Fourth Annual Meeting
of School Health Component of Mega Country Network

REPORT

Paris, July 15–18, 2001
Final Version, December 2002
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APPENDIX
A   The following documents are available online: http://www2.edc.org/hhd/who/mega4_2.htm
C   Advocating for School Health: Presenting an Effective Case for Decision Makers, Presentation by Cheryl Vince Whitman, July 15th, 2001
D   Focusing Resources on Effective School Health: A FRESH Approach for Achieving Education for All, Document distributed by Cindy Joerger, July 15th, 2001
E   FRESH and the World Bank, Presentation by Donald Bundy, July 15th, 2001

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F  Worksheet for Integrating School Health into National EFA Workplans, Document distributed by Jack Jones, July 16th, 2001

G  Mega Country Health Promotion Network - School Health Component, Website document distributed by Carmen Aldinger, July 16th, 2001

H  Changing Hearts, Changing Minds; A Model School Tobacco Control Intervention for Students Ages 12-14, Document distributed by Cheryl Vince Whitman, July 16th, 2001

I  Rapid Assessment and Action Process (RAAPP), Document distributed by Scott Pulizzi and Phyllis Scattergood, July 16th, 2001
1. INTRODUCTION

The fourth annual meeting of the School Health Component of the Mega Countries took place in connection with the International Union on Health Promotion and Education's (IUHPE) XVIIth World Conference on Health Promotion and Health Education in Paris, July 15-20, 2001. This was an opportunity for Mega Country representatives to meet face-to-face, attend and present school health workshops, learn about the latest developments in school health such as the FRESH framework that was launched at the World Education Forum in 2000, and participate in interactive exercises.

2. MEETING OBJECTIVES

a) By the end of the meeting, Mega Country and E-9 representatives will: demonstrate strong arguments, using resources and other information made available at the meeting, for improving health and school health policies and programmes as part of a strategy to achieve EFA.

b) By the end of the meeting, Mega/E-9 Country representatives will be able to identify the four basic components of FRESH; why they are important to improving health through schools; and at least one way, each of the UN agencies and other relevant organizations can help them to develop the components of FRESH to improve health and education.

c) By the end of the meeting, Mega/E-9 Country representatives will be able to describe the EFA Framework and its school health and health components. They will have received guidelines, materials and instruction about the processes and procedures involved in creating a national EFA action plan and requesting needed funding to implement the action plan.

d) By the end of the meeting, Mega/E-9 Country representatives will be able to identify concrete steps they can take when they return to their countries to support EFA and to ensure that school health is an important part of their national EFA action plans.

e) By the end of the meeting, Mega/E-9 Country representatives will have analyzed the content of national and/or international school health policies relating tobacco use and/or HIV/STI, and discussed models of such policies that might be considered to develop or improve such policies in their countries.

f) By the end of the meeting, Mega/E-9 Country representatives will have participated in training and provided feedback on a “virtual network” for ongoing communication and resource sharing among the School Health Component representatives, E-9 participants and other partners. They will have also provided feedback on an outline for a Model School Tobacco Control Intervention and a draft UNAIDS policy for HIV/AIDS, Schools and Education.

g) By the end of the meeting, Mega/E-9 Country representatives will have outlined next steps and recommendations about specific actions they or the participating agencies should take to improve school health programmes during the next 12 months.

h) By the end of the meeting, Mega/E-9 Country representatives will recommend that FRESH be addressed at UNESCO’s Education Ministers meeting in August 2001 and delineate “next steps” and recommendations of this meeting be presented to the Education Ministers.
3. RECOMMENDATIONS

1. Multi-Risk Information Surveillance Systems
The Department of NCD Prevention and Health Promotion (WHO/NPH) should invite UNICEF, UNESCO, UNAIDS, UNFPA, FAO, WFP, UNDCP, Education International and other international agencies with relevant expertise to work with Mega Countries and other selected countries to jointly develop and implement a School-based Multi-Risk Information Surveillance System that provides comparable data about risk behaviour among students around the globe.

