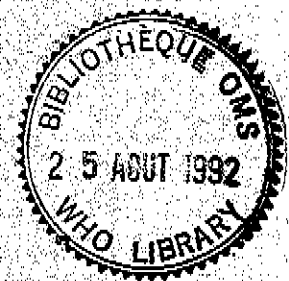


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**REPORT OF THE  
WHO/UNESCO/UNICEF CONSULTATION  
ON STRATEGIES FOR  
IMPLEMENTING COMPREHENSIVE SCHOOL  
HEALTH EDUCATION/PROMOTION PROGRAMMES**

Geneva, 25-29 November 1991



United Nations Educational,  
Scientific and Cultural Organization  
Paris



World Health Organization  
Geneva



United Nations Children's Fund  
Paris

The Director-General of WHO, Dr. Hiroshi Nakajima, has said, "Education prepares the child to be self-reliant and to be a healthy and productive citizen. 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. To learn effectively, children need to be in good health."

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## BACKGROUND

The health and well-being of children and youth must be a fundamental value for all countries. Recently, in addition to long-standing 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. That challenge provides the context for and the key questions to be addressed by a WHO/UNESCO/UNICEF Consultation proposed for both developed and developing countries.

The role of WHO and other UN agencies in advancing comprehensive school health education is more than four decades old. *Planning for Health Education in Schools* (1966), the result of the first UNESCO-WHO international consultation on school health education, noted that schools must seek to develop the kind of educated person who understands the basic facts about health and disease, protects and promotes his own health and that of his family, and helps to improve the health of the community.

Today's goals for the health education of school-age youth build on the past, but are more holistic and comprehensive in nature, recognizing the multitude of factors at work in the critical years when children and youth are maturing. In 1986, WHO and UNICEF published "Helping a Billion Children Learn About Health." It was based on an international consultation focused on:

- (1) the complexity of health learning among school-age children both in and out of school;
- (2) on assessing the current state of health education for this population; and
- (3) proposing strategies and guidelines for strengthening health education.

More recently, WHO has organized a number of working group sessions and in conjunction with UNESCO, UNFPA, and others, WHO organized working sessions and panel discussions on comprehensive school health education at the VII International Conference on AIDS (Florence, June 1991) and the XIV World Conference on Health Education (Helsinki, June 1991). The Consultation is another in a series of activities to promote comprehensive school health education.

There are important practical grounds on which to make the school health education of children and youth a high priority.

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. Thus, it may be possible for school health education programmes to reach many of the world's one thousand million children and young people of school age.

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. These benefits accrue:

- because of the documented linkages between the health status of children and their educational achievement;
- because one of the most important determinants of a child's health is the educational status of its mother. Therefore, efforts to increase the attendance and improve the school health education of girls can have a profound benefit.
- 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 health education guides people to think critically about health and social issues, encourages them to work collaboratively on problem solving, and provides them with the confidence and expertise to participate fully in their communities.

Knowledge about school-age youth on the one hand; and the benefits of school health education on the other, has accumulated valuable experience over the past four decades. With the collaboration of WHO and other international organizations, many countries have carried out successful programmes. Indeed, even when school health education programmes have been rigorously evaluated, there has been evidence of changes in students' health knowledge, attitudes, and most important, some evidence of changes in reported behavior.<sup>1</sup>

The health challenges facing school-age children and youth-and to which health education programmes must be directed-are complex and challenging.

For example, 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 infections, other infections, physical and mental disabilities, and reproductive problems (premature fertility, sexual violence, and exposure to sexually transmitted diseases).

The extent to which the health problems of developing and developed countries differ can be overstated. Certainly differences exist, but it is also crucial to appreciate the similarities.

Many of the lifestyle or behavioural choice-related health problems identified in recent reports about youth in developed countries (e.g., drinking, smoking, HIV/AIDS, pregnancy, sexually transmitted diseases, violence, and suicide) as well as unintentional injuries are equally problematic among school-age youth in many developing countries.

These, then, are the conditions that health and education planners and practitioners must address. Comprehensive School Health Education (CSHE) is the most efficient and effective approach to meet that challenge.

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<sup>1</sup> 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.

Realizing the significance of applying this approach worldwide, especially in the context of achieving the Education for All goals, WHO, UNESCO and UNICEF found it appropriate and timely to convene a Consultation on Strategies for Implementing Comprehensive School Health Education/Promotion Programmes to be held in Geneva, 25-29 November 1991.

## OBJECTIVES

- (1) To review the current strategies of health education;
- (2) To develop an understanding of the state-of-the-art characteristics of a comprehensive school health education programme and evidence supporting value of school health education.;
- (3) To identify barriers to and opportunities for strengthening school health education programmes;
- (4) To discuss and develop strategies and action steps to accelerate progress in school health education;
- (5) To develop guidelines for promoting and strengthening school health education.

A provisional agenda and programme (see Annex 1) were prepared for the Consultation to achieve the above objectives which were presented to the participants for adoption.

## PARTICIPANTS

The Consultation was attended by 18 participants<sup>2</sup> from 16 countries (Bahrain, Denmark, India, Kenya, Kuwait, Libya, Namibia, Nigeria, Papua New Guinea, Philippines, Poland, Sri Lanka, Syria, United Kingdom, USA) (see Annex 2).

Representatives from the UNFPA were present as well as observers from NGOs with programmes concerning schools - Commission of European Countries, World Organization of Scout Movements, World Federation of Teaching Professions, National Education Association, Education Development Center, and the League of Red Cross and Red Crescent Societies.

The Secretariat included staff from the three sponsoring agencies including staff from concerned programmes in WHO, the host agency.

