

Comprehensive School Health Education

Suggested Guidelines for Action

WHO/UNESCO/UNICEF Consultation on Strategies for Implementing
Comprehensive School Health Education/Promotion Programmes
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"Educating children at school on health should be given the highest priority, not for their health per se, but also from the perspective of education, since if they are to learn they need to be in good health."

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COMPREHENSIVE SCHOOL HEALTH EDUCATION:

SUGGESTED GUIDELINES FOR ACTION

Education for health is a fundamental right of every child. Health is inextricably linked to educational achievement, quality of life, and economic productivity. By acquiring health-related knowledge, values, skills, and practices, children can be empowered to pursue a healthy life and to work as agents of change for the health of their communities. This goal can be achieved if we have the will.

I. INTRODUCTION

The health and well-being of children and youth must be a fundamental value for all countries. Recently, in addition to longstanding health and nutritional issues, urgent worldwide health and social problems, including HIV/AIDS and increasing substance and alcohol abuse, have underscored the need for collaboration among young people, families, schools, agencies, communities, and governments in taking a comprehensive approach to school-based health education.

Yet, too few children have access to such programmes and their implementation remains a major challenge throughout the world. In response to that challenge, WHO, in collaboration with UNICEF and UNESCO convened an expert consultation with participants from 16 countries, as well as other experts in the field in November 1991, to (1) gain a common understanding of comprehensive school health education (CSHE) and (2) outline actions that countries can consider to strengthen implementation of such programmes.

This consultation was based on four decades of effort by UN agencies in advancing comprehensive school health education. In 1986, WHO and UNICEF published "Helping a Billion Children Learn About Health". It described the findings of an international consultation on (1) the complexity of health learning among school-

age children both in and out of school, (2) assessing the current state of health education for this population, and (3) proposing strategies and guidelines for strengthening health education. More recently, WHO organized a number of working group sessions in conjunction with UNESCO and UNFPA on comprehensive school health education at the International Conferences on AIDS (Florence, June 1991) and on Health Education (Helsinki, June 1991). The present consultation was the latest in a series of recent activities to promote comprehensive school health education which recognizes the multitude of factors at work in the critical years when children and youth are maturing.

THE CASE FOR SCHOOL HEALTH EDUCATION

There are important practical grounds on which to make the school health education of children and youth a high priority. These are based upon the size and accessibility of this population, the impact that health education can make on both health and education, and the existence of a rich tradition of success and innovation in school health education.

The population of school-age children and youth has grown enormously in recent decades. Children are receptive to learning. And, because many attend school, they may be reached readily and cost-effectively. By reaching these school-age children, health education can provide benefits to all levels of society: the individual, the family, the school, the community, and the nation. Over time, these benefits accrue

- because of the documented linkages between the health status of children and their educational achievement; as the nutritional and health status of children improves, so too does their ability to attend school and achieve. Therefore, "Efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education."¹
- because one of the most important determinants of a child's health is the educational status of the mother. Therefore, efforts to increase the school attendance and improve the health education of girls can have a profound benefit.

¹ National Commission on the Role of the School and the Community in Improving Adolescent Health. (1990). Code Blue. Alexandria, Virginia: National Association of State Boards of Education; p. 9.

- because schools themselves are an important channel of communication for health education messages (and potentially of health services as well) to the student, the family, and the community as a whole.
- because of the relationship that needs to be strengthened between in-school learning and out-of-school health behaviour.
- because education for life skills guides people to think critically about health and social issues, encourages them to work collaboratively on solving problems, and provides them with the confidence and expertise to participate fully in community activities.

The experience of the past four decades has demonstrated that comprehensive school health education can have a profound influence on students' health knowledge, attitudes, and behaviours. Often in collaboration with WHO and other international organizations, many countries have carried out carefully designed programmes, though few have been evaluated. Although little outcome data exists concerning changes in health behaviour in youth as a result of school health education programmes, recently there is new evidence of changes in students' health knowledge, attitudes, and most important, some evidence of changes in reported behaviour.²

The health challenges facing school-age children and youth, and to which health education programmes must be directed, are complex and challenging. Their complexity arises because the health status is largely a product of both the environmental conditions in which children live, and the lifestyles they adopt. Among the health and nutritional conditions that have been linked with failure to attend school or poor academic performance in developing countries are nutritional deficiencies, helminthic and other infections, physical and mental disabilities, and reproductive problems (adolescent pregnancy, and sexually transmitted diseases). Many of the lifestyle- or behaviour-related health problems identified in recent reports about youth in developed countries (e.g., drinking, smoking, HIV/AIDS, violence, suicide as well as accidents/injuries) are becoming issues of concern among school-age youth in many developing countries as well.

² See Ross JG, Nelson GD, Kolbe LJ (eds). (1991). Teenage Health Teaching Modules Evaluation. *Journal of School Health*. Vol. 61, No. 1:19-42; Also Connell DB, Turner RR, Mason EF. (1985). Summary of findings of the School Health Education Evaluation: Health Promotion Effectiveness, Implementation and Costs. *Journal of School Health*. Vol. 55, No. 8:316-321.

The health problems of developing and developed countries may differ, but it is also important to appreciate the similarities as well. For example, many developing countries are now experiencing increases in heart disease, cancer, injuries, and other causes of death and disability long associated with the industrialized nations. The pandemic of HIV/AIDS threatens young people in both developing and developed countries. And, throughout the world, disregard for the environment has resulted in damage to the ecosystem and the proliferation of pollution-related diseases. All of these problems pose important questions for the development and implementation of school health education programmes.

II. THE CONCEPT OF COMPREHENSIVE SCHOOL HEALTH EDUCATION

School health programmes include three related components: a school health services component, a school environment component, and a health education/instructional component. This consultation recognised all three, but focused on the health education component, which to be truly effective must be comprehensive. The health education component must collaborate with, and be conceptually related to the other two components, and consider the whole child in the context of living conditions in local communities.

School health education is comprehensive when it

- **views health holistically**, addressing the interrelatedness of health problems and the factors that influence health, within the context of the human and material environment and other conditions of life;
- **utilizes all educational opportunities for health**: formal and informal, standard and innovative curriculum and pedagogy, and by drawing upon services and opportunities available within and outside of the school;
- **strives to harmonize the health messages** from the various sources that influence students, including messages from the media, advertising, the community, the health and development systems, family and peers, and the school;
- **empowers children and youth to act for healthy living** and to promote conditions supportive of health.

Socioeconomic, cultural, psychosocial, environmental, and genetic factors influence health and behaviour. Students learn from a variety of sources, in a

variety of settings, and by a variety of ways. Comprehensive school health education must be developed within the context of these realities and help to interpret and address them.

A comprehensive school health education programme includes a broad spectrum of activities that take place within and outside of schools in their surrounding communities. They are designed to enable children and youth to enhance their health, and to develop to their fullest potential by achieving health as well as by acquiring education. Comprehensive school health education is reinforced by, and in turn reinforces community health and education programmes.

III. GENERAL PRINCIPLES TO GUIDE ACTION

Schools have the potential to reach a billion children worldwide. Therefore, development of international and national policies and action plans that include and give a high priority to comprehensive school health education can have a powerful and lasting impact. Recognizing each country's unique health problems, values, resources, and organizational structures, the consultation offers these guiding principles for action.

Developing and strengthening a comprehensive school health education programme:

- requires political will and commitment as well as policy, legislative, and fiscal support at international, national, and local levels.
- requires advocacy at all levels and through all channels, including the media, to reach policy-makers and other influential individuals and groups.
- requires integration into national educational and health policies.
- should capitalize on and join with global efforts such as education for life skills, and worldwide concern over such issues as environmental degradation, AIDS and drug abuse. Through such movements as Health for All and Education for All, leaders are exploring ways in which education and health professionals can work together to advance healthy development of children worldwide. It is essential to build on these efforts.
- can be championed by a group of committed professionals, visionaries, and citizens.