2. Declaration of Support and Effort for School Health by Mega-Countries
The Mega Countries developed a Declaration of Support and Effort which was provided to UNESCO to be delivered to the Ministers of Education of the E-9 countries at their August meeting. Health is recognized within the EFA Framework for Action and should be addressed in national action plans to achieve the goals of Education for All. FRESH is identified as a flagship programme by EFA planners and serves as a means of improving health through schools. Mega-Country support was essential in the effort to include school health in EFA and this Declaration will help to reinforce the focus on health that is needed to improve learning, schooling and the educational environment.

3. Tobacco Policy
WHO/NPH should provide technical support to 2 - 3 countries to pilot test guidelines for creating and enforcing school tobacco use policies and to pilot test a draft of the WHO Model School Tobacco Control Intervention. Each assisted country should consider setting up an advisory group, including representatives of the Ministry of Health, Ministry of Education, teacher unions, and other relevant organizations interested in the health and welfare of students and teachers. The advisory groups should select 5-10 schools where school personnel and students are prepared to make a commitment to co-develop interventions with WHO and its technical partners. The countries should report the results of these efforts at the next meeting of the School Health Component of the Mega Country Network. Mega Country representatives from Indonesia, Mexico and Pakistan volunteered to work in support of this effort.

4. Funding
The Mega Country representatives commend the World Bank for making the commitment to ensure that no feasible national action plan to achieve EFA will go unfunded. They also support FRESH, the joint WHO, UNESCO, UNICEF and World Bank Initiative that calls for focusing resources on effective school health programmes. The Mega Country representatives recommend that World Bank and FRESH partners help countries integrate funding and coordinate efforts from various sources for school health and HIV/AIDS prevention, especially in countries eligible for debt relief. The Mega Country representatives also recommend that the language about funding for EFA and FRESH include the word ‘grants’ as well as loans.

5. Mega Country Website
The Mega Country representatives recommend that the following items be updated or added to the Mega Country section of the website:
Mega-Country accomplishments and challenges (countries which have not yet provided information to EDC should do so as soon as possible)
Contact information about Mega Country representatives and partner organizations
Links to resources and new documents that are developed and submitted Mega-Countries on an ongoing basis
Ongoing guidance on the development of EFA workplans with documents from UNESCO,
Information about multi-risk factor surveillance
A “Submit/Post” button on the first page of the Mega Country section of the website so countries can submit information
In addition, the representatives recommended that WHO/NPH and its partners investigate how the site can be used as an assessment tool and identify ways of making materials and documents available in the member country’s languages, in addition to English, Spanish and French.

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6. Inviting additional UN agencies to participate as partners
The Mega Country representatives recommend that additional UN Agencies be asked to participate in the School Health Component of the WHO Mega-Country School Health Promotion Network, such as UNAIDS, UNFDP, WFP, UNDCP, UNFPA, FAO and that WHO continue to convene and facilitate the meetings and related consultations. WHO should also continue to consult with other partners, such as Education International and solicit additional partners. At future meetings, it may be useful for the UN Agencies and other partners to meet on the day prior to the Mega Country meeting to agree on activities and collaborations.

7. Sharing of concrete country experiences at the next Mega-Country meeting
The Mega Country representatives recommend that the next meeting include the opportunity for 1-2 countries to make an in-depth presentation of their school health efforts. They also recommended that the next meeting of the School Health Component of the Mega Country Network be held in a Mega Country and that the host country make a presentation on school health in their country. The host country could bring in children, teachers, representatives of other partners, and representatives from the Ministries of Education and Health. India extended an offer to host the next Mega Country meeting in New Delhi.

8. Consideration of Multi languages in Mega-Country meetings
Mega Country representatives recommend that WHO and other UN Agencies explore the possibility of providing translated material at the Mega-Country meetings, concurrent translations of presentations, and translated proceedings.

9. Meetings with country and regional level representatives of UN Agencies
It was recommended that representatives of the School Health Component of the Mega Country Network contact regional and country offices of UNICEF, UNESCO, FAO, WHO and other relevant international organizations to obtain up-to-date information on topics such as EFA, national AIDS plans, Health-Promoting Schools, Child Friendly Schools, etc. Many regional and national offices have websites. As much as possible, the offices should also be briefed on school health issues underway in the Mega-Countries.