## METHODOLOGY

Prior to the Consultation, participants were sent an outline for providing information about school health education in their countries including current status, problems encountered (re coordination mechanisms, policy formulation and programme development), current challenges and the extent of

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<sup>2</sup> The participant from Uruguay was unable to attend.

comprehensiveness. Information received was diverse in nature and participants were given some time to make a brief presentation during plenary sessions and to answer questions from the floor. Many participants brought with them health education materials developed for their schools and other audiovisual materials to describe their school health education programme.

A working paper entitled "Strategies for Implementing Comprehensive School Health Education Programmes: An Agenda for Action" was prepared to serve as a basis for directing deliberations at the Consultation (Annex 3). The paper, in addition to making a case for school health education and emphasizing the health of youth, pointed out the elements that are critical along the path towards comprehensive school health education. The four main elements identified were policy development, coordinating mechanisms, programme development and implementation and programme evaluation. An end piece was on strengthening health education in schools.

The Consultation was opened by the Director-General of WHO, Dr Hiroshi Nakajima, was Dr V. Kolybine, Director, Division of Health Education for the Quality of Life, UNESCO, and Mr A. Hewett, Chief, Programme Communications/Social Mobilization, UNICEF, and Mr H.S. Dhillon, Director, Division of Health Education, WHO, offered their remarks.

The Consultation elected Dr Trilok Sundari Kariyawasam as Chairperson, Mrs Khatoon Sanquor as Co-Chairperson, and Dr Ian Young as rapporteur.

The Consultation used both plenary and group work sessions to consider the agenda items.

Plenaries were used to make country reports, present outcomes of group discussions, to review and reach a consensus on the concepts and principles of comprehensive school health education and then to endorse a statement of CSHEP concept as well as to discuss strategies for action and ways of overcoming constraints and for utilizing opportunities.

Participants in four small groups discussed three themes namely, critical issues related to implementing national school health education programmes, opportunities and constraints that participants are aware of during planning and implementation of programmes, and formulating strategies for action (re advocacy and policy, the health curriculum, training of school personnel and health education opportunities and the classroom). Groups were provided with broad guidelines to focus their discussion.

## OUTCOMES

After lively discussions in groups and plenary, a consensus statement on the concept of CSHEP was prepared. Arising from the concept, ten principles were identified to guide actions. Using these principles and in the context of differing global situations, strategies for implementing CSHEP were developed with the understanding that each country will adapt and adopt these to their national conditions.

Based on the deliberations of the Consultation, a guideline on CSHEP has been prepared for the use of all those interested in modifying and planning school health education programmes along the way

to comprehensiveness. Appended to the guidelines are highlights of the country reports focusing on significant experiences and plans from which lessons can be learned.

## RECOMMENDATIONS

The Consultation proposed a variety of priority actions to advance the implementation of CSHEP internationally and to provide support for national activities:

- This document should be disseminated widely by the sponsoring agencies to ministers of education, ministers of health, and other officials.
- WHO should plan to promote the use of the Guidelines through regional and country workshops and encourage joint activities between the Member States. An international, ministerial-level meeting on school health education should be convened to endorse and support comprehensive school health education.
- Participants in this consultation should use this document in national and international efforts to advocate for CSHEP. Members of the European Community should explore ways to collaborate with other regions.
- An effort should be made by all participants to place CSHE on the agendas of the Health Promoting and Healthy Schools initiatives, the European Community School Health Initiative, WHO's Eastern Mediterranean and School Health Programme and Southeast Asian Regional plan for school health as well as the follow up activities to the Education for All Conference (Jomtien). Particular attention should be paid to infusing CSHE in the following international conferences:

World Federation of Teaching Professionals Meeting, 1992

UNFPA/UNESCO Population Education Conference, 1991

International Union of Health Educators (IUHE) 1994.

- Educating children for health through schools should receive the highest priority in countries not only from the point of view of health, but also from the point of view of education. Supporting evidence should be collected and shared between countries to make advocacy efforts effective.
- Those with expertise in health and education must be encouraged to play a major role in advocacy for school health education. Citizens who care about the future of their children and their nation should be made aware of their responsibilities to advocate for CSHEP.
- In each country, advocates will have to look at the prevailing conditions and needs (policies, resources, political climate, etc) before deciding when, where and how to initiate the process

towards educating children for health in a comprehensive way. The Guidelines would provide general directions to be adapted by each country.

- The participants recommend that WHO and UNESCO explore the development of model national CSHEP policies, the provision of technical assistance to Member States in using the Guidelines, in identifying priorities for action and in developing CSHEP marketing strategies.

ANNEX 1

**WHO/UNESCO/UNICEF CONSULTATION ON STRATEGIES FOR IMPLEMENTING  
COMPREHENSIVE SCHOOL HEALTH EDUCATION/PROMOTION PROGRAMMES,  
25-29 NOVEMBER 1991**

WHO/HQ, Geneva, Salle A

**PROVISIONAL AGENDA**

1. Opening of the Meeting
2. Election of the Chairman, Vice-Chairman and Rapporteur
3. Adoption of agenda and programme
4. Review of the current strategies of health education and developing an understanding of the state-of-the-art characteristics of a comprehensive school health education programme and evidence supporting value of school health education
5. Barriers to and opportunities for strengthening school health education programmes
6. Strategies and action steps to accelerate progress in school health education
7. Preparation of guidelines/documents for promoting and strengthening comprehensive school health education