- calls for alliances among various sectors of society, including all relevant ministries and agencies, as well as teachers, health workers, parents, youth, media, and others.
- must inspire and ensure the participation of teachers and teachers' organizations.
- must focus on participative learning and engage children in community action projects for effective learning.
- must strive to increase the school attendance of all children, particularly girls. Sixty percent of the 105 million school-age children who do not attend school are female. Because the educational status of a mother has been shown to be an important determinant of a child's health, special efforts must be made to increase the educational participation of girls and young women. This is essential to address both their health and well-being, and the health of future generations.

IV. CRITICAL TASKS

School health education programmes, like other large-scale societal initiatives, follow a process that includes formulating policies that reflect a clear understanding of the problem, designing and implementing practical interventions, and evaluating the results. And while different programmes will grow in ways best adapted to their national and cultural realities, the critical tasks in the process include

- policy development
- creating a coordinating mechanism
- programme development and implementation
- research and evaluation

These tasks are not meant to be a prescribed sequence of actions. Indeed, some may need to take place simultaneously or to overlap. The important link between them is to determine where and how it is most practical to intervene. Action for a coordinated approach to comprehensive school health education, can be guided by the suggested strategies that follow. Although the tasks may seem complex, a small group of committed individuals, professionals, and other interested persons can initiate the process.

V. STRATEGIES FOR ACTION

In putting into practice the general principles described previously, this section describes the key strategies for action. It is recognized that individual countries present a wide variety of physical, social, cultural, health, economic, and political circumstances to which these strategies or approaches must be adapted. The focus here is on actions to be taken at national and local levels.

POLICY DEVELOPMENT: Creating Political Support

For comprehensive school health education to be a national priority, it is necessary for advocates and policy-makers to reach a common understanding of the issues involved, consensus on direction and goals, resources required, and benefits to be achieved. The process of creating political support for a policy on CSHE is a critical step. This calls for creative advocacy efforts. The following sequence of events is but one illustration of how a strategic plan might be designed.

- activation of a nucleus of committed individuals to initiate the process and advocate for school health education.
- gaining an understanding of how national policies are developed and assigned priority; the identification of key decision-makers and how they are reached. Their roles and responsibilities for policy development tasks within and across sectors at the national, regional, and local levels should be clearly defined.
- gathering all available data (on health problems, and behaviours of children, such as smoking, substance abuse, and teenage pregnancy) as well as evidence on effective interventions in schools so that it can be used by political parties and governments, and for background papers, documents and in forums.
- organizing and presenting such data to policy/decision-makers in a clear, understandable, concise, and persuasive manner. The case should demonstrate that CSHE is politically viable, feasible, and cost effective.
- forming of alliances with initial stakeholders (e.g., parents, teachers) and influential groups (e.g., religious and political figures, organizations and institutions) with other interested parties such as media, professional organizations, voluntary non-governmental organizations and mass organizations (trade unions, women, youth and teachers organizations).

Of particular importance is a collaborative arrangement between education and health. Other sectors such as social welfare, communications, food and agriculture, housing, industry, and transportation, as they affect health and education should also be involved.

- securing of human, material, financial and community resources to support school health education.
- stimulating the interest of international organizations, foundations, business and development agencies, and professional groups.

COORDINATING MECHANISM

An essential element in the process of developing or strengthening CSHE is the creation at all levels (i.e., national, state, local) of mechanisms that are charged with the responsibility to transform policy into action. These coordinating mechanisms provide direction, guidance, monitoring, and linkages to the key players. Key functions and activities of these groups follow:

- An important step in the process of developing and strengthening CSHE is the establishment of a joint committee of the ministries of health and education that could also include other appropriate ministries with responsibility for programme development, resource identification and allocation. The joint committee would play the lead role in coordinating CSHE planning and programming. It should be chaired by a nationally respected figure and should include representatives from all influential sectors and ministries. Such a committee could develop policy papers and strategies that can be disseminated through the health and education structure (particularly to teachers and health workers). After consultations with a wide range of people at the local level, the resulting policies and strategies can be used to influence decision-makers.
- The joint committee could assign issue-specific task forces that would address such topics as curriculum and resource materials, teacher preparation and supervision, and monitoring and assessment with the support of interested parties. The task forces will be made up of subject experts. For example, the curriculum task force would draw from professionals working with existing agencies/institutions concerned with curriculum development, training and research.

- The joint committee should work towards the establishment of an advisory council at the highest level to advise on policy matters and to provide an overview and guidance on programme direction. The advisory council, which could be built upon the intersectoral commission described above, could include representatives from all relevant sectors, academics and professionals from the education and health sectors, influential public figures, and policy-makers. The council may meet once or twice a year.
- The focal point or an executive unit responsible for the day to day planning, implementing, and coordinating school health education programmes could be housed preferably in the Ministry of Education with a technical counterpart in the Ministry of Health. The resources of the unit will depend upon the nature and extent of the tasks involved. The unit could draw upon the expertise and support of an informal group of professionals, public figures, teachers and parents.
- Interministerial assignment of roles and responsibilities and accountabilities for managing the programme at various levels should be clearly defined.
- Coordinating mechanisms similar to those established at the national level need to be put in place at the regional, provincial, state, and local levels. These will require both technical and financial support from higher levels, and may have to be done in a phased manner, depending on availability of resources.

PROGRAMME DEVELOPMENT AND IMPLEMENTATION

Development of a programme must be based upon a sound rationale with goals that are realistic in light of prevailing conditions and available resources. The issues that need special attention are described below.

1. Needs Assessment

- A needs assessment is an essential step in programme planning and development. It should identify the health needs and problems of children in school, their knowledge, values and practices, the nature and extent of existing programmes, a review of content and teaching methods in schools and teacher training programmes, and available resources for implementing the programme.

- Data from existing reports and surveys should be carefully reviewed before deciding on the necessity to undertake a survey of current needs. The data collected during the assessment should be used in determining the nature, scope and sequence of the health content to be taught, so that they are appropriate for different age levels and within the context of local culture.

2. Action Plans

- Plans to guide action at the national or local levels should be focused on the short term but remain within the context of long-term goals.
- Plans should be flexible and adaptable to changes in national plans and availability of resources.
- Planned activities should include adequate financial, material, and human resources. External sources such as international agencies and bilateral donors, in addition to those locally available, could also be tapped when appropriate.
- Topical global and regional issues such as population growth, environmental protection, human rights education, AIDS, and substance abuse have been able to attract funds and a place in the school curriculum. Skills must be cultivated to use these opportunities to promote a comprehensive approach to school health education.
- During the planning process, planners should endeavour to obtain the active involvement of principals, teachers, pupils, and parents.

3. Health Instruction

Health instruction should be an integral part of the total curriculum. Health can be taught as a separate subject, be infused into existing subjects, or both; it can be enhanced through school and community-based projects.

The school health education curricula should

- enable children to acquire health knowledge, health promoting values, and to practice health promoting behaviour.
- offer a planned, sequentially developed programme throughout the child's school life. This programme should aim at being appropriate to the age and developmental stages of the pupil and be sensitive to local cultural values.

- Even where health is taught as a separate subject it should be integrated into other subject areas.
- consider including, but not be limited to topics such as: personal and dental hygiene; nutrition, food safety and dietary habits; exercise and fitness, water, basic sanitation and environmental issues; lifestyles, tobacco, alcohol and drug abuse; human sexuality, unintended pregnancy, HIV and other STDs; mental health, coping and life skills; intentional and accidental injuries; common communicable and noncommunicable diseases.
- allocate adequate time to cover health issues so that improvements can be made in attitudes and behaviours, as well as knowledge.
- be based on participatory learning through the use of active learning methods, such as role play, small group discussions, case studies, and interactive radio and community action projects, which can go beyond the classroom and can help pupils to explore and practice positive health behaviours. Such active learning allows students to gain experience as agents of change in these various settings.
- include health education messages that are not only easy for students to understand themselves, but easy for them to explain to others, leading to the follow-up of messages from child to child and child to family and community. The development, testing, production and proper use of both teaching and learning materials are key elements in providing adequate school health education.
- consider children, parents, and others not just as target audiences but also as active disseminators of health messages to their families, communities, and others.
- ensure that health messages communicated by teachers are reinforced by their own personal behaviour and lifestyles. These should also be reinforced by educational programmes in the community.

