2nd ANNUAL MEETING OF THE SCHOOL HEALTH COMPONENT
WHO MEGA COUNTRY HEALTH PROMOTION NETWORK

WHO, Geneva, 15-17 June 1999
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Recommendations and Proposed Collaborative Actions to Help Schools Improve the Health of Nations (Final Session)

Facilitated by Lloyd Kolbe and Cheryl Vince-Whitman

Participants spent the final session of the meeting discussing actions to support schools to improve the health of nations. The following recommendations were agreed upon by the group:

Recommendations to UN Agencies

1. WHO should convene relevant UN agencies (including UNAIDS, UNESCO, FAO, UNFPA, UNICEF, WHO) and the World Bank to develop a framework of complementary actions each agency might take to support schools in their efforts to improve the health of nations. As part of this framework, these UN agencies should identify processes by which they might work together and give priority to essential actions that can be implemented by schools in resource-poor countries to improve the health of pupils, families, school personnel and community members. The draft framework should be implemented in at least one nation to test and modify the framework.

2. Ministers of Education from the nine most populous developing nations (the “E-9”) regularly meet to achieve the goals of Education For All. At one of their recent meetings they asked to have one of their meetings focus on developing school health programmes as a means to attain Education For All. Since the E-9 nations include all of the nations in the Mega Country Health Promotion Network except Egypt, WHO and other relevant UN agencies should collaboratively plan an E-9 meeting at which the Ministers of Education might explore concrete options for improving school health programmes within their respective nations.

3. WHO and UNESCO should work together to develop complementary strategies for improving school health programmes (e.g., provide training for school administrators, teachers and college of education faculty through distance learning and technical training websites) as explored by both these UN agencies at the Second Annual Meeting of the School Health Component for the Mega Country Health Promotion Network convened in Geneva on 15-17 June 1999.

4. The Director Generals of WHO and UNESCO should jointly sign a letter addressed to the Ministers of Health and the Ministers of Education of at least the 10 Mega Countries to say:

   a. That school health programmes provide one of the most efficient means available for most nations to continuously provide for young people all five elements of an "essential public health package", including:

      • an expanded programme on immunization, including micronutrient supplementation
      • programmes to treat worm infections and micronutrient deficiencies and to provide health education
• programmes to increase public knowledge about family planning and nutrition, about self-cure or indications for seeking care, and about vector control and disease surveillance activities
• programmes to reduce consumption of tobacco, alcohol and other drugs
• AIDS prevention programmes with a strong STI component.

b. That consequently, both WHO and UNESCO have made school health programmes one of their priorities

c. That WHO and UNESCO, and other UN agencies, are working together to help schools around the world to improve the health of young people

d. The Director Generals call on the Ministers of Education and Health to jointly improve school health programmes within their own nations, and to work together with WHO, UNESCO, other UN agencies and Mega Countries to achieve that goal.

5. WHO has drafted a technical book on Improving Health through Schools: National and International Strategies. Participants welcomed the relatively detailed information in the six sections of the book as very useful to those responsible for implementing strategies to improve school health programmes internationally, nationally, regionally, in states/provinces and locally. WHO also provided leadership in drafting a chapter on “Building the capacity of schools to improve the health of nations,” which is scheduled to be published in the book Global Health in the 21st Century in the Spring of the Year 2000. Participants encouraged WHO to publish the two documents as soon as possible, translate them into the most commonly used languages, and distribute them to Member States.

6. Mechanisms for ongoing learning and capacity building among countries, WHO and other UN agencies and the Collaborating Centres are needed to sustain momentum between annual Mega Country meetings. WHO and its Collaborating Centres should use electronic methods and conference calls to moderate ongoing discussions and exchange among participants on substantive topics that will support country work. Initially, the focus on building these mechanisms for ongoing learning should be with meeting participants and gradually extend to others. Evaluating the extent to which these mechanisms take shape and support learning would be advantageous.

Recommendations to Mega Countries

7. Representatives from the Ministries of Health and Education who attended the meeting could jointly write and sign a letter to the Ministers of Education and Health of their respective nations to brief them about their participation in the School Health Component for the Mega Country Health Promotion Network. The letter could:

• include the final Report of the Second Annual Meeting of the School Health Component for the Mega Country Health Promotion Network (as an enclosure).

• apprise the Ministers that they may receive a letter signed jointly by the Director Generals of WHO and UNESCO urging them to strengthen their
working relationship to improve school health programmes as a means to enhance the health and education of young people.

- invite them to work together with WHO, UNESCO and other Mega Countries to achieve that goal.

WHO and UNESCO might prepare a model letter for representatives from the Ministries of Health and Education who attended the June 15-17 meeting to jointly revise and jointly send to their respective Ministers of Education and Health.

8. Representatives of the Ministries of Education and Health from interested Mega Countries could provide technical support to those within their respective nations interested in improving school health by providing information to them about available school health websites (e.g., at WHO <http://www.who.int/hpr>; at the Education Development Center <http://edc.org/HealthIsAcademic>; at the US Centers for Disease Control and Prevention <http://www.cdc.gov/nccdphp/dash>; and at the World Bank <www.worldbank.org/html/schools>). They could also develop a school health website for their own respective nations, and link that site to other school health websites.

9. Representatives of the Ministries of Education and Health from interested Mega Countries, with the participation of their respective national teachers’ unions, could jointly apply for funding from WHO to implement at least one of the following actions within their respective nation:

- WHO’s Rapid Assessment and Action Planning Process to develop partnerships and a national plan of action for improving school health programmes.

- a Youth Risk Factor Surveillance System.

- a national conference to improve school health programmes.

- a pilot project, based on WHO’s Information Series on School Health, to create evidence of effectiveness; or adapt, implement, and evaluate interventions with evidence of effectiveness.

The application process is described in WHO’s “Request for Cooperative Action: Strengthening national capacities to promote health through schools,” which was provided at the meeting.

**Recommendations to the WHO Mega Country Health Promotion Network**

10. Relevant WHO staff might meet and/or correspond with representatives from the broader Mega Country Health Promotion Network, and with representatives from the School Health Component of the Mega Country Health Promotion Network, to plan how we might most effectively integrate respective activities, especially on the two priorities of the Mega Country Health Promotion Network-- i.e., tobacco and surveillance. WHO staff could describe the proposed plan at the next meeting of the School Health Component of the Mega Country Health Promotion Network.
11. The Third Annual Meeting of the School Health Component of the Mega Country Health Promotion Network could be scheduled one year after the Second Annual Meeting. WHO should schedule the next meeting to take place immediately before the Fifth Global Conference on Health Promotion, in June of the Year 2000, in Mexico City.

Conclusion

As illustrated by the proposed actions listed above, the Second Annual Meeting of the School Health Component for the Mega Country Health Promotion Network was successful in identifying and recommending a range of strategic actions that could efficiently enable member States to improve the health and education of the world’s young people by improving school health programmes. Representatives from the Ministries of Education and Health who attended the Annual Meeting expressed their gratitude for the leadership WHO is providing to develop collaborative actions within and among UN agencies, international nongovernmental organizations, and national Ministries of Education and Health.
DETAILS OF PRESENTATIONS AND DISCUSSIONS
OPENING SESSION

Welcome remarks and description of Social Change & Mental Health Cluster (HSC)

Dr. Y Suzuki, Executive Director, Social Change and Mental Health Cluster

Dr. Suzuki extended his heartiest welcome to participants from 10 of the most populated countries. He used the opportunity of his opening statement to:
1. Introduce the members of the Network to the new cluster called Social Change and Mental Health (HSC), in which the Department of Health Promotion is located;
2. Share ideas about why the Global School Health Initiative (GSHI) is important;
3. Outline what WHO is doing in the area of school health;
4. Invite participants to introduce themselves.

Dr. Suzuki explained that, since last July, WHO has been reorganised into nine “clusters”, seven of which are technical, including HSC. The mission of HSC is to bring down the disability threshold throughout all stages of the life course, and to help people live independent lives for as long as possible. This includes making the social environment friendlier to one’s health.

Dr. Suzuki presented the organigram for the new cluster, which includes four departments (Health Promotion; Disability/Injury Prevention and Rehabilitation, which includes violence prevention; Substance Abuse, which includes tobacco, alcohol and other types of substance abuse; and Mental Health, including mental health promotion in a positive sense, sound and sight development and life skills education) and two cross-cutting theme groups (Ageing and Health/Long-term and Home-based Care; and Assessment, Classification and Epidemiology). The Cluster also includes one research center, located in Kobe, Japan, which has a strong focus on Ageing and Health, and Urbanisation and Health.

Dr. Suzuki noted that, through schools, one can have access to young people, teachers, parents and community members. Mega countries represent more than 60 percent of the global population and perhaps that proportion in terms of the number of school-age children. Because health and education enhance each other, healthy children learn more, and high literacy improves health. The WHO Global School Health Initiative (GSHI) delivers very important health measures, in areas of violence, risky sexual behaviour and healthy nutrition – while creating opportunities to work with other domains of health. The Global School Health Initiative does this primarily through four strategies:

a. Capacity building in countries and regions;
b. Strengthening networks and alliances;
c. Promoting and coordinating research activities to improve school health programmes; and
d. Building capacity to advocate for improved school health programmes.

In closing, Dr. Suzuki thanked the two WHO Collaborating Centers for their contributions to the GSHI and making this conference possible: (1) the WHO Collaborating Centre on Health Education and Health Promotion among School-aged Children and Adolescents, at the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC); and (2) the WHO Collaborating Center to Promote Health through Schools and Communities at the Health and Human Development Programs, Education Development Center, Inc. (EDC).
Description of Department of Health Promotion (HPR)

Dr Pamela Hartigan, Director, Department of Health Promotion

Three months ago, Dr Hartigan was appointed as Director of the Department of Health Promotion (HPR). She recently drafted a five-page vision paper for the department (available to those who are interested), but preferred to make her opening remarks brief and personal. Dr Hartigan feels that the most interesting fact about her public health background is that she has a Masters in Education and worked for eight years in education for children of Hispanic migrant families recently arrived to the United States. She noticed a common behaviour among children coming to school for the first time: many thought school was a place where they needed to show off what they already knew, rather than a place in which to learn and share, or one to come to for help. Similarly, in a meeting such as this one, we need to share our strengths so others can benefit, but we also need to be honest about our weaknesses so we can support each other.

The second lesson Dr Hartigan learned in her past experience was that schools are a place for both learning and unlearning. It is unlearning which is often the more difficult, for example, giving up safe patterns of thinking and behaviour, and unlearning the arbitrary barriers between health and education.

Finally, to address the both the urgent and the long-term needs of young people, the school is a setting in which we must “put out the fires and build the water sprinkler systems at the same time.”