## OPENING SESSION

*Monday, 25 November 1991*

- 09h00 Briefing on Consultation
- scope and purpose of consultation
  - introduction of participants
- 09h00 Opening Speech by Dr Hiroshi Nakajima, Director-General
- 09h45 Remarks by Dr V. Kolybine, Director, Division of Education for the Quality of Life, UNESCO
- Remarks by Mr A. Hewett, Chief, Programme Communications/Social Mobilization, UNICEF
- Election of Chairman, Vice-Chairman and Rapporteur
- approval of agenda and programme
- Administrative announcements
- 10h15 Coffe break

## PROGRAMME

### *Monday, 25 November 1991*

- 09h00        Opening session
- 10h15        Coffee break
- 10h30        Presentation of country reports
- 12h00        Lunch
- 13h30        Discussion on background paper
- 14h45        Organization of small groups and assignments
- 15h15        Coffee break
- 15h30-17h30 Continuation of country reports presentation
- 18h00-19h30 Reception in WHO

### *Tuesday, 26 November 1991*

- 09h00        Plenary: Lessons learned from country experiences and introduction to Group work on theme I
- 09h15        Group Work on theme I - Critical issues and major steps in strengthening school health education
- 10h15        Coffee break
- 10h30        Group work on theme I - continued
- 11h30        Plenary: Presentation of reports of group work on theme I and discussion
- 12h00        Lunch
- 13h30        Group work on theme II - opportunities and constraints
- 15h15        Coffe break
- 15h30        Plenary: Consensus statement on CSHE concept
- 16h00-15h30 Plenary: Presentation of reports of group work on theme II

*Wednesday, 27 November 1991*

- 09h00 Plenary: Strategies for strengthening CSHE
- 09h15 Group work on theme III - strategies for action: ways of overcoming constraints and utilizing opportunities
- 10h15 Coffee break
- 10h30 Group work on theme III - continued
- 12h00 Lunch
- 13h30 Group work on theme III - continued
- 15h15 Coffee break
- 15h30 Plenary: Presentation of interim reports of group work on theme III and discussion

*Thursday, 28 November 1991*

- 09h00 Plenary: Governing principles on CSHE - review of draft
- 10h15 Coffee break
- 10h30 Group work on theme III - continued - examining governing principles on CSHE
- 12h00 Lunch
- 13h30 Plenary: Preparing guidelines for strengthening school health education
- 15h15 Coffee break
- 15h30-17h00 Plenary: Presentation of reports on group work on theme III

*Friday, 29 November 1991*

- 09h00 Plenary: Presentation and endorsement of statement on CSHE and governing principles
- 10h15 Coffee break
- 10h30 Plenary: Towards an understanding on guidelines for CSHE
- 12h30 Closing session

## CLOSING SESSION

*Friday, 29 November 1992*

- |       |  |
|-------|--|
| 12h30 | Closing remarks by Chairman                    |
| 12h35 | Presentation by representative of participants |
| 12h45 | Presentation of guidelines format              |
| 12h50 | Follow-up plans                                |
| 12h55 | Closure of consultation                        |

ANNEX 2

WHO/UNESCO/UNICEF CONSULTATION ON STRATEGIES FOR IMPLEMENTING  
COMPREHENSIVE SCHOOL HEALTH EDUCATION/PROMOTION PROGRAMMES,  
25-29 NOVEMBER 1991, GENEVA

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ANNEX 3

Original: English  
Distr.: Limited

**STRATEGIES FOR IMPLEMENTING  
COMPREHENSIVE SCHOOL HEALTH  
EDUCATION PROGRAMMES:  
AN AGENDA FOR ACTION**

**Working Paper for the  
WHO/UNESCO/UNICEF Consultation on Strategies  
for Implementing Comprehensive School  
Health Education/Promotion Programmes**

Geneva, 25-29 November 1991

**Division of Health Education  
World Health Organization**

WHO/UNESCO/UNICEF CONSULTATION ON STRATEGIES FOR  
IMPLEMENTING COMPREHENSIVE SCHOOL HEALTH EDUCATION/  
PROMOTION PROGRAMMES, 25-29 NOVEMBER 1991, GENEVA

WORKING PAPER

1. INTRODUCTION

The Director-General of WHO, Dr. Hiroshi Nakajima, has said, "Education prepares the child to be self-reliant and to be a healthy and productive citizen. 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. To learn effectively, children need to be in good health."

The health and well-being of children and youth must be a fundamental value for all countries. Recently, in addition to long-standing 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. That challenge provides the context for and the key questions to be addressed by this background paper and the WHO/UNESCO/UNICEF Consultation for which it was developed.

Health problems such as HIV/AIDS may be new, but the role of WHO and other UN agencies in advancing comprehensive school health education is more than four decades old. *Planning for Health Education in Schools (1966)*, the result of the first UNESCO-WHO international consultation on school health education, noted that schools must seek to develop the kind of educated person who understands the basic facts about health and disease, protects and promotes his own health and that of his family, and helps to improve the health of the community.

Today's goals for the health education of school-age youth build on the past, but are more holistic and comprehensive in nature, recognizing the multitude of factors at work in the critical years when children and youth are maturing. In 1986, WHO and UNICEF published "Helping a Billion Children Learn About Health." It was based on an international consultation focused on (1) the complexity of health learning among school-age children both in and out of school, (2) on assessing the current state of health education for this population, and (3) proposing strategies and guidelines for strengthening health education. More recently, WHO has organized a number of working group sessions and in conjunction with UNESCO, UNFPA, and others, WHO organized working sessions and panel discussions on comprehensive school health education at the VII International Conference on AIDS (Florence, June 1991) and the XIV World Conference on Health Education (Helsinki, June 1991). The present

Consultation is another in a series of activities to promote comprehensive school health education.