4. Educational Opportunities Beyond the Classroom

The school environment offers many opportunities to learn about health. Teachers must seek out such opportunities for both planned and incidental teaching. School health services, school meals, the school environment, and various events in the school and community offer teaching opportunities.

- Through the health services provided to children in school, health professionals and teachers can talk about health and reinforce the health instruction of the classroom. Medical examination screening or treatment for health problems provides an excellent opportunity for the school nurse to individually counsel or advise students and parents. Teachers with appropriate training can help in identifying children with health problems. The school nurse can act as the coordinator between the health services and classroom instruction.
- Meals at school, whether provided or sold in school or brought from home, provide educational opportunities. Proper nutrition, personal hygiene, and food safety are natural topics for health education. It is also important that health-enhancing standards must be applied to the management of school cafeterias and food vendors.
- Mothers and community members could be involved in school meal programmes; this will provide a valuable educational opportunity.
- Special events such as assemblies and discussions on current issues provide opportunities to address health and related problems.
- Regional and local audiovisual resource centers could be utilized, where available, for obtaining useful learning materials.
- Foster a multichannel approach using all available technologies and materials, such as interactive radio or other forms of distance education for promoting healthy behaviour.
- The total school environment, including physical and the psychosocial ambiance, are critical for students to acquire healthy values and habits and should be consistent with and reinforce health instruction and practice.
- School buildings and surroundings should be safe and health promotive. Lighting, heating, ventilation, safe water, and sanitation should be adequate. Persons trained in first aid should be available.

5. School-Community Relationship

Schools and communities are natural partners in health promotion and disease prevention. Schools can tap community resources for learning about and practicing good health habits. Communities can offer key support to schools for the critical role they play in promoting health.

- The community provides a good setting for students to better understand and practice what they learn about health in the classroom. Community resources for this purpose are available in various forms. Community leaders, religions and social institutions, voluntary agencies, businesses, parents and youth groups could be involved in students' projects in the community. Health workers, and community members can also be involved.
- School-community projects not only provide valuable learning opportunities for children but could also be designed to involve, inform and facilitate education of parents, family members, and others in the community. It is important that parents and key exemplars understand and reinforce what the school curriculum seeks to achieve.
- School-community projects not only provide valuable learning opportunities for children, but could also be designed to involve, inform and facilitate education of parents, family members and others in the community. It is important that parents and key exemplars understand and reinforce what the school curriculum seeks to achieve. At the same time their views and inputs into the school health curriculum and classroom experience can be extremely productive.
- Headmasters can play a key role in stimulating these interactions. Another mechanism would be the creation of a health committee at the school level, led by health workers and community leaders who can help to create and focus projects to be carried out by students, parents, and other volunteers.

6. Teacher Training

Teacher training, both pre-service and in-service, is one of the major factors in a successful school health education programme. Education and training to inspire and equip teachers with knowledge and skills to make a curriculum exciting is essential. Such training should also include activities to promote the teachers' own positive health behaviours to enhance their role as models. Ongoing support to teachers and monitoring of performance is necessary for quality teaching, as is granting teachers of health education equal status to teachers of academic subjects.

Teacher training institutions have a critical role to play in such functions as the preparation of teachers for health education, providing technical support to schools, and promoting research and evaluation of school health programmes.

Consequently, the following should be undertaken:

- review and upgrade teacher training at the pre-service, in-service and continuing education levels with a view to preparing them for the application of a comprehensive approach;
- teacher training programmes should ensure that student teachers educators receive field experience; use training methods and resources that are practical, interactive, and can be replicated in the classroom; and ensure that all student teachers have a minimum health education training;
- carefully design and implement summer workshops and short courses on a comprehensive approach to school health education to upgrade the teachers' abilities;
- train health teachers and staff, as well as non-teaching school personnel to play an educational role;
- develop mechanisms for continuing education and supportive supervision to maintain and enhance quality of teaching.

RESEARCH AND EVALUATION

1. Research

Research data are needed to drive agenda setting as well as for advocacy. Also, baseline data on the health of children, quality of school health services, the environment of schools, and the health knowledge, skills and practices of pupils are essential for evaluating the CSHE programme. For example, baseline data should include the health behaviour of school children and identification of health needs and information on local living conditions. These are necessary for programme development and evaluation. Baseline data is necessary to plot trends and monitor effectiveness of interventions. Research to develop and test innovative educational techniques and approaches is an important but often neglected area which deserves added attention.

2. Evaluation

Each country must find ways to address the following questions, from national to local levels:

- Is the CSHE curriculum being implemented as intended?

- Is the CSHE curriculum achieving the desired effect on children's health knowledge, attitudes, and health behaviours, and is this change also influencing the health of families and the community?

Formative (process) and summative (impact) evaluation provide information that can be invaluable in reshaping and revising programme development. Formative evaluation assesses how well the programme is working. Summative evaluation measures the impact of the programme on the target population. A few points should be kept in mind:

- During the planning stage, it is necessary to prepare the framework for evaluation which includes specifying programme objectives, selecting educational methods and interventions to be assessed, and identifying indicators to measure the achievement of objectives as well as their effectiveness. The methodologies for collecting, analyzing, and using the data also need to be specified.
- Ways must be found based on available resources to address evaluation, to see if the CSHE programme is being implemented as intended and that the desired results are achieved. It includes measuring preset objectives, using appropriate indicators to measure children's health knowledge, attitudes, and health behaviour and teacher performance in curriculum implementation, and also, if feasible, the influence on family health practices.
- The challenge lies in developing tools that are practical as well as valid and sensitive in measuring changes. Evaluation will remain a distant dream unless attention is paid to developing tools that are easy to use and effective.

3. Utilization of Findings

Evaluation of process and impact is important to monitor ongoing and long-term progress. Feedback of research and evaluation results to policy-makers, administrators, sponsors, teachers, and the community is an important part of programme management. A mechanism is needed for the rapid and clear communication of new information on technology and validated innovations from researchers to planners and practitioners for application. All research findings of significance should be systematically promoted through various channels including the media and followed up by seminars and discussions to raise awareness, create political support, and ensure action.

ACTIONS AT THE INTERNATIONAL LEVEL

Global organizations such as the United Nations and its specialized agencies, particularly WHO, UNESCO, and UNICEF can contribute by showing leadership. Their continued support is invaluable in advancing the comprehensive approach. They should foster policy and strategy development; encourage research particularly on effective interventions; facilitate the exchange of information and experiences on an ongoing basis; and provide technical support to countries in developing national capability. Support should be extended for institution strengthening, human resource development and organization of regional and national workshops involving the ministries of education and health and other appropriate sectors.

The International Agencies should be active participants in the promotional efforts for CSHE which needs to be put on the agenda of future conferences and be incorporated into the current global initiatives of Health for All and Education for All.

VI. MEETING THE CHALLENGE

Educating children for health through schools should receive the highest priority, not only from the point of view of health, but also from the point of view of education. Yet too few children have access to such programmes and their implementation remains a major challenge throughout the world.

At the same time, educating children for health in schools is being recognized globally as an effective and efficient way to influence health behaviour. Evidence points to significant improvements in students' health at minimum cost. And, although progress has been slow, most countries have made some attempts at school health education.

Advocacy for school health education is an immediate need and should be sustained, well-organized, and based firmly on scientific evidence. Those with expertise in health and education must play a major role, but so, too, must all citizens who care about the future of their children and their nation. It only takes a few committed individuals to initiate the process of change and innovation and act as a catalyst, drawing others in from across all sectors.

Key players also need to be identified and involved early in the process. Critical to any success is the active support of the ministries of health and education, along with school officials and teachers, students, parents and the community.

Mechanisms need to be in place to coordinate the development of areas such as teacher training, curriculum, teaching/learning resources, etc.