Summary: Mega Country Meeting, March 1999

Desmond O’Byrne, Focal Point for the 5th Global Conference on Health Promotion, Department of Health Promotion

Dr O’Byrne considered this a very special meeting, as it is the first time that all our partners are together at a School Health Mega Meeting. This is the first meeting in which representatives of both Ministries of Health and Ministries of Education are present, along with our partners from other UN agencies, our colleagues within WHO, Education International, and our formal collaborators, CDC and EDC.

Dr O’Byrne reported that at the recent meeting of the broader Mega Country Health Promotion Network (held in Mexico City, 25-26 March 1999), 11 Focal Points were in attendance, in addition to two collaborating agencies and WHO regional advisors. The major agenda items at that meeting included:

- Progress review and reports
- 5th Global Conference on Health Promotion, June 2000
- Global resolutions and initiatives
- Addressing WHO and country priorities
- Entry point activities

It was proposed at the meeting that the next meeting of the MCHPN focus on tobacco prevention and control, and be held mid-November 1999 in Kobe, Japan (in conjunction with WHO’s Tobacco Free Initiative). In addition, participants discussed surveillance of health risk behaviours and social determinants, and the development of model surveillance training programmes in Mega Countries. The U.S. Centers for Disease Control and Prevention is
organising a meeting in September, in Atlanta, on “Global Issues and Perspectives in Monitoring Behaviors in Populations: Surveillance of Risk Factors in Health and Illness.”

Finally, the 5th Global Conference on Health Promotion is an opportunity for Mega Countries to showcase successful health promotion strategies through case studies. A complete report of the Mexico meeting is provided in the folders for this meeting.

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**Side Bar**

At this point, Dr Siyal of Pakistan raised a question. He noted that the problem of smoking is growing rapidly throughout Asia. This is due in part to strong influences from out-of-school youth and adults. Do we expect that schools can play a role in overcoming this problem, especially when 50 percent of young people in some countries are out of school and famous brands are being advertised everywhere?

Dr Hartigan responded by reminding us that schools cannot work alone. The policy agenda more than anything else drives tobacco habits to continue. It is from this angle that Dr Brundtland and WHO’s Tobacco Free Initiative are tackling the tobacco problem. However, it is important to remember that more children are going to school, and the numbers of out-of-school youth are diminishing, so children in school are an audience that we should be working with.

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**Summary: School Health Component of the Mega Network**

*Dr Yu Senhai, Focal Point, WHO Mega Country Health Promotion Network, HPR*

In the past three years, school health has been an important focus of the Mega Country Health Promotion Network (MCHPN). The Global School Health Initiative and the MCHPN are meant to support and complement each other. School health became the first official “component” of MCHPN, in order to:

- Help Mega Countries improve national school health strategies;
- Provide a mechanism to create awareness of the Global School Health Initiative in Mega Countries; and
- Provide advice to WHO in planning and reaching the goals of the Initiative.

The first annual meeting of the School Health Component of the MCHPN was held last year, 18-20 March 1998, at which the ministries of health of seven Mega Countries were represented. By the close of that meeting, participants agreed on the following goals for future actions:

1. To improve the information base for health promotion
2. To mobilise resources for health promotion
3. To develop intersectoral collaboration
4. To address important health, population and setting challenges
5. To address mega issues of scale.

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**Summary: Progress made by WHO/HPR in the past year**

*Mr Jack Jones, Focal Point, Global School Health Initiative*

Mr Jones reported on the progress of the Global School Health Initiative in the past year, particularly in relation to requests and plans made at the School Health Component meeting of the Mega Network last March 1998.
Last year, Mega Country representatives called for more involvement of Ministries of Education in the Mega Network. In response, WHO/HPR invited each Mega Country to appoint representatives of their Ministries of Education (MOE), who are responsible for school health, to attend this meeting and serve as standing members of the Mega Network.

- Members of the Network were interested to learn more about strategic approaches to strengthen school health programmes. WHO/HPR asked countries and international programmes to articulate their strategic approaches: ten countries, five international agencies and two WHO collaborating centers submitted chapters. WHO/HPR and EDC have edited and compiled these chapters into a document entitled *Improving Health through Schools: National and International Strategies*. A draft of this document is included in the meeting folder. Jack asked that participants review their country/agency chapters one last time before the document is submitted for publication.

- WHO/HPR has created a website for the Global School Health Initiative, at [www.who.ch/hpr](http://www.who.ch/hpr). It will continue to grow as a resource for the Mega members.

- Members called for closer collaboration between ministries and teachers’ unions within the Mega Countries. In response, WHO, Education International and EDC held a meeting in Washington, D.C. last July, to bring together representatives from MOHs and teachers’ representative organisations in seven Mega Countries (Brazil, India, Indonesia, Mexico, Nigeria, the Russian Federation, USA) to help acquaint them with one another and develop working relationships.

- WHO/HPR organised several international activities in the past year, including three sessions on school health at the IUHPE Conference last June, to explore the school health strategies of international agencies, regional bodies and countries.

- Last year, participants identified a common health area for collaboration: tobacco use prevention. In response, WHO/HPR, together with the WHO Tobacco Free Initiative and UNESCO, developed a document to guide tobacco use prevention through schools (a copy of which is in the large! grey folder given to each participant). In addition, WHO/HPR has funded a project in China to implement recommendations outlined in the new document. There should be results to report by the next meeting of the Network.

- Participants asked for technical assistance to develop national strategies for school health promotion. WHO/HPR has worked with EDC and four ministries in Indonesia to further develop the Rapid Assessment and Action Planning Process (RAAPP), currently being tested in Indonesia. In addition, this year WHO/HPR has developed a “Request for Collaborative Action” to help strengthen relations between MOH, MOE and teachers’ organisations in Mega Countries.

- WHO/HPR has organised this second annual meeting of the Network so that countries can work more closely with other agencies and other WHO programmes.

**Points of concern regarding the “Request for Collaborative Action”:**

Dr Siyal of Pakistan expressed his concern about working with teachers’ associations. In many cases, teachers’ associations are not necessarily acknowledged by the government because many such associations form and then quickly dissolve. Without consistency or longevity, it is not realistic to think about working closely with them or giving them much recognition.

Mr Hossain of Bangladesh noted that since the MOE was invited to participate in this Network and the collaborative process at a later stage, there has not been sufficient time to meet with the MOH and teachers’ unions. There needs to be more time to return home and establish these working relationships before submitting the letter of intent.
PRESENTATIONS BY MEGA COUNTRIES
Facilitated by C. Vince-Whitman

School Health representatives from the Mega Countries were invited to share:
• This year's most important school health accomplishment
• This year's most important school health challenge

(A shorter summary of the following Accomplishments and Challenges was distributed to participants during the meeting)

BANGLADESH

This year’s most important accomplishment:
1. Provision for health education as a part of regular curriculum
   The School Health Pilot Project (SHPP), initiated by the Government of Bangladesh, has helped the National Curriculum and Textbook Board to develop and revise the primary and secondary school health curricula, in addition to selecting and/or producing health education materials (including such topics as hygiene, safe water, sanitation, common ailments, accident prevention, food nutrition, population education and AIDS).

2. Training of school teachers and health care personnel
   The SHPP has started to train approximately 8000 school teachers, 200 health care personnel and 160 trainers covering 39 thanas in four districts, in similar topics as those introduced in the curriculum.

3. Screening and providing curative services
   School health care centers are working to screen and provide curative services for different diseases among students. This service is offered in physical examinations during school visits and by attending to students in school health clinics.

4. Provision for first aid services
   First aid boxes with a first aid guide has been sent to schools under the SHPP area for proper case management and to help refer for curative care the most important health problems among students. A health card for each student has been prepared and distributed to the students.

5. Provision for a safe and healthy learning environment
   To provide a safe and healthy learning environment, access to safe water and adequate sanitation is being accomplished through collaboration and coordination with other projects.

6. Committees
   National, District, Thana and School level committees have been formed and are monitoring activities at their respective levels.

7. Teachers school health guide
   The guide is being distributed to teachers receiving training.

This year's most important challenge:
✓ Setting up a National Steering Committee to act as an advisory body to guide policy development, decide on strategic issues and monitor the progress of implementation.
Strengthening coordination between various Ministries and organisations.
Establishing links with professional bodies, educational boards, teachers’ associations, etc., and defining their roles in school health promotion programmes.
Ensuring orientation of relevant programmes (nutrition, communicable disease control, STD/HIV/AIDS, etc.) to introduce school-based interventions.
Introducing effective awareness-raising activities with particular attention to TFI, prevention of drug addiction and juvenile delinquency.
Organising dialogue for collaborative support from partners, including international organisations.
Identification of gaps, weaknesses and strengths of current school health programmes, through the RAAPP for example, before developing a comprehensive policy.

BRAZIL

This year’s most important accomplishment:
1. The implementation of legislation in Brazil -- turning laws into reality
A strong constitution was written and adopted in 1988. That law has now become reality in practical terms. For example, Brazil has identified national “Referentials”, or transversal themes, including health, that must be integrated into the school curricula. The inclusion of health as a Referential has allowed it to be addressed in schools for the first time; not as a separate subject, but incorporated into traditional subjects like math and biology. Brazil is also implementing the Statute for Childhood and Adolescent Rights, through a decentralised system where councils address rights.

2. There is the beginning of very articulated actions between ministries in the area of health promotion. For example, there is now an officer in the Ministry of Education devoted to working on school health. There have also been actions to link the federal and local level government agencies.

This year’s most important challenge:
In Brazil, as in almost all of Latin America, social, economic and political inequities result in privileges for the few, at the expense of many others. The same opportunities are not available to all individuals and communities – something that is a fundamental right, a resource for quality of life, and an important social investment. One of the great challenges in Brazil is to guarantee to all children access to education, to support their development and opportunities for a healthy life. Factors such as political exclusion, impoverishment, the growth of urban slums, drug trafficking, the increase of domestic violence and child abuse, etc., contribute to children and adolescents’ exclusion from school. Thus, a huge challenge is to guarantee the access of children to a quality school that facilitates choices for a healthy lifestyle.

CHINA

This year’s most important accomplishment:
- The Ministries of Health and Education have worked together to develop Guidelines for Health Promoting Schools to help facilitate the creation of Health-Promoting Schools (HPS) in China. The guidelines include: tips for organizing a HPS; a list of indicators at the school level; and criteria, methods and procedures for evaluating HPS (both urban and
rural schools). Although restructuring in the ministries has prevented the Guidelines from being issued as a joint document, efforts are ongoing to achieve this.

- WHO’s Department of Health Promotion and the U.S. Centers for Disease Control and Prevention have collaborated with the Ministry of Health, China, to adapt and pilot test the Youth Risk Behaviour Survey. This work was initiated two years ago.

**This year’s most important challenge:**
- A major challenge in China is the priority placed on academic success, often at the expense of students’ health. For the vast majority of students in middle schools, for example, health education class is only offered for one hour every two weeks. In addition, pressure to do well academically is causing students to spend more and more time studying and to pay less attention to their health (e.g., getting enough sleep). In addition, school health services are still poor, especially in rural schools.