## 2. A 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 availability of this population, the impact that health education can make on both health *and* education, and the existence of a rich tradition of successful experimentation 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. Thus, it may be possible for school health education programmes to reach many of the world's one thousand million children and young people of school age.

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. 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 and achieve. Therefore, "Efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education;"<sup>1</sup>
- because one of the most important determinants of a child's health is the educational status of its mother. Therefore, efforts to increase the attendance and improve the school health education of girls can have a profound benefit. And, of the 105 million school-age children who do not now attend school, at least 60 percent are female;
- 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 health education guides people to think critically about health and social issues, encourages them to work collaboratively on problem solving, and provides them with the confidence and expertise to participate fully in their communities.

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<sup>1</sup> 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.

Knowledge about school-age youth on the one hand; and the benefits of school health education on the other, has accumulated valuable experience over the past four decades. With the collaboration of WHO and other international organizations, many countries have carried out successful programmes. Indeed, even when school health education programmes have been rigorously evaluated, there has been evidence of changes in students' health knowledge, attitudes, and most important, some evidence of changes in reported behavior.<sup>2</sup>

### 3. YOUTH AND HEALTH

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 they reflect both health status and the environmental conditions in which children live, as well as the individual behavioural choices students make and the lifestyles they adopt.

For example, 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 infections, other infections, physical and mental disabilities, and reproductive problems (premature fertility, sexual violence, and exposure to sexually transmitted diseases).

The extent to which the health problems of developing and developed countries differ can be overstated. Certainly differences exist, but it is also crucial to appreciate the similarities. 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 scourge of HIV/AIDS has devastated citizens of both developing and developed countries. And, across the family of nations, disregard for environmental protection is leading to the proliferation of pollution-related diseases. Each of these health problems poses important questions for the development and implementation of school health education programmes.

Simultaneously, many of the lifestyle or behavioural choice-related health problems identified in recent reports about youth in developed countries (e.g., drinking, smoking, HIV/AIDS, pregnancy, sexually transmitted diseases, violence, and suicide) as well as unintentional injuries are equally problematic among school-age youth in many developing countries.

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<sup>2</sup> 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.

These, then, are the conditions that health and education planners and practitioners must address. Comprehensive School Health Education (CSHE) is the most efficient and effective approach to meet that challenge.

#### 4. THE CONCEPT OF COMPREHENSIVE SCHOOL HEALTH EDUCATION

It is appropriate to consider four ways in which the word "comprehensive" applies to Comprehensive School Health Education (CSHE).<sup>3</sup> 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, traditional and alternative curriculum and pedagogy, and by drawing upon services and opportunities available within and outside of the school;
- *harmonizes all of the health messages* by which the student can be influenced, messages from the school, from family and peers, the community, the health and development systems, and the media;
- *Empowers students to act* for healthy living and to promote conditions supportive of health.

Experience and research evidence suggest strongly that a CSHE approach can influence the health-related knowledge, attitudes, and behaviours of students. It is also recognized, however, that primary determinants of health status such as socioeconomic, cultural, environmental, and genetic factors will require that realistic expectations of such an approach need to be established by each country on an individual basis.

A CSHE approach includes a broad spectrum of activities and services that take place within and outside of schools in their surrounding communities in order to enable children and youth to enhance their health, and to develop to their fullest potential by achieving health as well as education.

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<sup>3</sup> All definitions of comprehensive school health programmes include an educational component, a health services component, and a school environment component. This paper and the WHO/UNESCO/UNICEF Consultation for which it is prepared deals with comprehensive school health education and focuses on the educational component.

CSHE provides a mechanism to facilitate learning for better health. However, it is not a panacea; for after all, the student learns from a variety of sources, in a variety of settings, and by a variety of ways, which they then internalize according to the realities of their living conditions to make it acceptable to them as individuals.

A comprehensive approach to school health education (CSHE) may be compared to the working of a clock (see Figure 1). Both require many components that work in synchronization to produce the desired result; in the case of CSHE, a well-informed health student. Successful implementation of CSHE requires leadership from key officials, adequate funding, administrative support, and appropriate policy.

## 5. CRITICAL PATH AND POINTS OF INTERVENTION

Health education efforts, like plants, have a natural history that stretches from the first seed of interest to the flowering of a fully developed programme. And while different programmes will grow in ways best adapted to their national and cultural realities, there is a critical path through which that natural history expresses itself.

The critical path in the evolution of comprehensive school health education is illustrated in Figure 2, which identifies stages in the process by which school health education takes place:

- Policy Development
- Coordination Mechanism
- Programme Development and Implementation
- Programme Evaluation

These four stages are listed, not as a prescribed sequence of actions, but rather as the key tasks to be accomplished. The important link among these steps, for any given country, is determining where and how it is most practical to intervene.

### POLICY DEVELOPMENT

This is the stage at which advocacy and interest in school health education, no matter what its source, become institutionalized. Both policies and the broad strategic framework of CSHE must be developed. Key questions of content and of process, addressed here, will determine the ultimate direction and speed with which the critical path to CSHE can be traveled.

Figure 1  
**COMPREHENSIVE SCHOOL HEALTH EDUCATION  
(CSHE)**  
A Reinforcing Approach!