Human and financial resources within and outside the education and health sectors need to be identified and secured early as well. Potential resources available from international agencies and institutions should not be overlooked.

In each country, advocates will have to look at the specific conditions (policies, resources, political climate, etc.) before deciding when, where and how to initiate the process towards educating children for health in a comprehensive way. But, although the starting point will vary from country to country, generating political and professional commitment early in the process is critical. Evidence of effectiveness, when well promoted through influential groups and the media can quickly put the issue on a nation's agenda. This will help capture the interest of community leaders to champion the issue.

Initial activities should build upon what already exists. Expertise available both within and outside government should be mobilized around topical issues of common concerns such as AIDS, alcohol, drugs or tobacco. These offer an entry point to get involved and gradually build towards comprehensive school health education programmes.

Examples of success stories of student involvement in national programmes such as immunization and sanitation should be highlighted as models of the expanded programme of school health education.

Still, questions remain unanswered. We do not yet know everything about school health education. But we do understand the dimensions of the health and education needs of children and youth. And we have a growing understanding of what programmes work and under what circumstances. Much of what we still need to know will be learned through designing, implementing, and evaluating school health education programmes.

What we know very clearly are the consequences of not acting. And because those consequences for children, their families, communities, and nations are unacceptable; the challenge to implement effective comprehensive school health education must be met. Our investment in children's health today will ensure a healthier world tomorrow.

ANNEXES

SOME SCHOOL HEALTH EDUCATION EXPERIENCES FROM
COUNTRIES PARTICIPATING IN THE CONSULTATION

Every country around the globe has some form of on-going school health education programme which might lend itself to a more comprehensive approach.

School health education experiences presented by participants from the 16 countries have been summarized and are annexed. The processes through which school health education has evolved, and some of the approaches used in these countries, can be good learning experiences.

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Box 1

Bahrain Implements the Action-Oriented School Health Curriculum for Primary Schools: a prototype prepared for the Eastern Mediterranean Countries by WHO/UNICEF/UNESCO/IESCO

The State of Bahrain adopted the Action-Oriented School Health Curriculum for Primary Schools in October 1988.

The following phases were used to adapt and implement the prototype curriculum.

Planning phase

1. A joint Expert Committee with representatives from the Health and Education Ministries was formed to supervise implementation and provide needed resources.
2. A National Coordinator for health education was identified to chair the Expert Committee and deal with international agencies.
3. The Department of Curriculum, Ministry of Education is responsible for adapting, implementing, monitoring and evaluating the curriculum.
4. A Task Force, composed of curriculum specialists, was formed to integrate health topics in other subjects, follow-up implementation, prepare resource materials, design evaluation tools and monitor and evaluate the project.
5. A preliminary investigation of all selected schools for implementation were conducted before implementation started.

Implementation phase

1. During 1989/90 the project was implemented in 30% of schools and in 1991/92, the project was implemented in 71% of the schools.
2. Training workshops were held for teachers during this period covering objectives, contents and teaching methods, focusing on problem-solving and field experiences.



Box 1 (continued)

3. For each education block teaching aids were developed.
4. Schools that developed the best education block exchanged experiences with other schools.
5. The Ministry of Health arranged for health workers to participate in the teaching, where parents were also invited to attend. Student visits were arranged to health institutions.
6. The Ministry of Education distributed teaching aids and arranged for sharing experiences between schools.
7. The Ministry of the Interior, Department of Traffic, organized a campaign on road safety. The Department of Civil Defence arranged visits and demonstrations on safety and accidents. Parents were actively involved in these sessions.
8. Other institutions involved were the Central Council Corporation. Local councils played a role in promoting environmental health awareness and organizing cleaning week campaigns.
9. Schools visited shopping centers and learned about available foods, food safety and hygiene.
10. Factories were visited to learn about socio-economic development.

Evaluation phase

1. Tests were developed to measure knowledge and skills.
2. All phases of the project were evaluated.
3. The project has been extended to cover 57.4% of elementary schools during 1991/92 □

Box 2

School Health Education - the Denmark Experience***Development of Health Education in Danish Comprehensive Schools***

Health education in Danish schools has been going on for many years focusing on hygiene and functions of the human body. Since the late fifties, alcohol, tobacco, drugs, nutrition, sex and contraception have been compulsory topics taught in schools. Though health education has not been a separate subject, it has been integrated into biology and many health topics are dealt with by the teacher during the weekly lesson assigned to social matters.

Discussions on current topics and conditions are often started by single or groups of teachers or by the school authorities as the Danish school system allows such initiatives. Action-oriented teaching, learning about topics instead of subjects, and working on projects, using society as teaching material are being increasingly used in schools since the eighties.

The reforms made in the Danish school system in 1975 focused on influencing the lifestyle of children and preparing them to be active citizens in a democratic society, involving them to contribute to the whole ethos of the school.

New approaches to health education

A special committee set up by the Ministry of Education prepared in January 1991, "Provisions and Guiding Proposals Concerning the Curriculum in Health and Sex Education" based on the Ministry's aims set out in 1988 about the type of knowledge, understanding and ability children should gain about health. Health and sex education was to be integrated in other subjects and will be the responsibility of the class teachers. In each municipality, these guidelines must be made into a curriculum to be taught by local education authorities or they must adopt the one that has come from the Ministry. In November 1991, the "Provisions and Guidelines" were discussed in meetings, conferences and by teacher training institutions all over Denmark.



Box 2 (continued)

At the *national level*, the Ministry of Health has prepared a booklet to support the nationwide dialogue with the teachers, parents, boards and politicians, titled "Is it healthy to go to school?" The Royal Danish School of Educational Studies has taken initiatives for teacher training, interdisciplinary training of teachers and school nurses and organizing a conference on future collaboration between the different ministries, the comprehensive schools and the different post-compulsory education institutions. A recent Conference organized by the Royal Danish School of Educational Studies, addressed the ways in which the different Ministries could coordinate with educational institutions in promoting education on topics such as the environment, alcohol, tobacco, drugs, AIDS, etc. for which the Ministries launch national campaigns. While the effectiveness of such campaigns can be debated, there are spin offs like cheap or free teaching materials that are distributed. Better coordination can support teacher training on campaign topics and development of new teaching methods and materials.

In Denmark, regional governments take care of certain social services including education in the counties under them. In every county there is a center for educational materials. In 1991, many of these centers have worked with regional governments in launching projects and campaigns related to health issues. These events have had a strong impact on the teaching in schools. The centers also buy books in sets which can be borrowed by the county schools and they also arrange for teacher training in collaboration with the school system.

At the local level, there is much variation. While some municipalities have health and health education high on the agenda and have worked out a policy for action, there are other municipalities that have not made a start and need support to incorporate health education in their school systems.

Current trends in Denmark encourage teachers to cover social matters in weekly sessions which provides scope for introducing health topics. Making available "Provisions and Guidelines" to teach health and sex education is a resource to teachers helping them to integrate health in other subjects. The effort of The Royal Danish School of Education Studies to bring about intersectoral coordination in dealing with important health issues both in the school and community is a commendable step for promoting a nation's health □

School Health Education in England Today

The Health Education Authority (HEA) is the national organization responsible for leading and supporting the promotion of health of England's 48 million people. Sister organizations exist in Scotland, Wales and Northern Ireland. However, the education systems of England and Wales are virtually identical.

The 1988 Education Reform Act introduced a national curriculum of ten statutory *foundation subjects* (English), Mathematics, Science, Technology, History, Geography, Modern Foreign Language, Art, Music, Physical Education) and Religious Education. Although health education is not itself a foundation subject, aspects of it are included within the foundation subjects of Science, Technology and Physical Education.

Health education is non-statutory and is not usually taught as a separately timetabled subject, nor is it separately examined. Under the Education Reform Act, health education is defined as one of five major *cross curricular themes*. Cross curricular themes are not additional subjects: they are intended to be coordinated through the foundation subjects, through special timetabled provision (such as Personal and Social Education), and through the wider aspects of school life.