10. Resource List
Mega Country representatives recommend that WHO coordinate development of a current and up-to-date resource list. The list would include names and contact information of all individuals involved in the School Health Component of Mega Country Health Promotion Network, including all UN agencies, international agency partners, the Mega Country representatives, and other relevant individuals or groups. The listing might identify specific topics about which the organization is ready to provide information or consultation, such as for questions about where and how to submit national EFA plans of action, processes for their evaluation and procedures for requesting related funding.

11. EFA Action Plans
Each Mega Country should plan to bring copies of their country’s most recent draft of the EFA Action Plan, to the next meeting of the School Health Component of the Mega Country Network.
3.1 DECLARATION

of Support and Effort delivered to the Ministers of Education of the E-9 countries

1. Meeting in Paris, 15-18 July 2001, we, the Ministry of Education and Ministry of Health representatives of the School Health Component of the WHO Mega-Country Health Promotion Network and the Ministry of Education representatives of the UNESCO E9 initiative, commit ourselves to working towards the achievement of the goals of Education For All (EFA), notably through fostering the integration of efficient school health programmes into national education action plans and supporting their implementation.

2. We recognize the fact that health and nutrition are important conditions for school participation, retention and performance, and that a vast number of poor health conditions, such as malaria and worm infections and nutritional deficiencies, seriously undermine the progress towards the goals of EFA by 2015.

3. We also draw attention to the serious impact of the HIV/AIDS pandemic, seriously affecting the demand, supply and quality of education in many countries world-wide.

4. We are convinced that poor health and malnutrition can be addressed efficiently through schools, as described in the EFA 2000 Assessment Thematic Study on School Health and Nutrition, and that poverty elimination and development goals cannot be realized without attending to the health and life-skills needs of the population.

5. We also believe that effective school health cannot be achieved without attending to the crucial role of teachers, and that it is vital to provide teachers with specific education and training in this respect.

6. We endorse the inter-agency initiative FRESH (Focusing Resources on Effective School Health), launched by UNESCO, UNICEF, WHO and the World Bank, in collaboration with Education International, during the World Education Forum, Dakar, April 2000, calling for the implementation in all schools of four basic core components of school health. These include: school health policies; safe water and sanitation as first steps towards a healthy, safe and secure learning environment; skills-based health education; and basic health and nutrition services. These four core components should be implemented together in all schools and supported by effective partnerships between the education and health sectors at all levels, with the full participation of communities, parents, children and youth.

7. We welcome the partnership that this initiative represents, and the effort to raise awareness of the importance of school health among the international education community, and to assist countries in implementing effective school health, hygiene and nutrition programmes as one of the strategies to achieve EFA.

8. We fully support the collaboration between the School Health Component of the WHO Mega-Country Health Promotion Network and the UNESCO E-9 initiative to in order to help Governments to achieve their EFA goals.

9. While recognizing the progress in many countries in furthering EFA and in establishing and reinforcing school health, we are concerned that in the year 2001 the number of schools that are implementing effective school health programmes is still very low, a situation which calls for urgent action.

10. Therefore, we call upon governments to take a lead role in addressing health and nutrition issues that threaten the present and future health and nutrition of school-age children and impede progress towards EFA, and for this:

• To ensure a school health co-ordinating body or mechanism within the Ministry of Education, which should ensure links with EFA follow-up actions and school health efforts of the Ministries of Health;
• To ensure inclusion of effective school health programmes in National EFA Action Plans and other educational reform efforts and to implement the four FRESH components and their supporting strategies, together, and in all schools, linked with similar efforts in teacher education and training;
• To build upon the experiences within the E-9 / Mega countries, and exploit possibilities for technical and financial resources as offered within the FRESH initiative.
11. We, the Ministry of Education and Ministry of Health representatives of the School Health Component of the WHO Mega-Country Health Promotion Network and the Ministry of Education representatives of the UNESCO E9 initiative:

- Commit ourselves to promote and support the above recommendations at the level of our respective ministries;
- Encourage countries throughout the world to ensure the implementation of effective school health programmes;
- Request the FRESH initiative agencies to expand its Partnership and continue their important efforts to further effective school health as a means to achieve EFA.