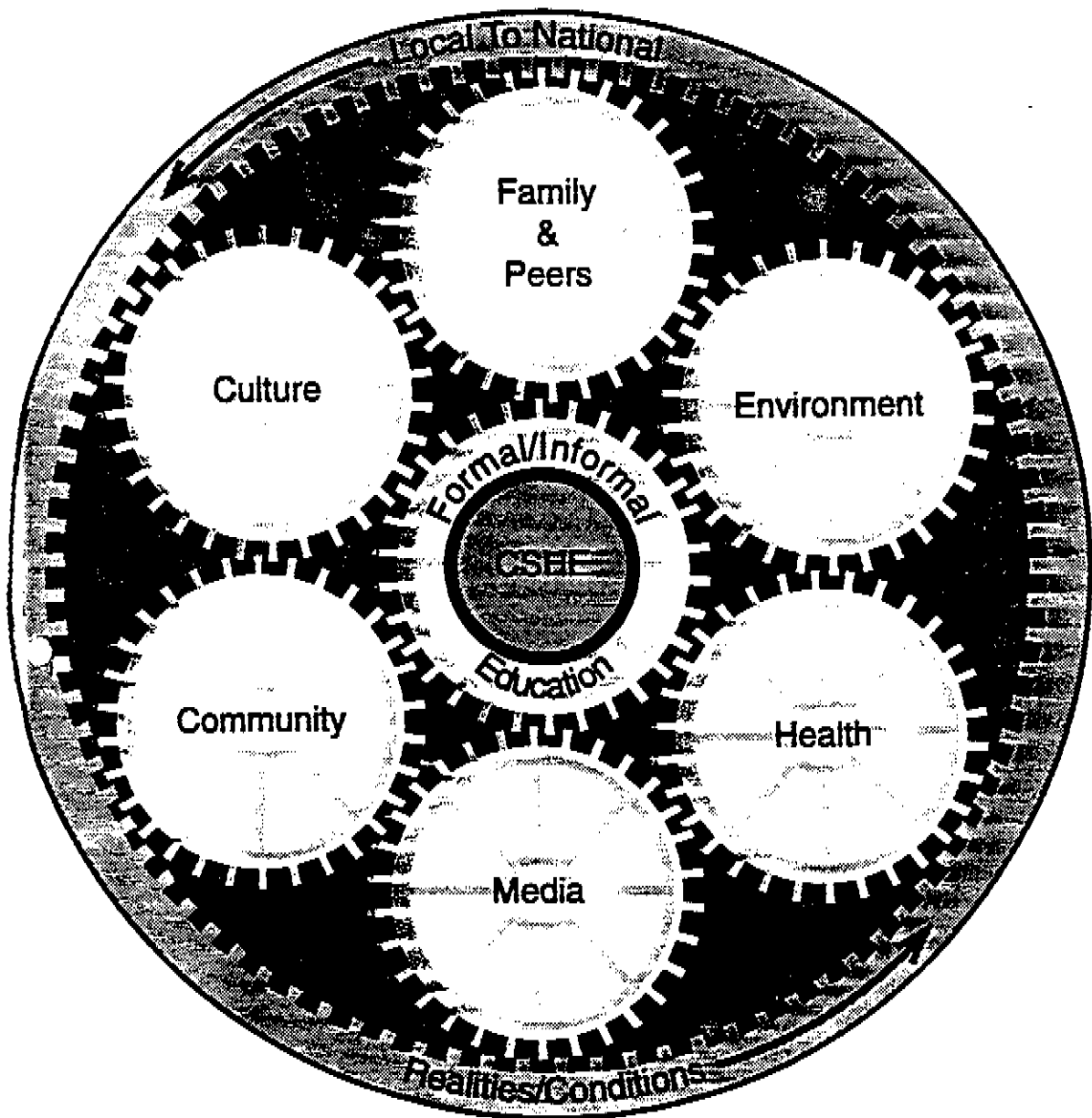
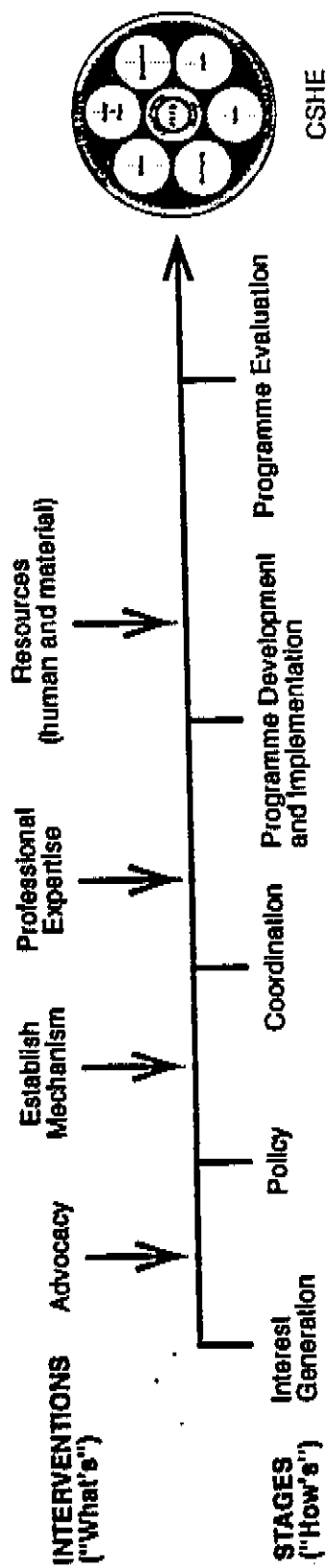


Figure 2  
**CRITICAL PATH IN EVOLUTION OF  
COMPREHENSIVE SCHOOL HEALTH EDUCATION (CSHE)**



The foremost question is the extent to which school health education is a national priority. Then the goals and objectives of the educational system must be examined to determine how they can best facilitate CSHE. What should the primary focus of school health education be—primary schools, technical schools, secondary schools, or all levels simultaneously? The policy development stage is the place to develop or strengthen collaborations with all relevant government agencies, as well as with non-governmental and community organizations that can support health education.