**INDIA**

**This year’s most important accomplishment:**
- A school health accomplishment this past year has been the introduction of adolescent population and AIDS education in schools. This was organized by the National Council of Educational Research and Training with the assistance of UNFPA.

**This year’s most important challenge:**
- The increasing number of young people becoming addicted to drugs and smoking. Education, especially health education, faces the challenge of resolving this problem and instilling in students an enthusiasm for living healthy lives.
- Another important challenge is the increasing stress on students. This has created concern about cases of suicide, attempted suicide, running away from home, mass copying and cases of truancy. Two major reasons for this stress are curriculum load and examination. An important question is how to identify the causes for increasing stress and take steps to relieve them (e.g., by delineating the specific roles that parents and teachers can play).

**INDONESIA**

**This year’s most important accomplishment:**
Through the strong coordination of the four-ministerial National School Health Coordinating Board, and Coordinating Boards at the Province, District and Sub-district levels, Indonesia has been able to achieve the following:
- Massive immunization coverage of schools through a one-month campaign every November.
- School Feeding through a Presidential Instruction intended to cover three million underprivileged school children (the deworming programme is also part of this scheme).
- School Health Competitions at the local, provincial and national level provide good pulling power to develop health promoting schools.
- Implementation of Adolescent Reproductive Health, to replace the previously controversial Sex Education.
- Adopting Sanitation Week in schools.

**This year’s most important challenge:**
To implement the concept of the Health-Promoting School. To address this challenge, it is important to “break the ice” at the upper levels of government. Many decision-makers in the Ministry of Education and the Ministry of Religious Affairs are not aware of the importance of school health and more efforts for socialization/awareness are necessary (e.g., through the popular milk programme).

It is also important for Indonesia to assess its strengths and limitations in the area of school health. For this reason, four ministries are working with WHO, CDC and EDC to develop and use tools for the Rapid Assessment and Action Planning Process. The hope is to conduct regular assessments every two years, and to use the results of the assessments to attract support and assistance.

Manpower development (teachers, health staff, auxiliaries).

Clear programming and priority-setting.

MEXICO

This year’s most important accomplishment:

- Progress has been made in strengthening intersectoral collaboration, particularly between the health and education sectors. By coordinating the work of these agencies, it has been possible to: create school health action plans at the state and federal levels; include health promotion text books; and provide guidance for regional councils.
- 428 schools in 24 states of Mexico have registered to become Health-Promoting Schools; 84 schools have received certification (indicating that significant advances have been made in the implementation of a “participatory project”). One hundred more schools are in the process of certification.

This year’s most important challenge:

- An important challenge has been to create a common vision and a common vocabulary between the ministries of health and education. The different sectors are not always speaking the same language.
- There is also a need to provide professional development and training in order to clarify the differences between health education, health promotion and disease prevention. There are often misunderstandings of these concepts, and through training, the importance of health promotion can be emphasised.

NIGERIA

This year’s most important accomplishment:

- A National Conference on Adolescent Health was held in January this year, with over 300 participants including young people (30%).
- Development of a national strategic framework for action.
- Formation of a national working group including all major stakeholders.
- Presentation and recognition of the increasing number of young children with health and social problems, especially STIs/HIV/AIDS, by the National Council of Education at its 46th Meeting in March, 1999, and its subsequent directive that sexuality education be incorporated into all school curricula at all levels.

This year’s most important challenge:

There is a strong need for each of the following:
Nationwide Assessment of school health needs to identify the current situation on the ground.
Develop guidelines and indicators for the promotion and monitoring of school health in Nigeria with all key stakeholders.
Advocacy amongst policymakers at all levels of government to create an enabling environment through political and financial commitments.
Implementation of the National Strategic Framework in schools.
Sourcing for resources, especially financial, to implement activities.

PAKISTAN
(Government of the Punjab)

This year’s most important accomplishment:
- Organised six high-level national workshops with UNESCO, which covered such health issues as smoking, drug abuse, and HIV/AIDS.
- National Education Policy includes health education, although no input has yet been made by the health sector, and health concepts are not included in exams.

This year’s most important challenge:
- Need to move to integrated health care.
- Need support to translate useful materials (such as WHO documents) into local languages of Pakistan.

RUSSIAN FEDERATION

This year’s most important challenge:
- To improve the legislative base, e.g., to find ways to coordinate the efforts of different authorities on health issues, and to create a legislative base for equal participation of non-governmental organisations in the process of fortifying the health of children and adolescents.
- To standardise the health condition criteria of schoolchildren.
- To conduct research to define minimum medical standards of primary and secondary prophylaxis for healthy school age children.
- To develop an integral educational programme aimed at health fortification in educational institutions, with the following objectives:
  - To reduce the number of the most widespread diseases caused by behaviour
  - To decrease the number of risky behaviours, which may result in present and future diseases (e.g., smoking).

UNITED STATES OF AMERICA

This year’s most important challenge:
- One of the most discouraging things to happen this past year was the April shooting by two students in a Colorado school. It has led many to ask the Department of Education why this would happen. What can schools do to prevent such tragedies in the future? And how is the Department of Education going to collaborate with the Department of Health and Human Services to address this problem? In this case, local awareness and support has created an opportunity and incentive for the two sectors to collaborate.
This year’s most important accomplishment:

- The Department of Health and Human Services has recognised the importance of assisting state and local agencies in learning to communicate with each other. HHS has developed and is now pilot testing a dialogue guide, which can be used by community-based organisations. HHS also offers technical assistance to local communities in use of the guide.

- It has taken 10 years to achieve the following accomplishment: In November 1998, the Mortality and Morbidity Weekly Report reported a major decline in sexual risk behaviours among adolescents. There were lower numbers of young people engaging in sex with multiple partners, and higher numbers of those using condoms. There were also lower rates of gonorrhea and pregnancy reported.

- The Division of Adolescent and School Health (DASH) was created with money for HIV/AIDS. So, the primary goal of DASH is to reduce the incidence of HIV. However, DASH recognises that that goal can be attained while also addressing other important health problems (e.g., drug use, diet, violence, unintentional injuries, etc.), as the risk factors are often closely related.
PRESENTATIONS BY WHO/HQ DEPARTMENTS

Departments at WHO/HQ working in areas related to school health were invited to address the following points:

- How does their department help countries improve health through schools?
- What resources do they have available now?
- How do they plan to do it even better in the future?

Mrs Rhona Birrell-Weisen  
*Department of Mental Health Promotion (MNH)  
Cluster for Social Change and Mental Health (HSC)*

The Department of Mental Health uses technical documents and training workshops to help countries develop integrated, developmentally appropriate approaches to life skills education in schools. Life skills education promotes healthy psychosocial development and contributes to the prevention of behaviour-related health problems amongst school children. Life skills education in schools is gaining recognition as an important part of national strategies to combat major threats to public health – including HIV/AIDS, violence, substance use, adolescent pregnancy and suicide.

Life skills education itself is not new, but the way that it is developing and the scale by which it is being implemented is a new trend internationally. By monitoring and synthesising the nature and ongoing evolution of life skills education in schools, the WHO Department of Mental Health has been able to contribute to shaping and supporting advancements in the life skills field. The department has developed four technical documents in the life skills series. The first, *Life Skills Education in Schools*, offers a basic working definition of life skills and provides a framework for planning the development of national life skills education initiatives. The other documents in the series describe case studies, training workshops and research. Additional documents currently being prepared include a document on life skills education as an essential element of health promoting schools, and guidelines on the design of life skills education curricula for schools.

Dr Chandra-Mouli  
*Department of Child and Adolescent Health (CAH)  
Cluster for Health Systems and Community Health (CHS)*

The new Department of Child and Adolescent Health and Development has united the previous Division of Child Health & Development and the Programme on Adolescent Health & Development, and is concerned with the age band 0 - 19 years. The objectives of the new department are:

- To develop and support countries in implementing policies, strategies and plans for child and adolescent health in order to reduce risk, morbidity and mortality and to improve growth and physical and psychological development.
- To undertake research to support the development of evidence-based integrated interventions for child and adolescent health care.
- To strengthen capacity in countries to work with communities to devise, test and implement health promotion, prevention and care interventions for children and adolescents in homes and communities.
- To advocate policies and strategies to protect the rights of children and adolescents in relation to health and health care.
In planning its future work, CAH has identified health problems and behaviours affecting children and adolescents which are of concern to WHO, as well as appropriate intervention areas for their prevention. For example, to prevent pregnancy-related deaths in adolescents, relevant interventions through the school include health education and life skills curriculum. The Report of the First Meeting of the CAH Technical Steering Committee, 22-26 March 1999, notes:

“The Technical Steering Committee recognises that the school is a critical setting for many children aged 5 to 9 years, and the TSC recommends that CAH take a strong role in working with others who are programming and implementing health interventions through schools. In doing this, a greater potential of the school to influence the health of children in this age group can be realised.”

An indicative “limited package” that CAH would seek to promote includes:

- School policies that protect children and adolescents
- Healthy school environments (safe drinking water and clean toilets)
- Health education tied into life skills development
- Delivering some key “medical” interventions (such as de-worming and micro-nutrient supplementation)

Dr Yang Gonghuan  
_Tobacco Free Initiative (TFI)  
_Cluster for Noncommunicable Diseases (NCD)_

“Building Alliances and Taking Action to Create a Generation of Tobacco-Free Children and Youth” is a joint WHO/UNICEF project sponsored by the United Nations Foundation. Why focus on children? Because 80 % of smokers start before the age of 18 – often at the age of 14, 15 or 16. TFI does not believe that this necessarily reflects freedom of choice. Also, secondary smoke exposure is a risk to children’s health, increasing their vulnerability to respiratory illnesses, ear infections, low birth weight and sudden infant death syndrome. It is also associated with learning difficulties, behavioural problems and language impairment. The Alliance thus targets: children and adolescents; older young people; individuals who can influence and improve the “growing-up” environment of these groups.

The objectives of the project are:
- To demonstrate the effectiveness and feasibility of early country-specific interventions
- To provide evidence for action in developing countries
- To build human and institutional capacity within selected countries
- To build strong strategic alliances between UN partners, NGOs, academia and the media.

The project will be carried out in two phases:

_Phase I: Harnessing the evidence for action_ (research is currently underway in Brazil, China, India, Oman, Poland and South Africa.

_Phase II: Activating Phase_ (China, Jordan, Sri Lanka, Ukraine, Venezuela, Zimbabwe, Barbados, Costa Rica, Fiji, Grenada, Russian Federation and South Africa)  

Phase II will employ the Global Youth Tobacco Survey (GYTS), a school-based tobacco-specific survey focusing on adolescents aged 13-15; it assesses students’ attitudes, knowledge and behaviours related to tobacco use and ETS. WHO and CDC are providing technical support and training in Bangkok and Geneva.
Ms Monica Goracci  
*Violence and Injury Prevention (PVI)*  
*Department of Disability, Injury Prevention and Rehabilitation (DPR)*  
*Cluster for Social Change and Mental Health (HSC)*

The Programme on Violence and Injury Prevention (PVI) is concerned with the burden of violence and injuries on health. Violence, falls, sports, poisonings and road traffic accidents are important causes of death, disability and suffering among young people around the world. Injuries account for 15% of DALYs in 1999; this figure is projected to increase to 20% in 2020.