18 July 2001, Paris, France
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## 5. MEETING AGENDA

Sunday, 15 July 2001 - DAY ONE

Location: UNESCO Headquarters, 7 Place de Fontenoy, Paris

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<tr>
<th>Obj.</th>
<th>Time</th>
<th>Agenda</th>
<th>Suggested Resources</th>
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|      | 8:30 – 9:15 | Welcoming Remarks (Pekka Puska, WHO)  
Introductions  
Purposes of the Mega Network (Pekka Puska, WHO)  
Purposes of the E-9 Network (Anna Maria Hoffmann, UNESCO)  
Recommendations from the last Mega Meeting and status of follow-up, (Jack Jones, WHO)  
Summary of country interests based on E-mail survey, April 2001 (Cheryl Vince Whitman, HHD/EDC)  
Meeting objectives (Jack Jones, WHO) | Agenda w/ objectives  
Participant list  
Synthesis of country interests*                                                                                                               |
| b), c) | 9:15 – 9:45 | Overview of EFA and its relation to health  
Overview of FRESH (Anna Maria Hoffmann, UNESCO) | Extracted school-health related parts from EFA Framework  
Tri-lingual brochure on FRESH                                                                                                                  |
|      | 9:45 – 10:00 | Break                                                                                                                                       | --------------------------------------------------------------------------------------------------------|
| a), b) | 10:00 – 12 | Interactive small group activity on advocacy for FRESH (strategies to argue for the importance of school health or FRESH) (Cheryl Vince Whitman, HHD/EDC) | Facilitator  
Worksheets  
Summary at end by Rapporteur                                                                                                                   |
|      | 12:00 – 1:30 | Lunch (off-site)                                                                                                                                |                                                                                                         |
| c)   | 1:30 – 2:00 | Review of guidelines, materials and instruction about the processes and procedures involved in creating a national EFA action plan and requesting needed funding to implement the action plan; including how to include school health or FRESH in the EFA plan (Anna Maria Hoffmann, UNESCO & Don Bundy, World Bank)  
Questions and Answers                                                                                                                         | Guidelines for EFA Workplans and sources of needed funding.                                           |
| d)   | 2:00 – 3:00 | Facilitated small groups: Participants review sample work plans and identify concrete next steps for each Mega/E-9 Country to support FRESH in EFA (Don Bundy, World Bank)  
Potential for Declaration (Anna Maria Hoffmann, UNESCO)                                                                                      | Facilitator  
Senegal Workplan  
Worksheet customized for each country                                                                       |
| d)   | 3:00 – 3:30 | Report back from some Mega Countries (samples) about next steps to support FRESH in EFA                                                                                                               | Report Back Form                                                                                      |
Monday, 16 July 2001 –DAY TWO
Location: Palais de Congress, Paris

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<tr>
<th>Obj.</th>
<th>Time</th>
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<tr>
<td></td>
<td>4:30 – 4:40</td>
<td>Review today’s objectives, Summary of Day 1 (Jack Jones, WHO)</td>
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<td>f)</td>
<td>4:40- 5:15</td>
<td>Resources for Mega Countries: Seek participants’ reactions to Virtual Network for Mega Country Members – Prototype (WHO &amp; Carmen Aldinger, HHD/EDC)</td>
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<td></td>
<td>5:15 - 6:00</td>
<td>Seek participants’ feedback on Model School Tobacco Curriculum (WHO &amp; Cheryl Vince Whitman, HHD/EDC)</td>
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<td>6:00 – 6:20</td>
<td>Information about HIV skill building manual (Monique Fouilhoux, EI, Jack Jones, WHO, and Phyllis Scattergood, HHD/EDC)</td>
<td>Table with resources</td>
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<td></td>
<td>6:20 – 6:30</td>
<td>Closure</td>
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Tuesday, 17 July 2001 –DAY THREE
Location: Palais de Congress, Paris