At the same time, policies must be developed that concern such content issues as the extent to which health education will build on categorical issues or adopt an explicitly comprehensive framework. Will health education focus on the student as an individual or on the student as a member of his or her community? How will curricula and other materials be developed and approved and what topics will be considered appropriate? How will health education exploit both formal and informal mechanisms of learning and support the use of alternative educational strategies?

Beyond these specific questions, in every nation, there will be an appropriate and effective point of leverage from which to advance the development of school health education. That point may be different in each country.

### COORDINATION MECHANISM

It is through the designation of a coordination mechanism that policies move from the realm of agreed-upon goals to practical objectives. Although the impetus for school health education policy will likely come from either the Education or Health Ministries, it is important that representatives from both be included in the coordination mechanism. Staff of other relevant agencies and organizations should play a role, as well. In this way, the coordination mechanism can have access to the relevant data and can mobilize the necessary resources to develop and implement school health programmes.

The coordination mechanism will need to determine what data exist or can be collected about the health needs and health status of school-age children and what resources are available for CSHE. What teaching about health now takes place, by whom, and to which students? What training do teachers receive about health and what factors would motivate teachers to stress the importance of health education (both within the school and as respected members of the community)?

By providing answers to these and other questions, the coordination mechanism will make it possible to develop programmes that are grounded solidly in the reality and conditions of the country.

## PROGRAMME DEVELOPMENT AND IMPLEMENTATION

During the programme development and implementation phase, the broad strategic framework created during policy development must be converted into practical programmes. The health needs of school-age youth and the available health education resources are united in CSHE programmes with specific goals and feasible, measurable objectives. Human and material resources are identified and direct lines of authority are established. Pilot or demonstration projects may be developed for different local areas or regions of the country. Mechanisms that involve youth, themselves, their parents, and members of the community should be explored. Also important is the creation of mechanisms that encourage reinforcing health education messages in society at large, including the media. Plans should be made for the acquisition, development, and dissemination of health education materials. The preparation of teachers, at both the in-service and pre-service levels is critical.

Programme development and implementation, therefore, require both faithful adherence to the national goals of CSHE and *flexibility* in carrying out the specific objectives.

## PROGRAMME EVALUATION

When evaluation is done properly and consistently, it can determine whether and how a programme is effective. If demonstration projects in regional or local areas are evaluated, their broader applicability can be determined before more expensive national programmes are carried out.

Both process evaluation (how a programme is being carried out) and outcome evaluation (what were its effects) are important. And, while every programme should be evaluated, not every programme requires the same level of methodological rigor or expense. Without evaluation, however, it is difficult either to clarify the impact of the programme on its target population or to identify and correct problems in implementation as they arise. And, a strong evaluation can be an important tool in supporting and expanding the policies on which the school health education programme was based.

## 6. ISSUES AND CHALLENGES

In keeping with the framework discussed above, we will use the same four headings here. However, it should be noted that many issues and challenges apply to more than one of these headings.

For example, at each stage, it is necessary to identify a group of professionally competent and knowledgeable staff. Policy development may require the establishment of an interagency steering committee, which will need the assistance of a group of staff knowledgeable about the health and education for school-age youth. Programme development and implementation will not be

possible without a cadre of skilled programme managers and, especially, the critical mass of supervisory and technical support staff who will carry out the CSHE programme. Finally, programme evaluation is a complex endeavor that requires trained specialists.

## **POLICY DEVELOPMENT**

**Interest Generation.** Enhancing political commitment is an essential part of the process by which CSHE becomes a national priority. The most important element in policy development is to understand the policy making process, itself. How are policies established and priorities set? Who are the key actors? Challenges include developing strategies for advocacy, building alliances, and gathering the evidence of school health education successes.

**Information for Advocacy.** Interest generation and advocacy are two sides of the same process. What are the arguments that will support the elevation of school health education to a national priority? To what extent can moral and philosophical arguments be supported by empirical data? How can policymakers and members of society be convinced of the extent to which good health is a prerequisite for school achievement? Is the role of health education in reducing morbidity and supporting economic development understood? Working with the media to transmit these and other CSHE-supporting messages is an important challenge.

**Interagency Steering Committee.** Establishing an interagency steering committee will facilitate policy development and the creation of the broad strategic framework that must guide programme development and implementation. The steering committee may itself be divided into specialized working groups. The coordination mechanism, which is established to develop and oversee implementation of the CSHE Programme must be linked directly to the ministries and agencies represented in the steering committee.

**Resource Identification.** Policy development for school health education must include the identification of resources. To what extent can new programmes be funded through existing education or health budgets and other resources? Will the priority accorded to school health education generate increased expenditures? Are international organizations and donor agencies possible sources of support? The answers to these questions will affect the scope, depth, and sustainability of CSHE programmes.

**Impediments to School Health Education.** These include different and competing national priorities, financial constraints, and the lack of resources. Poorly trained or inadequately paid teachers may pose another constraint. And social norms or cultural beliefs (e.g., attitudes towards sex education or widespread availability of condoms) may impede the teaching of health. The challenge, at the national level, is to involve diverse constituencies in reaching a consensus that will advance CSHE.

## COORDINATION MECHANISM

**An Efficient Instrument.** The coordination mechanism must convert the broad goals and strategies for school health education to specific, effective programmes. It must facilitate CSHE and not become an impediment to smoother programme development and implementation. It requires, therefore, both a direct link to senior policy makers, as well as a high degree of autonomy. It must rely on a core staff of competent professionals, both within the coordination mechanism, itself, and at various levels in all of the relevant agencies required to transform policies into plans and strategies for action.