In 1990, the National Curriculum Council, the body set up to advise government and schools on the development and implementation of the curriculum, published "Curriculum Guidance 5: Health Education". This document advises schools on the knowledge, understanding, skills and attitudes which children can be expected to acquire at the various stages of their schooling.

Nine components were identified as forming a framework for health education: substance use and misuse; sex education; family life education; safety; health-related exercise; food and nutrition; personal hygiene; environmental and psychological aspects of health education.

"Curriculum Guidance 5" also provides advice on the importance of management and coordination of health education; progression and continuity in learning; and on the need for a balanced range of teaching approaches including the use of active learning methods.



Box 3 (continued)

Those aspects of school life which go beyond the curriculum are also considered - the physical environment of the school; the pastoral system; food provision; parental and community involvement; and the development and implementation of health education policies.

The importance of coordination within schools has long been known. A 1983 HEA survey showed that 18% of primary schools and 49% of secondary schools had a health education coordinator. By 1989, there had been a significant increase: a second survey showed that 55% of primary schools and 80% of secondary schools had appointed such a coordinator.

The HEA has for many years encouraged coordination between the 112 local education authorities (LEAs) and the 200 health districts of England. Many LEAs have drawn up health education policies, some of which focus on sex education, HIV and drug education, which they issue as guidance to schools. HEA research indicates that in 1989, 77% of primary schools and 91% of secondary schools had or were in the process of formulating their own written policies. Current research is taking place to learn more about the nature and quality of written health education policies, how they were developed, and their impact upon practice.

Since 1986, aspects of health education have been included in the Government's named priority areas for financial support to LEAs. Initially, the grant was for drug education, but since 1989 HIV/AIDS and alcohol have been included. These grants have been used to purchase in-service training for teachers (health education is not a statutory part of initial teacher training) and to pay for Advisory Teachers. However, there is uncertainty surrounding the future of the funding and, as a consequence, the future of the Advisory Teacher service. In-service training may suffer and this will have serious repercussions for health education.

The 1992 Education (Schools) Act proposes to privatise the system of school inspections, with schools being inspected by paid independent inspectors. Unless schools choose to include health education within their inspection requirements, it may well not be inspected. The new Act also proposes the publication of data on examination performance - "league



Box 3 (continued)

tables" - for schools. This may well encourage undue emphasis on examination performance, to the detriment of health education. Together, these two developments may contribute to a process of marginalisation of health education.

However, the HEA's extensive curriculum and staff development activities continue. The publication in Spring 1991 of "The Health of the Nation", a consultative document on a national strategy for health in England provides an important opportunity to improve health education for young people.

Health education has been part of the school curriculum for over 20 years. What started out as "education for personal relationships" has grown into a well established aspect of school life. Although non-statutory, it can be highly effective providing there is commitment from schools, families and communities. If, as is hoped, the UK joins the European Network of Health Promoting Schools, this commitment will have been demonstrated across Europe □

School Health Education Achievements in India***Development since independence in 1947***

Since 1947, a number of committees have been set up to incorporate health education in schools. In 1956, a National Plan for Physical Education and Research provided guidelines for incorporating health education, physical education and sports in the curriculum. In 1961, the Renuka Ray School Health Committee laid the foundations for a comprehensive school health programme which included health education at all stages.

The fifth five year plan (1974-1978) launched a Minimum Needs Programme (MNP) which aimed to deliver a minimum programme of basic needs including elementary education, health, nutrition, etc. Among the innovative education projects launched was one in 1975 on Nutrition Health Education and Environmental Education (NHEES). During the pilot phase (1975-1980), a curriculum package was developed and community contact initiated to generate awareness. During the expansion phase (1981-1989), activities were initiated in ten states. Evaluation studies included pupil achievement and impact of the community contact programme.

In 1975, simultaneously with the NHEEs, the National Council of Educational Research and Training (NCERT) brought out the curriculum framework which laid the foundation for health education.

In 1986, the National Policy on Education was formulated, when health and physical education were given a place in all stages of school education including vocational training. At the primary levels, learning outcomes, content, strategies and evaluation have been prepared. A substantial component of health education has been included in the instructional materials under environmental studies, which state governments have adopted and modified. Detailed curriculum for upper primary, secondary and higher secondary stages have also been developed. For each level, 8-10% of total curricular time has been given to health and physical education.

At the national level, there has been good collaboration between the NCERT and the Central Health Education Bureau (CHEB) in the Ministry of Health for developing a complete package of curricular material for the primary level. This is, however, not true for the upper primary and



Box 4 (continued)

secondary levels. There is also inadequate partnership at the state level between the State Councils of Education Research and Training (SCERT) and the State Bureaus of Health Education. This hinders effective implementation of the school health education curriculum. At the district level, there are no parallel units in the education or health sector. Lack of adequately trained teachers is a constraint at all levels. Physical education teachers are responsible for teaching health in the upper primary and secondary levels but they are not trained for doing this.

Though evaluation of learning outcomes is a major recommendation of the National Policy on Education, this is not done because of inadequate implementation of the programme.

Recently, the NCERT has developed a training package for the programme on Mass Orientation of School Teachers under operation *BlackBoard 1991*. This package gives samples of activities and guidelines for evaluation of outcomes.

Though national policies on health (1983) and on education (1986) strongly support school health education, a number of constraints have stood in the way of implementation. Even well-tested projects such as the primary education curriculum renewals (PECR) and the NHEES is yet to find its place in the general scheme of the health education curriculum at the state level. The unique feature of the NHEES project, community interventions, requires support at the state level in order to be implemented. However, the NHEES projects in the ten states have shown that education intervention can bring about significant change in pupil achievement in nutrition, health and environmental sanitation in spite of existing socio-economic conditions.

While India has strong policies that support school health and technically sound central infrastructures for developing school health education strategies and inputs, nationwide implementation have not been possible due to several constraints. State governments have showed varying interest in operationalising school health education strategies. Recognizing the limitations for nationwide coverage fairly comprehensive projects such as the NHEES have been successfully implemented and evaluated in 10 of the 22 states. Better advocacy and interministerial coordination at the State level can bring about wider and more effective implementation of school health education programmes □

Box 5

Multi-pronged efforts in School Health Education in Kenya

In 1986 a Conference on "Basic Education for Health" was held in Kenya and resolved that traditional approaches to health education had failed to change behaviour and called for new initiatives that related to the needs of local communities. Although school health education is in its early stages, a number of school based health activities are taking place.

1. Health has been incorporated in Carrier subjects such as, Science, Home Science, Agriculture, Social Education and Ethics in both primary and secondary schools.
2. Teachers are given in service training to teach health jointly by the Ministries of Health and Education.
3. The Kenya Institute of Education has involved Health Education Officers from the Division of Health Education, Ministry of Health, to develop a health curriculum and materials.
4. A number of NGOs are involved in health education for children and youth. For example, the African Medical Research and Education Foundation (AMREF), have comprehensive health education in two districts; the National Council of Churches and the Kenya Catholic Secretariat have family life education projects that have moved the Ministry of Education to develop a curriculum and teaching materials on family life education.
5. The Kenya Broadcasting Corporation has been enlisted by the Ministry of Education to undertake programmes for children, for example, on road safety.
6. During Agriculture Shows health education stands are set up and are popular with school children who have questions to ask.
7. Substance abuse is being addressed in the school curriculum. A preliminary study is to be carried out on the current status of substance abuse among children.



Box 5 (continued)

8. The child-to-child project is being implemented in selected schools with a focus on immunization, jointly by the Kenya Institute of Education and the Kenyatta University College.
9. During observance of days such as World Health Day, World AIDS Day, health education officers urge schools to take part using the folk media to carry health messages.
10. AIDS education in schools is being developed by the Ministry of Health and the Division of Health Education (National AIDS Control Programme), Ministry of Education, UNICEF and some NGOs.

It is recognized by the authorities that the above do not comprise a comprehensive SHE programme. Efforts must be made to expand health education activities nationwide and to coordinate single issue projects to make up a comprehensive programme □

Box 6

Current Status of School Health Education in Elementary and Preparatory Schools in Libya

Schooling up to nine grades is compulsory in Libya. There has been a rapid increase in enrolment in schools and reduction in drop outs with an increase in female students.