The goal of PVI is to strengthen the national capacity to reduce mortality and morbidity due to violence and injuries. The programme promotes a public health approach to violence and injury prevention, including the following steps to move from the problem to the response: surveillance; risk factor identification; intervention evaluation; and implementation. The main areas of work include: (1) surveillance; (2) prevention of violence against women and children; (3) landmine injuries; (4) road traffic injuries.

PVI is collaborating with the Department of Health Promotion/School Health Team to develop violence and injury prevention initiatives through schools. Together, and with UNESCO, the programmes have developed the document, “Violence Prevention: An Important Element of a Health-Promoting School” – to help individuals understand how efforts to promote peace and prevent violence might be planned, implemented and evaluated as part of a Health-Promoting School. In addition, PVI and HPR have drafted a proposal entitled “Safe Communities and Health Promoting Schools: A Joint Project to Prevent Injuries”. The goals would be:

- To promote safety and to ultimately reduce injuries at schools and in the community
- To integrate injury prevention into a comprehensive approach to the development of Health-Promoting Schools and Safe Communities
- To complement “Violence Prevention: An Important Element of a Health Promoting School”

Dr Greg Goldstein  
*Healthy Cities*  
*Department for Protection of the Human Environment (PHE)*  
*Cluster for Sustainable Development and Healthy Environment (SDE)*

In 1999, there continues to be a broad-based launch of healthy cities by WHO, with major events and initiatives to strengthen regional networks. Pilot studies in all regions have shown that the Healthy Cities initiative is a practical strategy to address living conditions, for making health part of urban management and for mobilising local communities to address priority health issues. It is considered that school health is a priority in every healthy city project, and in practice a majority of participating cities undertake a health-promoting school project.

Present activities and challenges include:

- A detailed external evaluation of a sample of healthy city projects to expand the information and evidence base on the implementation and effectiveness of projects. Too little is known about the practicalities of implementation and effectiveness, particularly outside of Europe and the Americas.
• Wider community and private sector participation in urban management is needed in order to ensure that social and environmental conditions support health (for example, that water supplies are maintained, food markets are sanitary, basic services are available, and that youth issues are addressed, etc.)
• The health sector role in urban management should place emphasis on health information, monitoring and analysis, healthy policy development, and health promotion and advocacy.
• Links to WHO programmes can prepare or strengthen “multi-city action plans” on the following subjects, to be disseminated to all cities in regional WHO networks: ageing and health; school health; tobacco use; women’s health; violence; mental health; water and sanitation; infectious diseases (dengue, AIDS, malaria, cholera).
• WHO will strengthen and enlarge the active networks of healthy cities in all regions of the world, through suitable partners and especially local government organisations such as IULA to increase the recruitment of new towns and cities and to strengthen the activities in existing healthy cities and towns.

Dr P Nordet  
Cardiovascular Diseases (CVD)  
Noncommunicable Disease Prevention (NCP)  
Cluster for Noncommunicable Diseases (NCD)

Within the context of the WHO Global Programme for Rheumatic Fever/Rheumatic Heart Disease Prevention, NCD/CVD has developed health education activities for healthy schoolchildren, school patients and their relatives. This is a service-oriented programme, integrated into the national public health structure and facilities of the country in close collaboration with the education system of the area. It relies on close collaboration of the health centre and schools of the selected area, to integrate prevention activities of respiratory infections and RF/RHD into the school curriculum and into school health services, if they exist. The participation of the school varies from one centre to another.

The programme is in progress in 23 developing countries. The activities are conducted by nurses, teachers and health workers, and sometimes primary health care physicians – to conduct case finding, registration, follow-up training of health and education personnel. Each centre involved has developed its own training and health education material and activities based on the WHO/CVD guidelines.

Since 1992, NCD/CVD has been working in collaboration with the UNESCO Section for Science and Technology Education. They, together with the World Health Federation (former ISFC), have developed health education material for the prevention of RF/RHD and Chagas’ disease.

NCD/CVD is also planning a large joint project for the prevention of RF/RHD and healthy lifestyle. A main approach will be the development or improvement of a comprehensive school health infrastructure, including:
• Integrating prevention of respiratory infections and RF/RHD into the school curriculum and into school health services
• Encouraging healthy diets, physical exercise, recreation and sport activities and promoting anti-tobacco activities
• Counselling and support for health and healthy lifestyles to pupils, their families and school staff.
Dr A Montresor

Programme on Planning and Technical Guidance (PTG)
Department of Communicable Disease Prevention and Control (CPC)
Cluster for Communicable Diseases (CDS)

The Department of Communicable Disease Prevention and Control provides support to school health programmes in Africa, through cost-effective interventions designed to improve the health and nutritional status of school-age children. For example, because school-age children are an important risk group for intestinal helminth and schistosome infections, and because schoolchildren are easy to reach and teachers can be very good health education providers, CPC has developed a minimal package for the control of intestinal helminth and schistosomes in schools. The package includes periodical distribution of anthelminthic drug and micronutrients, and health education.

In general, diseases that could easily be controlled by school health programmes in developing countries include: intestinal parasites; schistosomiasis; iron deficiency anaemia; Vitamin A deficiency; iodine deficiency. Steps in the implementation of such school health programmes include: collection of epidemiological data; training of personnel; drug distribution; health education; and monitoring and evaluation of the programme.

The next objective for CPC is to facilitate regular treatment to at least 75% of all school-age children at risk of morbidity for intestinal helminth and schistosome infections.

Dr Bjorn Blomberg

Programme on Country Support (CCS)
Department of Communicable Disease Prevention and Control (CPC)
Cluster for Communicable Diseases (CDS)

CCS has recently collaborated with the Department of Health Promotion to draft a new document for the WHO Information Series on School Health: “Tuberculosis prevention and control: An entry-point for the development of a Health-Promoting School.” Though schoolchildren are not typically a high-risk group for tuberculosis, the document explains why it is relevant to address tuberculosis (TB) through schools. Below are some of the reasons:

- There are 9 million new TB cases every year
- 3 million persons die from TB every year
- Millions of schoolchildren lose their parents from TB every year
- This reduces the wellbeing and learning potential of students
- Almost all TB deaths could be avoided by diagnosis and treatment
- School children and teachers should know that TB is a serious disease
- School children and teachers should know that TB can be controlled
- Reduce social stigma
- To create a healthy school environment
  - Physical (Ventilation, sunlight)
  - Behavior (Prevent HIV infection)
  - Nutritional
  - Psychological (Reduce stigma)
- To increase awareness of TB and existing cost-effective interventions
- To increase public demand for political commitment to control TB.
Mr J Cheyne  
*Communicable Disease Eradication or Elimination (CEE)*  
*Cluster for Communicable Diseases (CDS)*

Why are schools so important in communicable disease eradication and elimination?

- The answer is related to the age of first infection: polio and measles strike those under one year of age; Guinea worm and filariasis strike the 4-5 year olds; leprosy strikes the 5-10 year olds.
- To facilitate drug use and compliance, school-based campaigns (e.g., filariasis once-a-year campaigns and polio twice-a-year campaigns) can help remind children to take their pills. Over one million volunteers have supported the Polio campaign in India.
- Schools also provide good opportunities for early diagnosis, e.g., once- or twice-a-year skin patch surveys for leprosy; and to look for signs of measles.
- Teachers can play an important role by: keeping the leprosy-infected children in school; helping to organise once-a-year filariasis campaigns, combined with school de-worming programmes; and by participating in twice-a-year polio campaigns.
- Schoolchildren can act as agents for change, e.g., by taking the guinea worm messages home; by reducing the impact of filariasis with simple hygiene; taking part in annual anti-leprosy week; using bed nets for Chaga’s disease and filariasis; taking part in mosquito control; and protecting water sources for Guinea worm control.

Mr Cheyne emphasised that these good ideas have come from the countries themselves. CEE is here to support the important work going on in countries.

Mr J Jones  
*Global School Health Initiative*  
*Department of Health Promotion (HPR)*  
*Cluster for Social Change and Mental Health (HSC)*

The Global School Health Initiative has four main strategies to increase the number of schools that are Health-Promoting Schools:

1. **Building capacity to advocate for improved school health programmes**
   This involves consolidating evaluation research and expert opinion to create technical documents. The documents are intended to help individuals in international, national and local organisations argue for increased support of efforts to promote health through schools. In addition to the existing “School Health Series” documents that have been included in each participants’ large grey folder, new documents currently under development include: active living; life skills education (with MNH); sexual and reproductive health (with EDC and ADH); tuberculosis (with CCS); and Development for All (with Education International).

2. **Research**
   This involves synthesising research to strengthen knowledge and interventions related to each of the ten Expert Committee Recommendations. It includes the development of means to: 1) assess national capacity for school health promotion (e.g., the Rapid Assessment and Action Planning Process being developed in collaboration with EDC and Indonesia); 2) evaluate the extent to which schools become Health-Promoting Schools; and 3) monitor the health status of children and teachers.

3. **Creating Networks and Alliances for the development of Health-Promoting Schools**
   The first network was initiated by the WHO European Regional Office in 1991, and subsequent networks were established in the Western Pacific (1995), Latin America (1996)
and Southern Africa (1996) through joint efforts by WHO/HQ and the WHO Regional Offices. Toward the end of this year, efforts will be made to start the fourth network, in South East Asia.

4. Strengthening national capacities
The Mega Network is one means by which WHO, with CDC, attempts to build national capacity for health promotion through schools. This meeting will help decide collaborative work that can be done to strengthen school health programmes in the Mega Countries.

**OFF THE AGENDA: END-OF-DAY 1 GROUP DISCUSSION**

Comment: Despite all the work of NGOs and international organizations, health problems are still growing (e.g., the rising rates of HIV infections in Bombay). It doesn’t help that these different players are often working from different angles, on different issues.

Response: There does not need to be competition between traditional school subjects, such as math, science and reading, and health education. Health content can be used to improve skills in other areas. We see this complementarity in the way Brazil has built transversal subjects into the curriculum, such as citizenship participation. This is a new logic applied to pedagogy. If teachers are good teachers, they are good explainers and can contribute to health promotion. They can successfully relay messages, including health messages, to students through traditional subjects.

Comment: Indonesia is facing a big burden; there is so much that can be delivered through schools, but how can this be accomplished with only two hours per week dedicated to health and health education? We need closer working relationships between health workers and teachers.

