds are to be raised to execute the programmes, the assistance of the SBMC cannot be overemphasized. By doing this the work of the SBMC will not be limited to school administration, since good health as a result of good healthy living is a foundation on which the progress of the children is laid, to achieve this the parents and community members are expected to play crucial roles.

SBMC and Community Advocacy

Advocacy means any activity intended to raise consciousness among decision makers and general community about an issue or a disadvantaged group, with a view to bringing about changes in policy and improvement in their situation. It is an interactive, proactive and consultative process. In another tone, it could be a process made up of series of activities undertaken over a period of time aimed at challenging or changing a situation or issues. According to Akinsolu & Onibon (2008), the goals of advocacy include:

- challenging existing situation
- establish a cause/issues
- influence relevant authority
- sustain pressure
- promote desired group interest
- bring about change. (Akinsolu & Onibon 2008)

Advocacy is part of an overall programme. In advocacy, the SBMC should develop a community action based programme whereby community members will be sensitized on issue on HIV/AIDS and Malaria, this has become necessary because parents and community members in particular have vital role to play in their children and such roles include;

(1) influencing educational policy makers on policies that will lead to eradication or minimizing HIV/AIDS and Malaria.

(2) sensitising communities on the benefits of hygiene.

(3) mobilising communities against hazards of unhygienic habits such as HIV/AIDS and Malaria.

(4) organising co-coordinating and funding activities to raise awareness on learners health.

(5) dialoging with other stakeholders such as Non-Governmental Organisations (NGOs) local community leaders, Parent Teachers Association (PTAs) and Community-Based Organisations (CBOs) on how to promote school health.

Advocacy is usually effective if it

- is based on facts, not suppositions
- draws upon practical experience and shows legitimacy for the claims it makes
- is carefully and strategically planned – over short and longer term time-frames
- closely involves and honestly represents any group on whose behalf it is undertaken and who are able to speak for themselves whenever possible.

A successful advocacy approach is one that is:

- integrated
- planned
- influential

Strategies for advocacy with community:

Direct Approach:

-community dialogues in which parents, workers, employers take part.

-use of non-formal adult education venues, health services, women's group meetings, community meetings, etc to open up dialogue.

-small dramas and plays at schools and public gatherings where parents and community attend, i.e. local festivals.

- counselling parents and teachers about current issues and problems.

Indirect approaches are;

- involvement of religious leaders and other important community figures, i.e. village chiefs.

- use of radio air time in local languages

- support programmes in schools, i.e. no fees counsellors, etc.

- promote community schemes for income generation to improve family situations and reduce the use to send children out to work.

Strategies for advocacy with employers:

Direct approach:

- arrange meetings with employers that are non-threatening

- initiate a service, such as a learning centre-and invite employers to cooperate.

- (NB): Ensure that you have key information, existing laws concerning work and children rights)

Indirect approach:

- stories and opinions in papers

- abuse cases in court

- obtain endorsement from better treatment of workers and removal of under-age workers, especially in hazardous positions.

- compaign for a code of practices concerning child workers.

(Source: A Handbook on Advocacy: Child Domestic Workers- finding a voice; Black, M, 2002, Anti slavery International)

Examples of advocacy strategies by SBMC and PTA

To increase the enrolment and retention of children in schools, the SBMC/PTA could:

- hold regular meetings, develop plans and outputs with time-frames and designate persons responsible.

- coordinate house-to-house campaigns.

- organize school cultural and sporting activities.

- arrange 'open days' for parents to visit and for special awards to motivate children.

- provide recreational facilities in the school grounds and adults to teach/supervise children.

- discuss needy children within the community and how to support them, i.e. fund-raising activities and projects and or approaches to agencies for support.

- work with other agencies or systems to identify children who are not in school and/or at risk of drop –out, i.e. civil unions, church-based groups, local NGOs and CBOs, etc.

- make announcements about enrolment, and government policies such as compulsory basic education, no school fees and capitation grants, etc.

- enact bye-laws to deal with parents who refuse to send children to school.

This is to acknowledge that most materials on section is culled from the training manual on extending EFA to child laborarers which took place at Ghana in 2005.

Conclusion

The role of community in combating health issues such as HIV/AIDS in particular is part of multi-sectoral response to HIV/AIDS prevention and treatment. The community can play a role in combating malaria scourge which has been recognized as number one-killer disease particularly among children. The SBMC presents an obvious vehicle for reaching the parents, community and the students. On issues relating to HIV/AIDS in particular or sexuality education, the community has a role to play. This is because without the approval of the community the school will experience resistance (Adelabu 2009). Therefore, the SBMC involvement in community health is of vital fundamental to pupils learning outcomes.

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