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<tr>
<td></td>
<td>4:30 – 4:40</td>
<td>Review today’s objectives, Summary of Day 2 (Anna Maria Hoffmann, UNESCO)</td>
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<tr>
<td>b)</td>
<td>4:40 – 5:20</td>
<td>How UN and international agencies can help Mega/E-9 countries to address FRESH – including Q&amp;A (Jack Jones, WHO)</td>
<td>1 Overhead with 3 bullet points per agency</td>
</tr>
<tr>
<td>e) f)</td>
<td>5:20 – 5:50</td>
<td>Amaya Gillespie, Interagency Working Group on HIV/AIDS: “Global Strategic Framework for HIV/AIDS, Schools and Education” and FRESH, including Q&amp;A</td>
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<td>g)</td>
<td>5:50 – 6:00</td>
<td>Summary: School based multi-risk factors surveillance meeting held on 14 July, including Q&amp;A. (CDC)</td>
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<tr>
<td>a) d)</td>
<td>600 – 6:20</td>
<td>Hugh Hawes, Child to Child: “A New Look at School Health Education Content Planning: Dilemmas and some ways forward, including Q&amp;A</td>
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<td>g)</td>
<td>6:20- 6:30</td>
<td>Wrap Up and Closure</td>
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**Wednesday, 18 July 2001 – DAY FOUR**

**Location: Palais de Congress, Paris**

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<th>Time</th>
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<th>Suggested Materials</th>
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<tr>
<td>1:00 – 1:15</td>
<td>Review today’s objectives, Summary of Day 3 (Don Bundy, World Bank)</td>
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<tr>
<td>e) 1:15 – 3:00</td>
<td>Policy workshop: Policies/guidelines at different levels Components of strong policies Facilitated small group activity: analyzing the content of policies using tobacco, HIV and overall school health as possible examples (Phyllis Scattergood &amp; Scott Pulizzi, HHD/EDC)</td>
<td>Worksheets (e.g. criteria checklist)</td>
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<tr>
<td>3:00 – 3:15</td>
<td>Break</td>
<td></td>
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<tr>
<td>e) 3:15 – 4:45</td>
<td>Policy workshop (cont’d) : Facilitated small group activity: beyond analysis, what does it take to have policy implemented? Strategies to advocate and argue for policy. Reporting back (Phyllis Scattergood &amp; Scott Pulizzi, HHD/EDC)</td>
<td>Sample policies &amp; analysis form; Sample role plays Report back form</td>
</tr>
<tr>
<td>g) h) 4:45 – 5:45</td>
<td>Next steps and recommendations (Jack Jones, WHO) Review of Declaration (Anna Maria Hoffmann, UNESCO)</td>
<td>Rapporteur</td>
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<tr>
<td>5:45 – 6:00</td>
<td>Wrap-up (Pekka Puska, WHO)</td>
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Rapporteurs: Jack Jones, WHO, Paula Morgan, CDC, Carmen Aldinger, HHD/EDC
6. PROCEEDINGS FROM THE MEETINGS

6.1. DISCUSSION HIGHLIGHTS


**Pekka Puska, Director, NPH, WHO: Welcoming Remarks**

- Recent developments at WHO since Gro Brundtland became Director General:
  - major reorganizations to respond to new challenges in world health situation:
  - creation of a cluster of non-communicable diseases and mental health vs. traditional focus on infectious disease
  - new department NPH is focus on health promotion: school health, ageing, nutrition, health behavior surveillance, national community programs
- Importance of networks to share experiences: in Europe: CINDI network, AMAN(?) in Mediterranean, etc., Mega Country Health Promotion Network
  - Mega Country Network is a major tool that we want to strengthen, Mega Countries represent 60% of the world population
  - two components: school health; health behavior surveillance among adults (health risk factor surveillance)
  - plan to have other components related to three main disease determinants: tobacco, healthy nutrition, physical activity
- School Health Network: collaboration with health authorities and education authorities (MOH, MOE)
  - what are effective strategies: sharing experiences together with international partners enables to do better work and implement global strategies, e.g. EFA, FRESH
  - WHO gets “real life feedback” from countries
- May 2001, World Health Assembly: Health Promotion was the special topic: many countries emphasize health promotion and school health is a high priority