The curricula is planned at the national level and is the responsibility of the Secretariat of Education aided by the Supreme Council of Education.

Since 1971, the unified curriculum of the Arab countries has been adopted by the Libyan public schools. Here, health is taught as part of science. The topics under the health curriculum from 1-9 grades includes personal health care, food, water, safety and first aid, diseases, growth and development, etc.

Student science and health textbooks for the nine grades have been prepared.

There is no health curriculum at the secondary level. Health topics are taught to first year general students and third year science majors. They are not taught to art majors.

During the five years of pre-service teacher training, health instruction is provided to all student teachers during two periods every week.

Refresher training and other forms of in-service training in health is provided to teachers, school directors, inspectors and administrators.

A recent survey showed that 6th and 9th grade students showed some weaknesses in health knowledge regarding certain topics. These may not have been taught well. A need to revise resource materials was also indicated. In addition, the need for refresher courses for teachers was underscored □

Box 7

Health Education Programmes in Namibian Schools

The newly independent country of Namibia had a long history of providing services based on the policy of apartheid. Services were provided on a racial basis under the auspices of eleven ethnic administrations.

Within the newly constituted primary health services, a school/adolescent health programme has been identified to serve both in-school and out-of-school youth.

Curriculum and instruction is provided by health personnel who work for the Ministry of Health and Social Services. They visit schools to provide immunization, perform physical examinations and to a limited extent educate pupils on health matters. This is not a nation-wide service at present and target mainly school beginners and school leavers - grades 1 and 6 according to pre-independence policy.

There is yet no policy guidelines and new and innovative approaches are needed. The Ministry of Education and Culture is only beginning to introduce instructions to pupils in grades 5 and 8 on life skills lessons, mainly providing career guidance. Limited health education is integrated in subjects such as home economics, physiology, hygiene, biology, agriculture and physical training. There is no provision for family life education either for teachers or pupils.

The very recently established Ministry of Youth and Sport is focusing mainly on sport but plan to address the needs of unemployed youth, school drop outs, and street children. Illiteracy, substance abuse, especially alcohol abuse and teenage pregnancies are priority areas to be considered.

Pressing problems to be addressed relate to a history of isolation from international interaction, a fragmented education system, inadequate teachers in quality and quantity, neglect of rural areas, poor intersectoral collaboration, lack of legislation and traditional beliefs and attitudes that are not supportive to health and education.



Box 7 (continued)

To meet the current challenge, the Government is making an effort to build infrastructures and plan programmes to meet priority needs. International agencies including WHO and UNICEF are assisting in planning, preparation of proposals for funding and in providing technical resources for implementation. WHO has helped prepare a proposal to develop and strengthen health education at the national level with provisions to implement planned activities including school health education in a district in the North West Region, seeking funding from an already committed donor agency □

Box 8

The Emergence of Health Education in the School Curriculum in Nigeria

Introduction of health education in the school curriculum was stimulated due to the African Curriculum Conference of 1969 and subsequent national workshops of 1971 and 1973. The Ministries of Health and Education have worked with UNESCO, WHO and UNICEF since 1969.

In 1977, the National Policy on Education was promulgated in which health education was specifically listed as one of the key subjects to be taught not only at the primary level but also at the junior, secondary and senior secondary and tertiary levels. Thus, what was taught as "hygiene" became "health education" on the timetable. Problems in developing the school health education curriculum arose because of leadership conflicts between the sectors.

The integration of health education into the school curriculum as a separate subject, however, was approved at the primary school level only in August 1991.

All teacher training institutes include health education in their curriculum.

In 1986, the Federal Health Education Unit carried out a survey to study the status of school health education. As a result, some model pilot projects were set up in selected schools at national and state levels.

The National Advisory and Implementation Committees set up in 1988 with representatives from the National Education Research and Development Council, Federal Ministry of Health, WHO and UNICEF have worked hard to enlist the support of policy-makers to integrate health education in the school curriculum. The result was the introduction of school health education into the primary school curriculum in August 1991.

Continued efforts over two decades by the Ministries of Education and Health, and the support from international agencies have brought in tangible results. During this long wait, survey findings and lessons in collaboration with interministerial and international agencies have contributed to setting up pilot projects and introducing a health curriculum for primary schools nationwide □

Box 9

**Meeting the Challenge of School Health Education in
Papua New Guinea**

School health education is a non-prescribed subject in the Community School Curriculum and allotted sixty minutes per week in all grades.

Responsibility for school health education has been transferred from the Health Department to the Education Department. However, there is close collaboration between the two bodies.

The Curriculum Unit under the Education Department involves teachers and representatives of other educational institutions in planning, drafting and evaluation of all courses and materials.

Implementing School Health Education

Each teacher has a *Community School Health Curriculum Statement*. This is a document that contains a preamble; rationale; course organization; scope and sequence chart; flow charts for topics: me and others, healthy families and communities, food and health, safety and first aid; skills; values and attitudes; approaches to learning and developing pupil materials.

The teacher also has a *Teachers' Guide* for all six grades with 100 lessons covering the above-mentioned four topics.

A supplement to the Teachers' Guide is the *Guidance Book*.

The Department of Education has also prepared pupil books on the four topics for grades 1-6. These books have health posters, health charts, stories, health songs and cassettes.

Community school teachers are trained in Teachers' Colleges for three years. All colleges have demonstration schools near them so teachers can practice teaching during their training.

In 1988 the Inservice Handbook to keep teachers up to date has been modified to focus on student-centered learning for grades 1-6. School coordinators must make sure their teachers are familiar with the revised Handbook.



Box 9 (continued)

Evaluation

Programme evaluation takes place five years after implementing the programme. Some schools have already been evaluated but in other schools new health teaching materials have only been introduced in 1987 and 1990 and must wait for five years to be evaluated.

Students are evaluated at quarterly exams each year. School health education is examined, also during the national examination after grade 6.

Curriculum development is done very carefully. Many people are involved in the development, the draft is scrutinized, cleared and tested before it goes to the production coordinator and graphics section for mass production.

Papua New Guinea has gone about health teaching in schools in a systematic way. Their pupil's books and teachers' guides are good teaching/learning materials using stories and songs and field experiences. They have given health education the importance it deserves and have made it an examination subject □

Box 10

**School Health Education in the Philippines -
Towards Being Comprehensive**

Health promotion is an explicit state policy of the Philippines and enunciated in the law of the land. Health education, nutrition, health services and health-related programmes are supported by four staff bureaus responsible for elementary, secondary, higher and non-formal education as well as the School Health and Nutrition Center. These central offices have corresponding regional and field units.

There are 15 regional offices, 127 city and provincial schools divisions and 2,167 schools districts that oversee 34,382 elementary schools, 5,523 secondary schools, 945 post-secondary and 810 tertiary education institutions. There are also 536 teacher training institutions. The 1990-1991 school enrolment data shows 15 million young people in schools and colleges.

The Philippines has a comprehensive school health programme. Health services cover medical and dental services as well as school health nursing. School health guardian services are provided through trained teachers, who monitor the health of the pupils.

There are special programmes that include surveys and interventions for such issues as anaemia prevention, goiter prevention, deworming, control of tuberculosis, sodium fluoride mouth washing and so on. Emphasis is also placed on improving school sanitation.

The school nutrition programme includes nutrition education, self-help, school feeding, income-generating projects to support school feeding, supervision and management of school canteens, supplementary feeding and monitoring nutrition and health status of children. As part of this applied nutrition programme, teacher-child-parent approach to health, bio-intensive gardening, and school milk projects are implemented.

Health instruction is provided through character building, allotted 100-150 minutes per week in grades I and II and science and health, allotted 200 minutes per week in grades II-IV as separate subjects. In addition, around 35%-53% of the objectives of these core subjects are health related.