**Building True Multisectoral Efforts.** In developing the coordination mechanism, it is a challenge to create lines of authority and participation that encourage multisectoral support. Who should be responsible for initiating such efforts? What practical steps can be taken? What coordinating mechanisms are necessary at the national, intermediate, and local levels to sustain and strengthen collaboration? These are a few among the questions that must be addressed to meet this challenge.

**Resource Mobilization.** The resources identified during policy development that can support school health education will always be limited. Certainly this is true during a period of worldwide recession. The coordination mechanism's challenge, therefore, is to identify and maximize the use of national community and natural resources.

## PROGRAMME DEVELOPMENT AND IMPLEMENTATION

**Curricula.** In developing a school health education programme, it is critical to determine whether curricula are focused on the 3Rs, overcrowded, or can otherwise easily accommodate school health content. Should health education be conceived of as a separate subject or integrated into other areas? Does the curriculum reflect the health needs and conditions of local communities? Are the teaching methods active and directed at changing behaviour? Is it age-appropriate and easy for teachers to use? How, specifically, can the curriculum be made responsive to the needs of girls and young women? What will the process be by which curricula will be developed or adapted from existing material?

**Educational Approaches.** The challenge is to identify and utilize all of the available educational approaches, formal and informal, traditional and alternative. Can interactive radio instruction (IRI) or other forms of distance education play a role? Answering such questions can help to determine the content of the school health education programme.

**Learning Opportunities.** In addition to identifying the primary educational approaches through which CSHE will be taught, it will be necessary to identify all of the additional learning opportunities offered through the school (e.g.,

school sports or health services) or community. Then the challenge will be to blend and coordinate each of these possibilities. Further, it is important to bring together the school health education-reinforcing linkages with school health services and the school and community environment, in general.

**Teacher Preparation.** Teachers must be prepared, through inservice, pre-service, and continuing education, to support, transmit, and exemplify the messages of school health education. Teacher preparation is as important as curriculum development, in reality, a curriculum is only as good as the teacher who is prepared and motivated to teach it. What type of training do they need? Who will provide it? What are the resources to support teacher preparation? How do you create the demand for better-trained teachers? And, most important, how do we inspire and motivate teachers to adopt healthy behaviors, themselves, to model for students the attitudes and behavior embodied in the school health curriculum?

**Teacher Support.** In addition to good training, teachers of health education require good materials and ongoing support. Unlike the 3Rs, health education raises additional questions of values for teachers, administrators, and students alike. What kind of supervision and support will be provided? Will there be periodic retraining and ongoing communication with teachers or their supervisors? Responding effectively to such needs for support will improve the programme's chances for success.

**Harmonization of Health Messages.** The model of comprehensive school health education, as pictured in Figure 1, recognizes that a student's health learning reflects messages from many sources: family and peers, the community, the media, and health and development workers. The challenge is to minimize conflicting influences from these sources and to harmonize and reinforce the central messages of CSHE. Who are the people at the grass roots who can contribute to and support CSHE? What might be the role of religious institutions, development workers, agricultural workers, and others in advancing school health education?

**Effective Programme Management.** Finally, the success of even the best designed programme can be compromised by inadequate resources and ineffective management at any level. The need for sufficient numbers of staff with planning, supervision, and evaluation skills can not be overestimated. Building and supporting a cadre of dedicated, competent staff is a critical challenge in programme implementation. This includes making sure that staff have the necessary skills to conduct ongoing process evaluation and to support the outcome evaluation (even if the outcome evaluation is being conducted by specialists). Finally, the importance of disseminating the findings cannot be overestimated. It is a key both to replicating successes and avoiding pitfalls. It can also be important in generating additional support for CSHE efforts.

## PROGRAMME EVALUATION

A Commitment to Evaluation. Programme evaluation, when systematically carried out, produces critical insights into what worked and how. Yet evaluation is infrequent in school health education programmes. Thus, at the very earliest stages of policy development, evaluation must be identified as a component of the programme. Evaluation staff should participate at the inception of programme development and implementation, in order for evaluation to be an integral and reinforcing part of the process.

Ongoing Process Evaluation. Monitoring the implementation of new programmes can have enormous value in identifying successes as well as areas for modification. Simple procedures must be developed for local-level staff to carry out process evaluation and sufficient numbers of trained evaluators must be available to provide technical assistance when necessary. Early in the programme, formative evaluation can play a useful role in the development of curricula and other materials. Involving representatives of youth, parents, and of different community groups in the process of information gathering and development of curricula and other materials can help to maximize their acceptability. Working with teachers can help to develop materials that are not only relevant in their content, but teachable.

Appropriate Outcome Evaluation. Rigorous outcome evaluation is expensive and time consuming. While every programme can benefit from process evaluation (and usually formative evaluation also), not every programme requires a systematic outcome evaluation. This is an issue for policy development and should be determined long before the programme is implemented. However, it is only through such evaluation that we will ultimately know what effect the programme has had on the health-related knowledge, attitudes, and behaviours of students.

## 7. ACTING TO STRENGTHEN SCHOOL HEALTH EDUCATION

Education for health is the fundamental right of every child-to have access to the knowledge, values, and skills that will empower a child to pursue a healthy life.

For decades, there have been many activities in many nations to develop and improve school education. Research and practice have demonstrated the efficacy of a comprehensive approach. It is now crucial that we share our knowledge and experience about the implementation of CSHE programmes, to determine where we have come and how we will move forward.