**Anna Maria Hoffmann-Barthes: E-9 Countries**

- UNESCO E-9 countries: established in 1993(?)
- covers 9 high population countries
- E-9 representatives meet regularly; next meeting is in Beijing, China, in August 2001

**Jack Jones: Progress since previous meeting**

- School Health Network: reps from MOE and MOH
- 11 Recommendations from last meeting in Mexico a year ago:
  (For progress report, refer to http://www2.edc.org/hhd/who/mega4_2.htm)

**Cheryl Vince Whitman: Summary of Mega Country Interests**

- A survey among Mega Countries in April 2001 revealed the following interests:
  1. Convincing policy makers to support school health programmes
  2. Analyze school health policies, especially for tobacco control
  3. Review tobacco advocacy curriculum
  4. Provide skill-building in web use

**Anna-Maria Hoffmann-Barthes: EFA’s link to health**

(see 6.2.1)

**Cheryl Vince Whitman: Advocating for School Health**

(Refer to http://www2.edc.org/hhd/who/mega4_2.htm)
Cindy Joerger, UNESCO: A FRESH Approach for Achieving EFA

Health helps EFA: health problems impede what EFA tries to achieve
FRESH supports EFA in 2 ways:
• solving health problems that interfere with learning
• help governments to select the best mix of health services to be implemented
Schools are in a key position to promote health in a cost-effective way; therefore, education sector needs to take the lead
Networks are efficient mechanisms for sharing resources
Assess Needs: (1) statistics; (2) get input from a broad range of people
Each of FRESH’s core components points to an area where needs may exist
Identify and Describe Solutions:
• take inventory of what’s already in place;
• FRESH framework can help to show gaps and point to solutions
• important: interventions have to incorporate all four FRESH strategies
• school-based health education needs to be tied to the existing curriculum
Supporting strategies are equally important, they define the context
Mobilize resources: time, money, partnerships
recommendations from this meeting will be presented to UNESCO’s EFA high level meeting (meeting of Education Ministers in August)
countries are requested to set up EFA forums that include ministerial reps and community members, etc. to (create EFA work plans)
FRESH is “nothing new” but can often be fitted to the approach a country is already taking and can be merged with existing systems

Audience comments:
• EI’s concern is that teachers are left out of the FRESH initiative and there is a growing concern around that issue - however, effective partnerships between teachers and health workers is one of the supportive strategies of FRESH
• The USA do not have a strong presence from the Ministry of Education - would like to identify a person in charge/lead role and meet to explain what FRESH is. Create a partnership, including other key players such as teacher unions
• In Indonesia, a Forum is very important to bring people together.
• Training is needed before skills-based health education can be delivered.
• A key point of FRESH is to make all four strategies available together

Donald Bundy, World Bank: FRESH and the World Bank
• the World Bank is a funding and investment organization, not an implementation organization
• each country’s minister of finance is a director of the World Bank and thus “owns” the Bank
• Mr. Wolfensohn, World Bank President, made a commitment to EFA for viable and sustainable interventions
• “current active loans to Mega Countries” includes funding for social sector only (health and education) and is available for FRESH
• a substantial component of economic growth is having basic education
• the World Bank invests in social programs throughout the lifecycle
• education sector has to be clear about the impact of health on educational outcomes (in order to ask for money/funding)
• IMCI = Integrated Management for Childhood Illness
• Multi-country AIDS/HIV Program (MAP) - only for Africa
• there is an increasing realization about the need to invest early and to keep investing in childhood education
• there is no target limit of how much money countries can request for FRESH; World Bank works with country reps to work out individual plans
• if the World Bank doesn’t fund a proposal itself, it may be able to find a funder
• D. Bundy can help to find documentation relevant to programs in any country, but the country needs to specify what type of activity it wants to do and advocate for it