Box 10 (continued)

In the new secondary education curriculum (1989), the focus is on value development, productivity and technology. Health is a value that is promoted and incorporated in physical education, health and music (PEHM) from the first to third high school years. Citizens' army training is part of PEHM in the fourth year. PEHM is allotted 200 minutes a week. Population education is institutionalized in the minimum learning competencies for secondary level in health, home economics, science/biology and social studies. A corresponding revision of pupil textbooks accompany the new curriculum. While text books are written by private writers, pupil supplementary materials, poster and other teaching aids are prepared by the Bureau of Elementary Education and/or private agencies □

Box 11

Search for a New Approach to School Health Education - Poland

Till very recently, the National Institute of Hygiene was responsible for school hygiene and health education. They conducted studies on the practice of health education. At the provincial level, the Sanitary Epidemiological Stations looked after the health education programmes in the community and school. The Ministry of National Education has established a health unit staffed with three specialists. In some regions, there are also inspectors for a group of school authorities.

Many non-governmental organizations are involved in school health education, such as the Polish Red Cross, the Polish Hygiene Society, the Anti-Tobacco Society, the Anti-Alcohol Committee and the Society of Children's Friends. But there is no cooperation between these agencies and there is no integration of the different services they offer. Though guidelines for a health education curriculum were prepared in 1982 for both primary and secondary schools, this has not yet been implemented as a separate subject in schools. Though topics on health problems are included in many school subjects, the effectiveness of school health education is very low.

In 1991, the National health Programme stressed the importance of health education. Earlier in 1989, Poland participated in the WHO cross-national survey on health behaviour among school children and in 1991, Poland joined EURO's Healthy School Project. This was developed under the patronage of the Ministry of National Education with cooperation from the Ministry of Health and Social Welfare.

In the last two years, there has been some progress in implementing school health education. The Swedish method of health education "It is your decision" has been adopted. Two programmes concerning substance abuse for primary and secondary schools have been prepared. The English programme "Health for Life" and "Skills for Adolescents" will be adapted for use in Poland.

Over 380 schools are interested in participating in the healthy schools project. However, 10 schools will be first selected from the 330 applications



Box 11 (continued)

for being included in the project. The others will be given assistance and consultations and informative material.

Poland is trying out the healthy school project, an approach that is new to them but recommended by WHO's European Regional Office and used successfully by other countries. In spite of the popularity of the project, only a small number of schools are being identified to implement the project in view of the existing conditions and limited resources □

Box 12

School Health Education in Scotland

Scotland is part of the United Kingdom but has a separate and distinct education system. The Scottish Office Education Department has central responsibility for education and regional and island authorities are responsible for educational provision at local level. The Health Education Board for Scotland, (i) which replaced the Scottish Health Education Group (SHEG) as the national body responsible for health in 1991, has a key role in health education and regards schools as a priority setting for its initiative.

The joint SHEG/WHO symposium "The Health Promoting School" at Peebles in 1986 acted as a stimulus for the preparation of a major policy report entitled "Promoting Good Health - Proposals for action in schools". (2) This was published in 1989 along with a related report in association with WHO (EURO) entitled "The Healthy School". (3) Both of these documents explained the vital role of the wider life of the school in the promotion of good health and examined examples of good practice in both the formal curriculum and the "hidden curriculum". The concept of a partnership with parents was explored in these reports and this was followed up with the production of a booklet for parents explaining the aims and approach of health education and health promotion in schools. (4) (5) This booklet was distributed to all the parents of 10 and 12 year old pupils in Scotland.

There are important changes occurring in the curriculum in Scotland. In primary schools health education is often part of environmental studies and the Scottish Office have recently published a working paper on this. (6) In secondary schools health education is part of various subjects such as biology, home economics and physical education. In addition, many schools provide health education within social education classes as well as having health as a permeating element in the whole curriculum. A series of 40 hour courses under the collective title of Health Studies have been developed in Scotland to augment the main health education provision. These are not compulsory for pupils but are proving increasingly popular with young people in the 14+ age group. (7)

From the perspective of the Health Education Board for Scotland, the main priority for the future development of health education and health promotion in Scottish schools relates to increasing support for teacher training in health education □

From Policy to Action: The Sri Lanka Experience

Sri Lanka's Constitution calls for complete eradication of illiteracy. The government provides free education at all levels. Scholarships, free books, midday meals and nutritional support are available to those in need to achieve the goal of universal education. Sri Lanka is close to achieving first level education for all before the year 2000. Some provinces have in addition regularized pre-school education by an Act of Parliament.

School health education is part of all levels of schooling. At the primary stage, in classes 1-5, health is integrated into environmental and science education emphasizing on healthy habits. In the secondary stage, classes 6-8, health education is taught as a separate subject. From classes 8-11, health education is integrated into the science curriculum. In classes 12-13, home science includes health topics. Other health-related areas covered in schools are population education (since 1973), nutrition education for classes 1-11, and value education to help students make good choices in life. All subjects taught will be examined to assess value components and to make revisions accordingly.

In the post-secondary stages, the thrust is on individual contribution to peers, family and society. A unique feature is the establishment of Health Clubs where students play a role in school and community. Open discussions, peer learning, self-enhancement, and community service are part of club activities. The Health Club is a joint venture of the Health Education Bureau under the Ministry of Health and the National Institute of Education. The Health Club programme is sponsored by UNICEF. Having made a start Health Clubs will be extended to 200 schools in 1992.

The development of the school health education programme in Sri Lanka with many elements of comprehensiveness demonstrates how policy can become programmes within the context of country situations using national and external resources.

Teacher training in health education takes place for both elementary and secondary levels during pre-service and in-service preparation. In the



Box 13 (continued)

Bachelor of Elementary Education (B.E.Ed.), a 3-unit course on health is given. Three units for health is also provided during the Bachelor of Secondary Education (B.S.Ed.). Prior to implementing the new elementary school curriculum, massive in-service training programmes were undertaken. In each Region, a core of trainers undertake such re-training sessions. This is now institutionalized in Learning Action Cells (LACs), set up in every school in the country where teacher-trainers facilitate such training. Centrally and locally prepared training materials called learning episodes (modules) are used in the LAC sessions. The teachers identify their needs and plan the sessions. The above is also true for training secondary school teachers - training of trainers (teams of six trainers trained for four weeks) for each region, followed by training of teachers for 1-2 weeks duration in the regional learning centers or leader schools. Separate training for health teaching for PEHM teachers is arranged.

Health education training manuals have been prepared by year level and used for training trainers and teachers.

Research, monitoring and evaluation is a part of education development programmes. Findings have helped in policy formulation and programme development. For example, research on factors affecting learning achievement validated school health and nutrition interventions and identified areas for expansion of the programme.

Monitoring pupil and teacher performance is the responsibility of subject area supervisors and heads of schools.

Philippines is a good example of a developing country which may be considered to have a comprehensive school health education programmes in terms of its scope, coverage, content, coordination and policy. However, there is room for improving the programme further and integrating it with health promotion activities at the grassroots level □

The Development of School Health Education in Syria

In Syria, various aspects of a comprehensive school health programme are addressed by the Government.

School health services are provided by the Ministries of Health and Education and covers medical examination at entry, preventive and curative services including immunization, routine check up of height weight, and vision of primary school children and oral preventive services. School health services are now being integrated with general health services.

Schools are actively involved in nationwide EPI campaigns especially in the urban areas and in some rural areas. During this period, teachers covered health teaching on the six preventable diseases, and other health topics.

The Ministry of Education has published several teachers guide books on different health subjects. Also, teaching aids are made available to teachers and health workers.

The school environmental conditions are monitored and improvements made.

In 1988, a survey of health subjects and health information in the science curriculum in primary schools was undertaken. It was found that 105 minutes were given to teaching health every week. In the primary level, 15 health topics are covered dealing with personal and environmental health. In the intermediate level, health and diseases are covered including nutrition, sport and microorganisms.

In the secondary level, health and disease is continued and includes parasites and immunology.

Teacher training institutions cover health topics included in the school curricula. There are also short courses on health offered by the Primary Health Care Department of the Ministry of Health for school health staff and teachers.



