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SCHOOL HEALTH

Despite advances in health and the unprecedented social and economic development of recent decades, more than 3 million people between the ages 30 and 69 years die each year from preventable noncommunicable diseases (NCDs) in the Western Pacific Region. Common risk factors for NCDs often begin in childhood and adolescence. In the Region, there was a twentyfold increase in overweight and obesity among children and adolescents from 1975 to 2016. The current prevalence of heavy episodic alcohol consumption in the Region among adolescents aged 15–19 years is 13.6%; nearly 6 million children aged 13–15 years regularly use tobacco products; and almost 90% of adolescents are not doing enough physical activity. Other risks to the health and well-being of today's children and adolescents – such as bullying, mental health problems and other forms of substance abuse – are also precursors to significant health problems during adulthood.

Investing in health in schools is a strategic opportunity to change this: the Western Pacific Region is home to around 600 million children and adolescents, the vast majority of whom spend more than a third of their time each year in school. By investing in schools as “incubators for health”, we can nurture today's children and adolescents to recognize, learn, understand and embed the healthy behaviours that are the foundation of long, healthy lives.

The Regional Committee for the Western Pacific is requested to consider for endorsement the draft *Regional Framework on Nurturing Resilient and Healthy Future Generations in the Western Pacific*.

1. CURRENT SITUATION

Despite advances in health and the unprecedented social and economic development of recent decades, children and young people in the Western Pacific Region face a range of threats to their current – and future – health. In 2019, almost 280 000 people aged 5–29 years, including nearly 53 000 children aged 5–14 years, died in the Western Pacific Region – most from preventable causes, such as unintentional injuries (road accidents, falls and drowning) and intentional injuries (suicide). NCDs continue to be the leading cause of deaths among the adult population accounting for 82% of premature deaths in the Region, the seeds of which are often sown in childhood and adolescence.

The prevalence of NCD risk factors among children and adolescents is rising rapidly. There was a twentyfold increase in overweight and obesity among children and adolescents in the Western Pacific Region from 1975 to 2016, which is at least in part attributable to low levels of physical activity: in 2016, 89% of girls and 83% of boys aged 11–17 years in the Region were doing less than 60 minutes of daily physical activities. The current prevalence of heavy episodic alcohol consumption in the Region among adolescents aged 15–19 years is 13.6%. Nearly 6 million children aged 13–15 years are regularly using tobacco products. The prevalence of these risk factors is a problem for the health of children and adolescents today, but it portends even bigger problems – that is, significantly increased likelihood of NCDs – as this generation reaches adulthood.

Beyond NCD risk factors, infrastructure and resource gaps in schools arising from economic inequities can have direct harmful effects on children and adolescents' health in the short and medium terms – and subsequently on their educational performance and life prospects. In some parts of the Region, old and poorly maintained school buildings may pose risks to safety, such as lead contamination of drinking-water from ageing plumbing. Schools in disadvantaged communities are more likely to be situated near highways, factories, power plants and other sources of air pollution. Basic sanitation to protect against diarrhoeal disease and other bacterial illnesses may be absent or inadequate in schools situated within poorer communities.

The COVID-19 pandemic has also brought to light the need for a fresh and innovative perspective on school health. Evidence is now accruing about the adverse health impacts of prolonged school closures on students' ability to learn effectively, as well as their physical and mental health. Students who are not in the classroom report increased loneliness, difficulty in concentration and retention of information, and heightened anxiety. Depression and suicidal thoughts are increasing among school-aged children and adolescents, coinciding with the pandemic. Moreover, school closures have

contributed to physical inactivity, unhealthy eating habits, disruptions in sleep, and increased vulnerability to domestic violence and online exploitation.

Scaling up efforts to invest in health in schools is a strategic opportunity to address current – and future – threats to the health and well-being of children and adolescents. A large majority of the Region's 611 million children spend up to six hours a day for approximately nine months of the calendar year in school. By working with schools to ensure children and adolescents have the knowledge, attitudes and skills to adopt healthy behaviours for life, we can reduce the prevalence of NCD risk factors and, therefore, the burden of NCDs later in life. Conversely, if we do not grasp the opportunity to address risks to health and well-being faced by the current generation of children and adolescents, the burden of chronic ill health, disability and premature mortality in the future will continue to grow.

2. ISSUES

2.1 Schools as “incubators for good health”

Investing in healthy schools that will create a nurturing and inspiring environment on healthy living will have an impact on students' behaviour by ensuring they have the knowledge, attitudes, values and skills to adopt healthier lifelong behaviours. Schools have tremendous capacity to mould, influence and inspire children and adolescents to achieve their highest capability and potential. Schools also have a protective function, providing a safety net for children and adolescents exposed to health risks at home. Supportive environments – structural, social and policy related – also impact on the attitudes and behaviours of school faculty and staff, and others including the family and broader community. Furthermore, school policies and practices should reflect health as a core value, whether it is in the selection of classroom curricula or lunchroom menus, the adoption of tobacco, alcohol and drug-free policies, or the provision of student and staff mental wellness services. These policies and practices shape the physical environment of the school, which should address the need for safety, security and health-promoting resources. Likewise, the school curricula should reinforce the integral value of health while reaffirming the redemptive importance of a good education. There are also essential health services, including medical screening, eye and vision examinations, vaccinations and dental check-ups that, when integrated into the school setting, can provide greater access to health care for children and adolescents – especially for those who do not have good access to these services in their communities.

Schools are also workplaces. Investing in faculty and staff health can have benefits for individual staff and, through them, their students as well as their families and communities. Enhancing staff

capacities to embed health in curricula and learning activities, and to model healthy behaviours, strengthens their ability to be effective agents of change for their students.

Therefore, all Member States can reap short-, medium- and long-term benefits by investing in healthy schools to achieve the vision of health through the life course by focusing on nurturing healthy children and adolescents.

2.2 Healthy children who can influence and impact society

Schools are natural hubs within neighbourhoods, uniting families, educators and community partners to provide students with education, enrichment, health and social services, and opportunities to succeed in school and in life. Many positive outcomes occur when schools and the community work together. However, the potential of community involvement and engagement in schools is not always fully realized. Specifically, the benefits that accrue are not unidirectional, with the students merely as beneficiaries of the school–family–community partnership. The opposite is also true: students can transmit healthy behaviours to their families and communities. Acting as influencers, children and adolescents can internalize healthy behaviours and values acquired in school and effect change within their families, neighbourhoods and broader communities. Therefore, supporting schools with the ideal setting to nurture healthy children will have a positive impact on their academic achievements, health status and their community at large.

2.3 Investment in healthy schools for social capital

Education is inextricably linked with health, and thriving at school is an important predictor for adult health and well-being. This highlights the need to coordinate and integrate educational and health policies to promote positive outcomes in school performance, academic well-being and health during the significant years of development and learning. Further, governments and schools should pay attention to building social capital in the school context, as an essential component for ensuring health throughout the life course and the economic viability of society. Thus, investing in healthy schools is an investment in future health and development. Multisectoral participation, strong partnerships and networking are necessary for better coordination of resources and technical support to effectively establish and sustain healthy schools.

3. ACTIONS PROPOSED

The Regional Committee for the Western Pacific is requested to consider for endorsement the draft *Regional Framework on Nurturing Resilient and Healthy Future Generations in the Western Pacific*.