Responses:
- Utilise the two hours fruitfully with an integrated approach. Health education must have a promotion aspect which reaches out to the community and trains the child in skills for living. Whatever we want to call it – health promotion, health education, life skills education, living skills, etc. – let’s integrate it as a required subject. Physical education or human movement classes must also be given adequate time.
- With the curriculum being so full in most cases, and continuing to fill up, health content must be incorporated into other subjects.
- It’s not a question of *either/or* but *both*. However, we ourselves must learn to choose our priorities and come up with feasible strategies to reduce the chaos and the different efforts happening in parallel.
- Many of us would agree that general teacher development is one of the best health promotion interventions. This can help teachers to teach the classical subjects better, and apply interactive teaching methods to instil skills in health and living. Also, we must not overlook policies in schools. These can have more effect than the curricula. So, where do you put your emphasis? Can we find a combination of strategies that take advantage of what works best?
- Yes, teacher training is one of the most important interventions. It must consider a comprehensive framework for all the priority issues, rather than adding more and more onto the curriculum.
PRESENTATIONS BY INTERNATIONAL ORGANISATIONS
(Facilitated by Phyllis Scattergood)

Representatives of international organisations working in the area of school health were invited to share the following points:

- How does their organisation help countries improve health through schools?
- What resources are available now for that work?
- What plans does the organisation have for future action?

Hugh Hawes
Child-to-Child Trust

Who are we?
Child to Child is celebrating its 21st birthday this year. For 21 years, Child to Child has promoted the tenet that children are vitally important agents of health. This does not mean that children should be used as loud speakers, e.g., shouting “be wise, immunise” when they don’t know what an immunisation is. Rather, children can be activators. Child to Child is trying to remind us not to forget the children. This idea flew and many countries took it up in terms of programmes and initiatives. That is why you’ll find Child to Child activities with UNICEF, Save the Children, and others. A small coordinating team works out of the Institutes of Education and Child Health at the University of London.

Child to Child is like an ideas factory, producing high quality material. For example, “Health Promotion in our Schools” is now available in 30 languages. Child to Child is totally committed to the concept of Health-Promoting Schools, or Health Action Schools, especially when the school community feels ownership of their school and is proud of being health promoting. Each Health-Promoting School should be unique and fiercely proud. The Indonesian example of one “nucleus” school supporting other “satellite” schools, helps to instil pride.

What do we do?
- Ideas – the Child to Child Trust is a bag of ideas
- Materials, which are largely copyright free
  These include Activity Sheets in eight categories, Planning Booklets and “health across the curriculum” story books. The documents, “Health Promotion in our Schools” and “Children for Health” apply the Facts for Life messages.
- Training courses in the University of London for senior planners and field personnel.
  Popular training courses include “Planning Health Promotion in Schools” and “Child-to-Child and Inclusive Education.”

Peter Glasauer
Food and Agriculture Organization

FAO promotes lifelong healthy eating patterns with an emphasis on food and eating habits. Since people’s eating habits and lifestyles vary in different cultures throughout the world, FAO promotes a food-based approach to nutrition education, adapted to specific socio-economic and cultural contexts. If begun early, nutrition education can contribute to the physiological, mental and social development of schoolchildren, enhance their learning potential, reduce nutritional disorders and contribute to the prevention of diet-related diseases later in life.
FAO’s school-based nutrition programme also aims to strengthen the school’s position as a healthy setting for living, learning and working. FAO is thus committed to WHO’s idea of health promotion through schools.

FAO has identified the following strategies to promote lifelong healthy eating habits through schools:

- Advocacy and Promotion
- Formulation and support of technical assistance projects
- Development of nutrition education materials
- Promotion of FAO’s general nutrition education information package
- Collaboration with other research and training institutions and organisations

Among its current resources available to Mega Countries are:
1. Staff – the Nutrition Education and Training Group consists of three part time workers
2. Technical documents, which will be available at the end of 1999
3. Technical assistance

FAO’s plans for future action in the area of school-based nutrition education include:

- Technical documents – the new technical documents can be translated into languages which are not official UN languages, if the need is expressed.
- A teachers resource book
- A policy document, for advocacy at the national and regional level.
- Technical assistance – for such tasks as seeking funds from donors, providing indicators for monitoring risk factors among school students, and assisting in the design of evaluation of school-based interventions.
- Training in the use of FAO materials for planning nutrition education activities in primary schools.
- FAO is also happy to help you get nutrition education on the agenda and to develop nutrition education programmes in the context of Health-Promoting Schools.

OJ Sikes
UNFPA

The UNFPA mandate focuses on the broad area of population and what that encompasses, e.g., gender equity, sexuality, family life, etc., all of which have a bearing on health. Population education is a key UNFPA strategy for promoting the health of school children in some 70 to 75 countries. UNFPA’s approach to population education includes participatory teaching techniques to help children care about others and what happens to the environment, and to learn to take decisions. Reproductive health is of great relevance early in life and in early adulthood, and often sparks controversy. UNFPA has found, however, that reproductive health programmes can introduce some of the most important concepts without creating controversy or criticism. This can be done by placing the emphasis on respect for others, self esteem, the possibility of planning families, the understanding that children are ideally born of a conscious decision of loving and responsible parents, and the importance of postponing first pregnancy and resisting peer pressure. Mr Sikes noted that UNFPA does not know the complete impact of its efforts in this area but they have established some indicators and are seeing some promising signs.
Finally, Mr Sikes explained that UNFPA has been working with the E-9 Initiative, a union of the Ministers of Education in nine of the most populated developing countries. Mr Sikes advocates for strengthening the linkages between the E-9 and the Mega Country initiative because the Ministers of the E-9 are all concerned with school health. It would be a natural progression of the Mega Network to now link with the E-9.

**Cheryl Vince-Whitman**  
*Education Development Center, Inc. (EDC)*  
*WHO Collaborating Center to Promote Health through Schools and Communities*

Ms Vince-Whitman began her presentation by expressing how much she personally cares about this work. She believes in an equal opportunity for all children to develop their potential – and school health provides this. She then explained what EDC does and what factors EDC has identified as necessary to creating change.

EDC applies research and education strategies in early childhood education, education reform and girls’ education, math/science/technology, youth employment, adult literacy, and health promotion and disease prevention. EDC’s Health and Human Development (HHD) programs aim to promote health across the lifespan, with an emphasis on preventing health problems associated with reproductive health, nutrition, alcohol/tobacco/other drugs, sexually transmitted infections, violence, and mental health.

What does EDC do? In short, research and capacity building. EDC works to bring about change in the behaviour of individuals, policymakers and practitioners, and organisations. From more than twenty years of experience in this area, EDC has identified the following actors involved in changing policy and practice: a powerful and clear vision; policies; leadership skills; management support; data driven planning and decision making; team training/ongoing coaching; a critical mass; time and resources; and attention to local concerns.

To serve the Mega Countries, EDC is available to:

- Help promote the school health concept
- Conduct the Rapid Assessment and Action Planning Process
- Pilot test innovations (including the transfer of innovations)
- Develop programmes on particular issues, e.g., tobacco (policies of non-use, the intolerance of the behaviour, access and availability, cost, life skills)

Research on health education (in particular, a meta-analysis of 207 programmes, 19 of which were international) indicates that a life skills approach is the most effective in changing health-related behaviour; interactive methods have the largest effect, and are more important than class size; and that interactive methods produced results in 10 versus 30 hours.

There is lot of knowledge in this room. The question is, how do we apply it? How can we be knowledge brokers with each other, and use knowledge to make a difference?

**Lloyd Kolbe**  
*Division of Adolescent and Child Health (DASH)*  
*U.S. Centers for Disease Control and Prevention (CDC)*

Dr Kolbe began by expressing how gratified he is by CDC’s international work with WHO and EDC. He has found that the key to implementing school health programmes as well as
they can be, is substantial collaboration. For example, CDC has many specialised units, focusing on issues such as HIV, tobacco, TB, etc. All of these different units are now beginning to understand the impact they could have in schools, but, their beginnings in school health work lacks coherency. When thinking of the difficulties he has personally faced, he thinks of the following:

- We all have different ideas about what’s important to be done. Whose idea becomes implemented? When we work with others, we are concerned about the quality of the work – is it up to our own quality of work?
- Perhaps there is a competition for recognition and resources. There are finite resources out there for this work. We must compete with each other for those resources.
- There is also a competition for leadership.

Much more work is required before we can collaborate well. We need to find out what compromises are necessary, what our resources are, etc. Enormous potential exists in this room. Could we potentially reach half of the world’s population? We already have political support and resources invested. Dr Kolbe is grateful that CDC has invested so heavily in this initiative, i.e., by building DASH and gaining the support of every CDC director since the division’s establishment. There is no internal resistance since they all see for themselves the accomplishments of these international efforts.

**Monique Fouilhoux**  
*Education International (EI)*

What is EI? EI is a world-wide trade union organisation of education personnel. Its 23 million members represent 294 national trade unions and associations in 152 countries and territories. EI sees the school as an extraordinary setting for improving health, and a means of supporting basic human rights of education and health.

EI is convinced that education and health are mutually complementary and reinforcing. It believes in making youngsters responsible for their own health, whether that is for better or worse. In 1993, EI formed a school health alliance with WHO, UNESCO, EDC, CDC and UNAIDS.

Together, the partners organise regional workshops to strengthen the awareness of teachers and educational personnel of the importance of developing school health and to develop policies and programmes to prevent HIV through the school setting.

Some of the lessons that EI has learned in its experience with collaborative school health work include:

- Speaking with one voice gives more credibility to each organisation’s actions
- Partners from different sectors, such as health and education, need to learn each others’ language, organisational culture and particular procedures
- Tasks are more efficiently accomplished when partners develop a working knowledge of each others’ capacities
- National AIDS plans are not commonly known to union leaders and teachers

EI is organising a teacher training workshop for Anglophone African countries later this year. The training manual being prepared by EDC will be easy to translate into other languages. Finally, Ms Fouilhoux shared that, at the Second World Congress of Education International meeting in Washington D.C. last year, members adopted a policy resolution on “Health Promotion and School Health.”
A. Parsuramen  
*Division for the Renovation of Secondary and Vocational Education*  
*UNESCO*

Mr Parsuramen was glad to follow Education International, with whom UNESCO have worked for many years. EI is a very constructive organisation, dispelling many of the impressions we have of unions (organising strikes, etc.). As former Minister of Education in the Mauritius, Mr Parsuramen has learned that it is necessary to involve the teachers’ organisations all along. There is always a need to work with stakeholders and teachers’ unions in particular. It is important to train union leaders to be effective partners in health education and development.

Mr Parsuramen wanted to very sincerely convey to WHO, on behalf of UNESCO, praise for the excellent way in which WHO organised this meeting and the considerable efforts WHO has deployed over the years to initiate and promote the Global School Health Initiative. He also expressed his appreciation to the countries attending, and commendation to the other international organisations working in this important area. This meeting is a very useful experience and UNESCO is committed to working with all of you.