Box 14 (continued)

Health teaching is undertaken by other sectors than health and this sometimes leads to duplication.

Health education is not part of the education policy but recently steps have been taken to promote the implementation of health education in schools.

- A national planning committee for health education has been established within the framework of PHC in the MOH. Representatives from the Ministries of Health, Education and other organizations and members from the community comprise the Committee.
- The WHO/UNICEF/UNESCO prototype action-oriented curriculum with guidelines, teachers guideline and resource both containing 22 units have been adapted by the Ministry of Education. Its implementation in primary schools will be supported by UNICEF.

Since 1982, the government school feeding programme covers some schools in low economic areas assisted by the World Food Programme. This has shown an impact on health, learning achievement and dropout of pupils.

Though the six years of primary education is free and compulsory, there is a 10% drop out among girls in general. In rural areas, it is high. In the Northeastern provinces, 31-46% of girls drop out.

Ad hoc surveys have shown that 12% of boys and 6% of girls - 15 years old - smoke in urban areas. Data for accidents are not available but considered high.

UNICEF took very important action to promote teaching health and health education in schools in Syria through adapting facts for life to local setting and educational environment. A set of ten messages were produced covering the following subject areas: safe motherhood, breastfeeding, child development, vaccination, diarrhoeal diseases, respiratory diseases, prevention of accidents, sanitation, AIDS and child mental developments.

A special area near Damascus was selected which cover UNRWA schools for implementation and testing, a plan to utilize these health education



Box 14 (continued)

materials for all primary schools in Syria will be established taken into consideration results of testing and evaluation.

Priority areas for action include intervention for wide immunization coverage, oral rehydration, expanded school feeding programmes, school sanitation, safe water and disposal of wastes.

A plan of action to enhance school health education has been presented in the context of implementing the action-oriented school health education programme and includes establishing an intersectoral board, situation analysis, teacher training, implementation and monitoring and evaluation. Some activities under each of the above phases have already been initiated □

Planned Health Education Curriculum for Schools in Uruguay

Until 1990, health education in schools dealt with national health problems such as tuberculosis, chagas disease and equinococosis. In secondary schools, nutrition, substance abuse and sexually transmitted disease were part of the biology syllabus. The focus was on giving information and not on behaviour change. Recently, the ministries of health and education are addressing the prevention of AIDS and have a successful programme that receives the cooperation of teachers.

Starting in 1988, the Community Medicine Department in the medical school has initiated school health education activities involving teachers, student and parents covering current health problems in the community.

Since 1986, training programmes for teachers of biology and assistant teachers in secondary and technical schools have health education included in their curriculum.

In 1990, the secondary and technical school authorities adopted a national health education programme. At present, it is part of biology, but there is agreement to integrate it in other subjects as well. The WHO concept of health and the strategies of primary health care form the basis of the health curriculum. The objective is to promote healthy behaviour through making healthy choices.

Expectations of students, parents and the community in terms of meeting health needs have been taken into consideration in developing the health education programme.

A committee of subject experts and teachers was formed to develop the programme. A survey of biology teachers was made to know about their views on preparing a new programme.

The health education programme addresses community health problems and includes information about the problems and their solution using community resources and participation. It also focuses on practices both dangerous and conducive to health and helps children to make wise choices and cultivate healthy lifestyles.



Box 15 (continued)

In order to implement the new curriculum, workshops were held throughout the country for teachers. This was to familiarize the teachers with content and to prepare them to use the new work methodology in teaching.

In spite of developing a new health education programme and efforts to implement it, there are *several difficulties* in making it fully operational.

- Though there have been difficulties to ensure coordination at the central level with the Ministry of Health and the National Institute for the Welfare of the Young, it has been easy to form work groups at the provincial level, gaining the participation of teachers, members of the community and officials from institutions.
- Health has not been integrated in subjects other than biology.
- No policies have yet been formulated.
- The number of hours available to teach health is limited.
- Teachers need better training.
- Teachers have to do other work or leave for more lucrative jobs because of low pay.
- New teaching methodology requires more resources for application.
- Better coordination between the institutions and the community is essential.
- Values of individuals and social groups about sexual and addictive behaviour must not be transferred as the only valid opinion to students. Dialogue and thinking together must be facilitated.

In spite of the shortcomings, the new health education programme meets the approval of students, teachers and parents.

A step in the right direction has been taken in 1990 and measures to ensure implementation with support from the top will strengthen the health education programme. Policy support needs to be mobilized through strong advocacy efforts

Box 16

**Status of School Health Education in the
United States of America**

Public school education in the USA is a state and local school district prerogative. The Federal Government is involved with education at all levels but most public policy related to laws and regulations, curricula, guidelines, funding and overall decision-making is the responsibility of the respective state governments, agencies and about 15,000 local school districts.

Though school health education has made substantial progress over the past 10 years, an analysis of current status shows that the gap between the state-of-the-art and actual practice in school health education is larger than in any other area of the school curriculum.

The health education *curriculum* is variable and not really standardized, generally not well planned and often redundant. *Instruction* is heavily teacher and textbook oriented. *Teaching learning resources* are readily available and are generally good to excellent excepting in poor school districts. Outside agencies provide abundant resources and materials at little or no cost. Almost all secondary school teachers (grades 7-12) who teach health are certified to do so while most elementary school teachers (grades 1-6) are not adequately prepared for health teaching. However, certified teachers are better prepared in content than in methodology, implementation and evaluation.

Evaluation of health education is variable but generally poor at the school district level though progress made is encouraging. The national level studies initiated by the Federal Government during the 1980s is beginning to confirm the efficacy of school health education.

Some *problems* responsible for inadequate state of the practice in school health education are:

In terms of *coordination*, there is no real leadership at the Federal Department of Education, and near absence of school health coordinators. Health education is not a basic subject in the overall curriculum and is a local school district prerogative.



Box 16 (continued)

In the area of policy formulation, non-compliance with state regulations is common place and there is cultural resistance to mandates. Education about certain health topics is a controversial issue and until recently, there has been limited leadership for policy formulation from appropriate professional groups.

Programme development has been variable though recently this is being encouraged from both national and local level concomitantly. It is recognized that strong local involvement and support, being consistent with local values and mores, parent participation and strong support from district administration and school principals can contribute to successful programmes.

Major *obstacles* that need to be surmounted are the non-priority status afforded to school health education, school dropouts, rapidly changing community needs that need to be addressed in the curriculum, funding, teacher preparation, competition for time, resistance to change and past failures.

There are also opportunities which should be seized to promote health education, such as the concern for HIV/AIDS, drug abuse and adolescent health, impetus for school restructuring, recognition that healthy kids are better learners, need to control escalating health care costs and growing evidence of the efficacy of health education.

Taking note of the problems and obstacles and recognizing the opportunities to be seized and acted upon, there is a pressing need for promoting school health education nationwide by building coalition with all concerned parties, advocating to increase awareness among policy and decision-makers as well as with the public, ensuring social support, improving professional preparation, mobilizing funds and undertaking evaluation □

Programme Activities: Global and Interregional

“Continued attention will be paid to the development of strategies and approaches for health education and health promotion, in particular settings, and to the identification of high priority issues and target groups for the different activities such as school-age children, young people,....”

Source: WHO's Proposed Programme Budget 1992-1993. PB/92-93.



Health Education and Health Promotion for Specific Population Groups Children in Schools

“Children and young people attending school have to be given high priority. Not only does this age group represent one quarter of the world's population but it is a “captive audience” and hence cost effective to reach. Of these young people, 80% live in developing countries where four out of five now attend school. Thus the schools offer a feasible delivery system to 1,000 million young people!”

“The significance of education for health in schools has been recognized in official documents of WHO dating back four decades. Today's goals for this age group build on the past. They are more holistic and comprehensive in nature, recognizing the multitude of factors at work in the critical years when children and young people are maturing.”

Source: Health Promotion, Public Information and Education for Health, Progress Report presented by the Director-General of WHO to the Eighty-ninth Session of the Executive Board. EB/89/14, 10 December 1991