The critical path in the evolution of CSHE illustrates the many possible points of intervention to strengthen the health education of school-age children. The best stage to begin will be dictated by the realities and conditions of each country. However, strengthening CSHE will include a number of critical steps.

- It requires enhancing the recognition of the importance of equipping children with the knowledge, attitudes, and skills to empower them to pursue a healthy life, and the understanding that schools offer the best opportunity to achieve that end.
- It requires political will and commitment as well as policy, legislative, and fiscal support. CSHE must be elevated to a national priority, through advocacy based upon the evidence of its benefits to the individual, the community, and the nation. Advocacy must be conducted through all channels, including the media, to reach senior policymakers and stakeholders in all sectors.
- It can be championed by a few committed professionals and visionaries through well-considered efforts.
- It calls for involvement and alliance-building with various sectors of society.
- It is possible to capitalize on and join with global efforts, such as Education For All and movements for education-for-life-skills or environmental education, to emphasize that education must be defined broadly to include health. The worldwide concern over such issues as AIDS and environmental pollution can also provide support for school health education programmes.
- Investment in teacher preparation and the development of teaching/learning materials and a space in curricula are essential and could be managed with limited additional resources.

Comprehensive school health education programmes have the power to make enormous differences in the lives of children, their parents, their communities, and nations. Every year, the evidence supporting that fundamental belief grows stronger. Certainly, we do not know everything, but just as surely we know *enough* to act, and we are obliged by that knowledge to act. If we turn our attention now to the implementation of CSHE in every country - how each of us, whether from education, health or other related sectors, can move forward from our own strengths - we can bring much closer the goal expressed by the Director-General, Dr Hiroshi Nakajima, that every child will be educated and able to live a healthy and fulfilling life.

ANNEX 4

WHO/UNESCO/UNICEF CONSULTATION ON STRATEGIES FOR IMPLEMENTING  
COMPREHENSIVE SCHOOL HEALTH EDUCATION/PROMOTION PROGRAMMES

Geneva, 25-29 November 1991

Opening Address by Dr Hiroshi Nakajima  
Director-General, World Health Organization  
(25 November 1991)

Mr Chairman, distinguished colleagues, ladies and gentlemen,

It gives me pleasure to welcome you to Geneva and to thank you for having accepted our invitation to participate in this consultation on strategies for implementing comprehensive school health education/promotion programmes.

I am pleased to welcome representatives of the sister organizations sponsoring this consultation and also the representatives of nongovernmental organizations.

I consider this to be a very important consultation. A healthy and educated child population means a healthy and prosperous future. There are about 1000 million children and young people of school age in the world today. Out of this number, hundreds of millions are actually attending school. They constitute the greatest single readily reachable population.

Are we able to take up the challenge of educating children for health? Schools provide an excellent opportunity for helping children to acquire health knowledge, skills and values, and thus for shaping a brighter future.

Education prepares a child to be self-reliant and to be a healthy and productive citizen. 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.

It is sad, but true, that all too often school health education is considered as "something extra", a matter of peripheral interest, and is given low priority. Yet, these young people are the parents, the citizens, and the leaders of tomorrow. Theirs is the health of the future. We cannot afford to leave the future to a generation only casually educated about life. Indeed, everybody agrees with the importance of school health education, but goodwill alone, however important, is not enough.

An urgent task before us, therefore, is to place school health high on the educational agenda of our schools. To achieve this, we must furnish evidence that effective school health education programmes make an important difference, not only in knowledge, but in the attitudes and behaviours that result in healthy life-styles, and contribute to educational achievements and future prospects. Such evidence exists. Let us share it effectively.

Major breakthroughs have been made in strengthening school health education in both developed and developing countries. Some have used innovative approaches for effective national coverage. We need to study these experiences; learn, adapt and make improvements to suit our own needs and circumstances. WHO has been an active partner and has supported its Member States in these efforts.

In today's world, school education is expected to expand beyond the teaching of reading, writing and arithmetic to include education in life-skills. Education for health must form an essential component of education for life-skills.

I need not dwell on what is meant by comprehensive school health education. Such education must take a holistic view of health, and use to the best effect all opportunities for health learning and action for health. The school setting, the home environment, the community and the influence of the media must all be utilized in a working association to make the health education of children comprehensive in its truest sense. This has been shown clearly in a number of countries where schools collaborated with the local health services to achieve the immunization programme's impressive success.

Intersectoral collaboration is essential for the proper planning and management of school health education programmes, especially between the health and education sectors. Unless such collaboration is secured at country level, efforts to promote health through schools will remain, at best, sporadic and disjointed. It is our duty to join hands with governments and with concerned international agencies, so that experience and expertise can be shared for achieving well-coordinated and comprehensive school health education programmes.

When talking about the large number of school-age children, let us not forget that many of them do not attend school and are often hard to reach. The learning needs of out-of-school children was in fact one of the subjects discussed at the Technical Discussions on The Health of Youth, held during the Forty-second World Health Assembly in May 1989, and at the World Conference on Education for All, held in Thailand in 1990.

It is common to emphasize the economic benefits of a programme. No doubt this is important. However, there is a need also to recognize the moral basis for ensuring education and health for all. Also, leaders in health and education, while seeking to capitalize on the new infusion of political will, must not abandon their obligation to promote an educational system which focuses on the "whole" student - that is a system which not only prepares children for employment but also helps them to be fully-functioning individuals in society.

As experts in this multisectoral field - for educating school-age children for health is truly multisectoral - I am confident that at the end of the week you will leave us with a tangible product: a draft set of guidelines for a comprehensive approach to school health education.

I wish you every success in your deliberations and an enjoyable stay in Geneva.

SCHOOLHED  
PB/sa  
22.11.91