UNESCO has been in existence for 50 years. While UNESCO has done much in those 50 years to promote health and development, what is it currently doing in the area of school health?

- the E-9 Initiative
- architects at UNESCO are advising countries on the construction of buildings
- promoting the mainstreaming of health education in education
- contributing to the improvement of quality of life and promotion of a culture of peace, e.g., UNESCO collaborated with WHO and EI on a new document for violence prevention. The Department for the Promotion of a Culture of Peace has produced a kit on education for citizenship, which includes publications and teachers’ manuals for schools. As others have stated, UNESCO too is happy to share its publications, many of which are also copyright free.
- UNESCO produces an international science, technology and environmental newsletter; the lead article of a recent issue focused on “Health Promotion Schools: Promoting the World Health Organisation’s concept of health.”

Yet, Mr Parsuramen personally feels that they haven’t done enough. For example, there is still inadequate collaboration between ministries of health and education. They are often unaware of what each other is doing. There is also a need for more outreach activities for street children to access the most vulnerable children, who have greater than average health problems and risks. Distance and open learning is a powerful tool for teacher training and children’s education, yet it has not been fully exploited.

Mr Parsuramen would like to see a clear commitment to school health from the Director-General of UNESCO, as within WHO. However, agencies like ours cannot succeed if countries don’t take the lead. Your commitment is vital for us to succeed. It is thus important for governments to take policy decisions. We can aim for a common framework of action between WHO and UNESCO, let our governing bodies examine the framework and then present it to the member states. UNESCO would also like to work with WHO on the website and interactive technologies. A technical and vocational education training workshop was
held recently at UNESCO. Such tools can help our organisations meet the many demands for consultancies and support, in an affordable way.

The last area Mr Parsuramen wanted to emphasise was teacher training. UNESCO does a lot of work in that area. It has developed a resource kit on science and technology education, including nutrition. Finally, Mr Parsuramen looks forward to moving from declarations to action programmes.

UNAIDS

Interagency Working Group on HIV in the School Setting

Jack Jones

Jack Jones spoke on behalf of Michel Carael who was unable to attend the meeting. The Interagency Working Group on HIV in the School Setting was formed shortly after the establishment of UNAIDS. It has recently hired a new school health focal point to work out of the UNICEF New York office, to replace Mariella Baldo. Sonia Bahri emphasises that the working group is striving to encourage countries to use HIV as an entry point for developing school health programmes. The Group disseminates a resource package that includes young people’s activities, a curriculum guide for teachers and training guide. The Group has also updated the document, The Impact on HIV of Sexual Education, and developed a new document, entitled, Sex and Youth: Contextual factors affecting HIV. (Copies were made available to participants at the meeting.) The Group provides a mechanism for the UN agencies to better understand each other and increasingly coordinate their school-based efforts.

Eric Bernes

International Federation of Red Cross and Red Crescent Societies

As a newcomer to this group, Dr Bernes wanted to “break the chain” tying us to a limited view of what the Red Cross is. First of all, there are three main components to the Red Cross: 1. The International Committee of the Red Cross, focusing largely on conflict and emergency situations 2. National societies, 175 worldwide (this number will increase by 5 to 8 this year) 3. The International Federation, which Dr Bernes represents

The mission of IFRC, which is in draft form, to be published in Strategy 2010 in October this year, is as follows:
The Red Cross/Red Crescent works with vulnerable people to:
- alleviate suffering by assisting and building the capacity of people living daily in a situation where their social and economic security, their human dignity and even their survival is threatened.
- Prevent suffering by helping people prepare for and avoid exposure to situations that can cause dramatic increases in their vulnerability
- Assist people who due to a sudden crisis suffer a dramatic increase in their vulnerability

The basic characteristics of IFRC is to act as a privileged partner. IFRC is the only international humanitarian NGO existing according to a special national law defining its auxiliary role. It is a national entity supported and backed by an international network. It is the largest youth network, and the leading organisation in First Aid. Another basic characteristic of IFRC is that it contributes as a recognised partner. The Red Cross/Red
Crescent National Society is rooted in civil society through its volunteer base. A volunteer is an individual who represents and works on behalf of the community (s)he serves. This large volunteer base keeps RC humble because it brings knowledge from the ground to the top and vice versa.

IFRC sees the following possible directions for collaboration:

- To encourage a comprehensive and integrated approach to service delivery with due attention to the characteristics of the communities and respect for local realities.
- To develop long-lasting partnerships from the local to the global levels. A recent example is the Memorandum of Understanding between IFRC and WHO regarding injury management and prevention. Also, the Global Road Safety partnership helps unite interested parties for a critical mass and momentum. As the agenda is shared amongst all players, they speak with one voice rather than through differing resolutions. Such unions also facilitate replication and transfer good practices across different contexts and regions.
- To complement the design of programmes and reinforce their implementation in the communities.

Colin Yarham
*Health Education/Health Promotion International (HEPI)*

HEPI works in regions, sub-regions, countries and states to enable schools and education systems to produce a useable, realistic, comprehensive and integrated health, life skills and social issues education curriculum. Essential to HEPI’s philosophy is that “Health” encompasses the physical, spiritual, mental and social. In this vain, the “Schools Total Health Programme” Teachers’ Manual, together with HEPI training workshops, inevitably lead to a resurgence of the teaching/learning environment, to focus on child-centred and action-oriented teaching methods which empower children regarding their health and that of their families and communities.

HEPI is dealing with children in need, not projects or programmes. It is dealing with care and love in outreach to children. It is dealing with a life orientation for children and young people who represent a country’s future. They may contribute very positively to their family and community.

Teaching should not be rote learning. It must aim to change behaviour as well as knowledge, attitudes and values. We must deal with anticipation for a changing future in our education. We must prepare the child for a future and for participation. HEPI deals both ways. In its working groups, it is a team including youth. Youth serve as trainers. HEPI wants the work with governments to be sustainable, and that money to be used in schools. Education for health is often ignored and teachers are often not adequately trained in health issues. Wonderful material like that distributed at this meeting, is not reaching those who need it so desperately.

The *Schools Total Health Program* is a comprehensive, sequential, action-oriented Health Education and Promotion, Living Skills Curriculum, for standards I to XII of all schools in Tamil Nadu, India. It has been developed by the users; they are the owners. It covers eight areas: the whole human, responsibility and health, social health, safety health, environmental health, human nutrition, drugs and consumer health. Living skills are used as the methods of teaching for all areas of the curriculum.
DETAILS OF DISCUSSIONS
SMALL WORKING GROUPS

Jack Jones

“Until this point, the meeting has focused on identifying the strengths and needs of the Mega Countries and the resources available to the Mega Countries from each of the international organisations represented. To use Mr Parsuramen’s words, the time is now right to move from a point of declaration to a point of action.” Participants broke up into three working groups to:

- Review the list of strengths/challenges/resources from previous sessions
- Identify additional strengths/challenges/resources among participants
- Consider what unique strengths countries and organisations can share to reduce their needs
- Determine what needs require support that is not available among the participants?
- Identify what tasks must be undertaken to share the strengths and fulfil the needs identified

Report from Group 1

Group 1 agreed upon the following tasks that can be undertaken to share strengths and fulfil needs of the Mega Countries:

- A comparative study between countries
- A call for attention to certain issues, such as teacher training
- Creating the total package which will be a training model for teachers and health workers
- Determining how many countries have a written national school health policy (It appeared from the hands raised that China, Indonesia, Brazil, India and Mexico do)

Report from Group 2

Strengths:
There is a trend in several of the countries to strengthen relationships between the national level and state and local levels. For example, Mexico and Brazil are moving more toward a united health system at the national level, with implementation controlled at the local level. There are national parameters (e.g., to provide funding and policies and means to implement them) with a lot of freedom at local levels. In Brazil, a centralised television channel provides opportunities for distance learning and teacher training across the country (it’s too early to evaluate its effectiveness so far). In Mexico, relationships between the National and 24 State Commissions are strengthening. The states and municipal governments have the right to decide what works in their area, their own curriculum, organisation, etc. In both Mexico and Nigeria, a national curriculum has been developed but can be adapted for local use.

Participants also noted that the role of local communities seems to be growing. Participants sense that communities are more interactive and involved with schools, not just perfunctory relationships, but a greater investment.

Challenges/Needs:
In Nigeria, many schools are closed because teachers are striking. In these conditions, it is an enormous challenge to get anything moving.

To reach teachers systematically, e.g., through telecommunication and distance learning. Need to work closely and constantly with teachers, especially where there is a lot of local autonomy. This includes pre-service, in-service and continuing education, and not only in the area of health.

To provide supervision and assistance to local communities, particularly rural areas. And to promote pilot projects.

To reduce barriers so that communities can work together to develop health-promoting schools. In the USA, tools have recently been developed to help communities dialogue.

Evaluation! Especially at the state and local levels.

Political and financial backing is often not there.

Flexibility to be ready to contribute to disasters which are related to health, and to be flexible to change in times of disasters (earthquakes, floods, conflict, etc.)

What can the participants of this meeting do together?

• Create opportunities for local people with local experiences to share those experiences. This could be done either by bringing people together and creating opportunities for people to meet, or by sharing experiences through the web.
• Create an intranet for the Mega Network members, e.g., to share good practices.
• Holding a meeting that focuses on curriculum development in the Mega Countries.
• Reflecting on what has worked and sharing practical action, or models that work.
• Generating political momentum to help create one voice through which politicians and others can be convinced.
• It may be useful to approach policymakers by citing the economic benefits of school health. An economic dimension is essential these days. For this, we will need to demonstrate cost-effectiveness, including the contribution of school health programmes on socio-economic development.

What tasks can be undertaken in the next 6 to 12 months?

• Identify best practices of school health; these can be shared through the 5th Global Conference on Health Promotion in Mexico.
• Create a scholarship, or short-term exchange system, to share experiences among Mega Countries. This can be an exchange of teachers or health professionals.
• International agencies can prioritise social issues and push national governments to prioritise social issues in terms of economic benefits, etc. International agencies can also try harder to work together rather than chasing their own goals and disrupting what exists. This should be communicated to the regional offices and country offices who are not present at this meeting.
• International organisations can advocate for national objectives, but need evidence and data from the countries to help them do that.

Report from Group 3

An additional resource: CDC’s research synthesis project looks at the evidence from a variety of studies on a variety of topics and programmes – those shown to be effective, e.g., in changing health risk behaviours. This information is available on CDC’s webpage, called “Research to Classroom
Programmes that Work”, at http://www.cdc.gov/nccdphp/dash, and may be helpful to the other participants here.

Collaboration
• The United States needs to find opportunities to collaborate, using existing mechanisms (such as ICSH)
• Collaboration may be more common at the local level. Perhaps a demand from the local level could facilitate collaboration at higher levels.
• Need to involve government at all levels for programme initiation and sustainability.
• Must develop political will at all levels.
• While coordination and collaboration may occur at the local level, there is often a need for national support.

Approaches and Definitions
• Countries and agencies must develop a common language, e.g., “health education” and “health information”
• Mandatory versus voluntary programmes, e.g., Russia
• The U.S. model of gathering feedback from 50 states rather than trying to reach all schools
• May want to start collaborative efforts by identifying the “common ground” on specific health topics

Action Steps
• WHO creates a sense of responsibility and participation, and assists ministries clearly define their roles
• International organisations could draft a letter to ministries/secretaries stating their support for school health promotion.
• Develop a framework for integrating existing strategies and resources

END OF DAY 2 GROUP DISCUSSION
Facilitated by Dr Pamela Hartigan

What should we do to take the first steps forward to implementing the tasks listed by the working groups? Specifically, what should WHO do in the next six months? What should Mega Country representatives do in the next six months? What can other international organizations contribute? What can WHO, other international organizations, and Mega Countries do in a concerted effort?

• In concert, the Mega Network can provide models of good working relationships between ministries (such as Indonesia’s 4-ministry School Health Coordinating Board and China’s collaboration between the Ministry of Health and the Ministry of Education since 1990). The Network can aim to offer ways and means for the two to work together, outlining the process of collaboration, including the relationship-building necessary and how to bring people together. This would stress the need to have clearly defined roles, avoiding ambiguity. The unique roles of both are very important, and they must work together hand in hand.
• Mr Parsuramen proposed that WHO and UNESCO, with their respective constituents – Ministries of Health and Ministries of Education – develop a joint framework for collaboration and present it to their governing bodies who would examine it before presenting it to the member states. Dr Kolbe agreed that since UNESCO has specific capacities and WHO has specific capacities, “let’s finally put them together for this purpose and reality test it in one nation.” Dr Kolbe also suggested that it may be feasible for UNESCO, with involvement of the Director General, other UN agencies and with EI, to jointly craft a letter to the Mega Ministers of Health and Education stating the following:
  ➢ School health programmes are important from each of our perspectives, and there is evidence that they work
  ➢ The UN agencies are going to work together and model partnership (complementing each other’s strengths)
  ➢ We encourage Ministries to make school health a priority

• Several participants stressed the importance of commitment at the national level, evidenced by a clear national policy developed jointly by the relevant ministries. It was acknowledged that laws don’t always solve the problems and having a policy is not necessarily going to help.

• UN agencies need to work at different levels, especially with countries to have the best chances for success. The UNAIDS Inter-Agency Working Group presented earlier is a good model of collaboration, to ensure that different agencies fill each others’ gaps and avoid duplication. It is a useful model for working at the international level. How can we use that model for other health issues, perhaps not as devastating in their impact as HIV/AIDS, but still relevant to communities?

• Most participants agreed that equally important to international and national commitment is the ongoing commitment of dedicated individuals at the local community level. What exactly is required at the local level? Is there anything we can do to ensure that a minimum amount of school health activities are taking place in schools? For example, could the Mega Countries even agree to tobacco-free schools? Dr Chandra-Mouli asked if there are five minimal conditions that should be in place. If we could find that commonality, we would have some comparable indicators to measure. But, can we find five universal elements? If so, would a minimal package be more damaging than a programme that addresses the multiple dimensions of health?

• How do you do both? How do you get the minimal package there, while also building the sustainable systems? Dr Hartigan noted that money from the outside may be one of the obstacles to sustainability. Some of the most sustainable programmes have been where no donor money has reached the shore, like Cuba for example. Yet, support from international agencies has been invaluable in some countries, like Brazil. Even if the international organisations don’t have unique policies, they are still playing an important role. We can’t keep them out of it.

• If UN agencies were to work well together on school health, what do we as nations go back and do? One thing we could do is reconfirm with our Ministries of Health and Education that it is vital for the same participants to come to these Mega meetings; otherwise, we are treading the same ground each time we meet.
Overheard on Day 2

“We don’t need to reinvent or create new establishments, but to improve the ones we have and connect with others. We need to bring sectors together, particularly for issues like teacher development.”

“The Ministers of Education in the E-9 countries are all concerned with school health. It is a natural progression of the Mega Country Network to now link with the E-9 initiative (which unites the 9 most populated developing countries to strengthen basic education).”

“The key to implementing SH programs as well as they could be implemented, is substantial collaboration. Why is that difficult? (1) We all have different ideas about what’s important to be done – who’s idea do we implement? (2) We’re all concerned about the quality of the work – is it up to our own quality of work? (3) Competition for recognition and resources. Much more work must be done before we can really collaborate.”

“All the valuable information in this room is not available within countries, to those who need it most. This is the obstacle.”

“We aren’t here to micromanage. We need to focus on the strategic planning required.”

“Let’s engage young people and hear what they have to say. Involve them at different levels. Sit down with them and let them talk to you.”
DAY 3

OFF THE AGENDA
Before moving to the first agenda item of the day, O.J. Sikes took a moment to describe the E-9 Initiative. It is a union of the Ministry of Education ministers from the nine most populated developing countries in the world, with three UN convenors: UNESCO, UNFPA and UNICEF. UNDP and the World Bank have also expressed interest in joining. At one point, the members specifically asked for WHO to join.

At a recent meeting of the E-9 Ministers, school health was identified as an important area of focus. With the political force this groups has, it would be useful to link the Mega Country Network with the E-9. This would be up to the ten Mega Countries to decide.

This led to a brief discussion of other networks and regional organisations with which the Mega Network could link, such as ASEAN. CDC and WHO have also had good discussions with the European Union, who may be interested to become a “Mega Country” member. As they have muscle and resources and expertise, they could be an asset to the Network. Some participants asked how we would relate to these important groups and networks? And is this discussion about EU one that the broader Mega Country HP Network has been having? Is input from this school health component group being sought? One participant noted that they stand confused from everything that is already on their plate. WHO needs to prioritise what is to be brought under the school health component of the Mega Network.

DISCUSSION: HPR'S REQUEST FOR CO-OPERATION
Facilitated by Jack Jones

- What it proposes to do
- How it can be improved
- Potential for international/national co-operation
- Recommendations for action

The Request for Cooperative Action (RCA; “Strengthening national capacities to promote health through schools”) was sent in advance to the Mega Country representatives. A copy was also placed in each participants’ folder. Jack explained that priority issues must be the primary consideration of WHO. The limited area of school health has so many facets to address, that even it can overwhelm us.

The RCA is an attempt to address one of the major barriers identified by the WHO Expert Committee: the barrier of collaboration and coordination between agencies. The Global School Health Initiative has as one of its four strategies, the strengthening of networks and alliances for SH promotion. The alliance WHO has formed with EI for the prevention of HIV in school, working closely with teachers’ unions, is one example. Last July, WHO, EI, EDC and CDC met with representatives of six Mega Countries, including the teachers’ unions. Together, they identified school health priorities. WHO agreed that we would try to put in place a mechanism to help support those priorities. This RCA is in response to those priorities identified in the Washington meeting.

Preparation involves only one proposal from each country, jointly developed by the “core group”, i.e., the Ministry of Health, Ministry of Education and the teachers’ union. However, WHO welcomes other organisations as participants in the core group.
The RCA outline five areas of cooperative action that proposals can fall into:
1. The Rapid Assessment and Action Planning Process
2. The Youth Risk Behaviour Survey
3. A national conference on school health
4. Pilot projects based on the WHO Information Series on School Health documents, which would include training in their use.
5. Adaptation of school-based interventions with evidence of effectiveness.

Do the participants have any questions, thoughts, concerns or worries at this point?

- Dr Suharto mentioned that Indonesia will soon run a big programme of deworming, using antihelminths. Does the group have advice regarding a blanket versus a selective approach to the distribution? Are there any countries with experience in this area that can help? Dr Yu provided examples of work already being conducted in Indonesia, e.g., in Sumatra and listed some of the rich resources at WHO on these technical issues, including the School Health Information Series on helminth programmes in Health-Promoting schools. Technical support on this issue is not a problem. Regarding the issue of screening, there is a recommendation from WHO that if the prevalence of helminth infection is over 50 percent in a community, there is no need to undertake mass screening for every child. Drugs are available and affordable and safe. In Indonesia they have been donated.
- Initiating helminth programmes can be a good opportunity to begin coordinating with other health efforts in schools, like nutrition education. There are comic books in Indonesian on nutrition, hepatitis, diarrhea, Dengue Fever, worms, with summaries in English, and which come with teachers’ guides. Children love them.
- Brazil has 42 videos for schools, being televised across the nation.
- In Nigeria, there are so many different teaching languages that it is difficult to provide these nice materials and reach all those who need them.
- Jack Jones noted that developing such materials is a capacity that ministries need to have, but they often do not. In many cases, this capacity needs to be built. The five action areas of the RCA were identified to build those capacities, as opposed to creating specific things, like videos or learning materials. Jack’s question to the group is, do you feel that the kinds of actions we are suggesting are a complement, or not?
- Dr Oyeledun cited the 1997 Progress of the Nigerian Child Report, produced with UNICEF and UNESCO. She read discouraging statistics about inadequate supplies of chalk, chalkboards, books, visual aids, etc. In these conditions, how is there any learning achievement? What needs to be done in Nigeria is to look at what is happening – do a rapid assessment to know exactly what the problems and solutions are. This will also help form a basis for indicators to monitor progress. WHO can not do everything, so what is most important? When the most basic facilities aren’t there, we can not do what WHO is proposing – build Health-Promoting Schools. Would it be feasible very simply for Nigeria to submit a proposal in response to the RCA and figure out how to work with UNESCO, to address teacher training and begin taking that step, and then bring in the capacities of WHO and other international organisations, and begin to address those issues and deepen understanding?
- If the proposals are due by August 31, when is funding available? Mr Jones explained that three countries would receive funding before the end of this year.
- Is the money enough for a small pilot project? Mr Jones clarified that the money is not meant to cover implementation of the projects, but to help the parties organise their own
resources so that they can implement the projects themselves. The funding is intended to support organising and collaboration and so that the central level is engaged from the beginning. International organizations working at the country level must be knowledgeable and aware of their role in school health promotion. They should facilitate and augment the national governments in the design and implementation of the programs, but should not drive the priorities.

- Peter Glasauer said that FAO is very happy with this RCA and understands it as seed money; a catalytic proposal. It is not to support a fully-fledged project over a long period of time, but intended as a starting point. Like WHO, FAO is a technical assistance agency, not a funding agency. We recommend that countries propose a project for which they need technical assistance or have difficulty starting. Remember that there will also need to be shared costs and investments by the government. FAO would like to assist in doing these activities as proposed. However, they got high blood pressure when they saw the timing, because the fiscal year planning has already been done for this year.

- The representatives from Pakistan expressed concern about the timeframe. With a large government bureaucracy, it is difficult to move this quickly.

- Colin Yarham sympathized with his colleagues from Nigeria and Indonesia. The mandate of WHO is to work with governments, but reaching people on the ground is a very worthwhile initiative. Health Education and Promotion International would be happy to work with any country at the local level. For example, teachers need support in classrooms, so dialogue needs to be established to reach this level.

Jack Jones noted that despite talk about building capacity and capitalising on our strengths and addressing our needs, few specifics have been mentioned. He posed this question to the countries in attendance: *What is it you want to do in the next year, and what are the resources you have heard here that can help you?* The responses follow:

(The representative from Bangladesh also wanted to hear what WHO is going to do in the next six months? And, what are the international organisations going to contribute? This has been discussed and we have indications of their areas of assistance, but this participant was interested to know what WHO is going to do in the short term.)

**INDONESIA**
- A training model for health providers

**PAKISTAN**
- A needs assessment
- A new curriculum
- Help translate WHO’s prototype materials
- Establish a monitoring mechanism as this is currently non-existent (Monitor implementation of health education curriculum in Pakistan)

**INDIA**
- Conduct a pilot study on the implementation of school health education, especially at the primary level, in 1 or 2 states.

**CHINA**
- Student nutrition improvement projects. The school lunch programme developed in the 1980s has been extended to numerous cities. A soy bean action program has been instituted by the national consulting committee on food and nutrition. The main
objectives are to improve the nutritional status of schoolchildren, by providing soybean products. Good linkages are possible with FAO, through Peter Glasauer.

- The development of Health-Promoting Schools. The MOH and MOE should reach consensus on these points, through which we can establish closer connections for health promotion in the future.
- A training course on the National Guidelines for Health-Promoting Schools, introduced earlier in this meeting. Health-Promoting Schools can be pilot test schools. Trainees can become trainers in the future, from both health and education sectors. The Local Action and Healthy Nutrition documents in the WHO Series may be helpful.

MEXICO
- Training of teachers and health personnel – the experience of the EDC/EI/UNESCO alliance could be very useful.
- Implement an evaluation project in terms of Health-Promoting Schools.
- Define specific indicators to help us gauge the impact of school health programmes.
- The first national Health-Promoting School meeting, within the next year. Mexico could benefit from technical support for that.

NIGERIA
- Conduct a rapid assessment of the situation on the ground, to know exactly what is happening and to identify the gaps.
- A plan of action to determine the direction we want to go in terms of promoting health through schools. To have a clear minimum package for what should and can be done to promote health through schools. To determine what resources we have nationally, e.g., local NGOs, in addition to international agencies that can assist. Because international organisations are often controlled by their mandate, it would also be helpful to call on groups like EDC and CDC.

BRAZIL
- We could not write a letter of intent, because we were unable to discuss this with the national union. They had elections recently and the new director was not familiar with WHO. We have provided information for them and will discuss again when we return. Jack Jones suggested that EI speak to their affiliates in Brazil and identify receptive people with whom the ministries can collaborate.
- Between the ministries, we have discussed all five possibilities and know that we do not want to make a diagnosis. We have already done this and now it is time to act.
- We need to work with teachers and provide continuing education to build a network of Health-Promoting Schools. A meeting is being organised with the secretariats of health and education of all Brazilian states, to be held in October, which will discuss Health-Promoting Schools.
- Produce a new series of videos and transmit them through distance learning, the only way to reach all teachers in the country.
DISCUSSION:
HOW CAN WE COOPERATE AND MAXIMIZE USE OF INTERNATIONAL AND NATIONAL RESOURCES TO IMPROVE COMMUNICATION AND LEARNING?
Facilitated by Desmond O’Byrne

Dr O’Byrne introduced this session by asking us to consider the minimum communication effort necessary if the Mega Network is serious about what it is doing. How can we develop and maintain dialogue and communication between the members? WHO/HPR has given a lot of thought to creating a global network of Health-Promoting Schools through the world wide web. Angela Raviglione and Amy Maines presented a mock-up of what this website would look like. It would in essence be a network of websites, connecting and providing resources for those working at the local, national and international levels. GSHI would provide links to the regional networks which link to their member states, which in turn link to local networks. The website would provide specific project information with menu items specific to each level. This website could be an “extranet,” accessible to members of different organisations via a password. The website could also be a forum for online discussions and listservs, to facilitate communication on a global level.

The HPR staff then posed these questions to the group: Does this format work and cover all our different needs? To what extent do we want to provide content in different languages, and with what resources? Do the countries have the hard and software needed? If not, could WHO provide it? Would it require training so that members can load information onto the web and download it off the web? This effort would also need full-time human resources to maintain and update the site. Would this kind of generic training be possible within the different ministries, for overall capacity building? If so, in what timeframe?

Cheryl Vince-Whitman shared experience the Collaborating Center at EDC has gained in supporting on-line communities. EDC has learned that a listserv needs a person who knows the content in order to both challenge and manage the discussion. The facilitator needs to provoke the questions and help exchange the information. EDC has found that conversations on the internet are different from those held face to face. For example, on-line, the quieter people have time to think and engage in the issues. This is a very different forum and the manager needs to know that. The costs of supporting this kind of forum need to include the salary of the facilitator as part of the management functions.

Cheryl then asked the participants to consider whether this is a means and mechanism they want to use.

One specific function Member States can now do is actively engage teacher training institutes in understanding the website, so that they can access a huge amount of resources. There is a worldwide wealth of resources already available. The members of this network could develop an online teachers’ course, with interactive activities that teachers can try.

UNESCO is developing a similar website to help implementation of technical education. At the recent World Congress on Technical Education, ILO and UNESCO officially agreed to sponsor this website together with the World Bank. It is as practical as it can be, and tries to affect different levels of users – teachers, students, etc. There is an accompanying CD-Rom to use offline.
Cheryl Vince-Whitman suggested a very specific action step: that everyone pledge to go to the WHO website when they return home, and send feedback to WHO. This will also help ensure interaction for the first month after the meeting. The website also has a comment box that viewers can fill in to help WHO evaluate its usefulness.

Peter Glasauer suggested that whatever we put on the web should be very user-friendly, including at the village level. It should also be in a language that is easily translatable. We don’t want to fill the website with junk, but make it as useful as possible. Also, because people are very busy, and the web can be overwhelming, we should only provide the most essential information. Amy Maines explained that text on the web needs to be short and concise because people read more slowly when they read from the screen.

Amy also stressed the importance of defining the purpose and user of any website. In the discussion, she has heard people refer to different purposes, such as a global website, a resource for teachers at the local level, and a reference for use at the headquarters level. She recommends that the group define the purpose clearly before the site is built, both in order to eliminate overlap and know the user group.

One purpose could be to use the website as a live link to coordinate and plan together; as a management tool, e.g., for upcoming meetings. To improve our management and coordination of this Network, we need to keep in frequent contact, as personal as possible. Mr Glasauer strongly suggested we evaluate this exercise, to know its usefulness and impact over time, and whether it helps the situation at the local level. Perhaps the moderator could deliver a skillful, high quality evaluation of both the process as well as outcomes. This would require building a timeframe with goals.

Are there communication methods other than electronic that we want to discuss? What about video links, telephone conferences, participation in each others’ conferences and meetings? The broader Health promotion Mega Network is establishing a centre of excellence in each mega country to facilitate and support work of the Mega Country Network.

To help us keep in touch, the following actions were suggested to all:

- Send a list of upcoming meetings, with their date, venue and objectives, to Angela raviglionea@who.ch so that we can know and avail of opportunities.
- Send an e-mail to WHO when you return, to let us know you arrived home safely and what you thought of the meeting.
- Try to send an e-mail to the group at least once a month.
DISCUSSION: 5TH GLOBAL CONFERENCE ON HEALTH PROMOTION, JUNE 2000
Facilitated by Dr Pamela Hartigan

Dr Hartigan began by announcing that this conference will be different than other conferences. She would like this conference to break open the “health promotion mafia” that has formed over the years and expand the health promotion universe. It will highlight what is happening in countries, defining the nature of change that people in the countries have seen. The theme of the conference is Bridging the Equity Gap, and will emphasise that health promotion is not intended to make healthy people healthier. This conference will look at what health promotion offers to people living in very minimal conditions. The goal of the conference is to show that health promotion makes a difference to health and quality of life especially for people living in adverse conditions. One hoped-for outcome is that health will be placed high on the development agenda of international, national and local agencies.

Dr Hartigan then outlined how the days will be organised. Case studies will be the focus of each day’s plenary sessions, illustrating examples of health promotion at work in developing countries and bringing to life (through creative multimedia presentations) the themes identified in Jakarta:
- Promoting Social Responsibility for Health
- Increasing Investments for Health Development
- Improving Community Capacity and Empowering the Individual
- Securing an Infrastructure for Health Promotion
- Strengthening the Evidence Base for Health Promotion
- Reorienting Health Services and Systems

The case studies will be followed by presentation of technical papers on each of these above themes. The idea is to spark interest in the thematic area by presenting case studies and then presenting the knowledge base on which this practice rests, through the technical reports. There will then be 90 minutes of break-out session to discuss and debate the issues raised. Two products will result from this process: refinement and publication of the technical reports and publication of the case studies.

All Ministers of Health worldwide will be invited by Mexico to attend the conference and to sign a Ministerial Statement that puts health promotion at the top of the development agenda, and through which they pledge to develop a national plan of action for health promotion.

Discussion following Dr Hartigan’s presentation
Where do Health-Promoting Schools fit in here? There are obviously many wonderful examples of Health-Promoting Schools all over the world. Perhaps we can pull together four to six examples worldwide that could be presented as one case study. This would showcase concrete examples of what is happening at the country level.

This conference aims not just to talk about health, but about the systems that affect our health, e.g., our systems for waste, water, transportation, etc. Health Promotion is not a discipline but nurtures itself from a variety of disciplines. There is still the impression that health promotion is all over the place, without focus, which this conference would like to correct. One participant asked how, in addition to health promotion people, or the ‘mafia’, do we hope to include a critical minority from the other sectors? Who will identify them? Dr Hartigan said...
that will be done through our existing networks outside the health field, for example, through our sister UN agencies, Education International, the World Bank, etc.

Chandra-Mouli noted that we often talk about successes. Who is going to present the failures? Where have we erred? One question for the case studies may be, why haven’t they expanded or mainstreamed? What were the limitations in scaling up?

Dr Hartigan agreed that humility is essential for gathering evidence of the effectiveness of health promotion efforts. We need to look carefully at what the evidence is telling us. Also, what are the measures we’re using? How are they going to show the successes and failures? The answers are murky because of the ways we are measuring. We will have a learning experience through the development of the cases themselves.

We have not yet discussed anything at all about the next meeting of this group – would that be in conjunction with the 5th Conference? Could these people come to the conference?

UNESCO offered to publicise the conference on their website. WHO can send them articles for the Connect newsletter.
ANNEX 1

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