- an audience comment clarified that not all countries that receive FRESH funding have an EFA work plan

(also see http://www2.edc.org/hhd/who/mega4_2.htm)
Ms. Bokhari, UNESCO: EFA Workplans

Guidelines for EFA Workplans
(see http://www.unesco.org/education/efa/country_info/country_guidelines.shtml)

- the ultimate responsibility remains with the country

How will UNESCO monitor/coordinate?
- partnerships are extremely important
- UNESCO Institute for Statistics will play a major role in monitoring this

What to do with EFA plan?
- set up EFA forum to monitor it
- call UNESCO for technical assistance
- create EFA action plan including budget, personnel, many sectors etc. - needs to be viable and credible
- in September UNESCO meeting will come up with a strategy how to handle it, utilizing partnerships
- EFA plan will be checked for credibility and viability
- EFA plans are supposed to be completed by 2002, but some countries will be late
- there is a UNESCO publication available on how to create the infrastructure for action plans
- there is an opportunity to share a statement on behalf of the Mega Country/E-9 group at a high level meeting in Beijing, China, in August

Audience comments/Discussion:
- grants are only available for highly indebted countries
- there needs be clarity where FRESH comes in under the six Dakar goals; get on the agenda of upcoming E-9 meeting; have a FRESH game plan for the September meeting; what will be monitoring indicators?

- Jack handed out Worksheet for integrating FRESH into EFA workplans to be used together as a team
  (get worksheet from http://www2.edc.org/hhd/who/mega4_2.htm)

Carmen Aldinger: Mega country Website Prototype

- Web site was created as a recommendation from the Mexico City Meeting last year; mainly for the School Health Component of the Mega Country Network
- Carmen conducted a demonstration of the prototype: http://www2.edc.org/WHO
- This will become part of the global WHO web-site - it is still based on the EDC set up. It is preliminary.
- It also links to the UNESCO web-site and other relevant links through the EFA component; series of documents can be downloaded to help with the process of developing and writing the EFA plans.
- Second and most extensive component is the Effective Strategies - FRESH, Health Topics from WHO Series on School Health, Elements of national infrastructure (RAAPP), and all will have examples.
- Next major session is the Country Profiles. Most of the information will come from the Mega Country book/report that will be updated after every annual meeting.
- At a different area you will find contact information from the countries (called People and Events), collaborating centers, UN agencies and collaborating agencies. The events section will serve as a posting area to post information on meetings and conferences
- A different session is a link to the chat room - can establish your own chats and post your own questions.
- Section on News and current events and web links

Comments from the Audience:
• Indonesia is developing a sub web-site for antismoking; it is in two languages (English and Bahasi). The url is http://www.bebasrokok.com Hopefully we can link to the Mega country website
• Nigeria is looking for links and ways that can be updated/posted sooner than waiting for the annual meeting; e.g. Nigeria is soon conducting RAAPP
• Information to be posted can be sent to Carmen (caldinger@edc.org) and the website will have a section from where to submit suggestions for postings
• Other issues raised:
  • Can the website serve as an assessment tool
  • Is it possible to create an executive summary
  • Will there be TA for countries how to develop their own websites
  • When will the content of the website be translated into WHO’s official languages

Cheryl Vince Whitman: Tobacco Curriculum
(handouts available at http://www2.edc.org/hhd/who/mega4_2.htm)
• Problem of Tobacco is a big one - especially with the issue of Tobacco companies
• WHO asked to develop a simple tool that focuses on 12-14 years old. Makes young people more aware that tobacco companies are targeting young people; e.g., giving away tobacco products for free because they know of the addiction problem.
• Three units of 5 lessons
  - advocacy skills
  - analysis & mapping (observation development)
  - taking action (presentations on what they learned)

Comments from the audience:
• Why focus on 12 to 14 when in some countries they start at around 9? Suggestion to lower target age to about 10
• Consider addressing smokeless tobacco and the growing of tobacco in rural areas at the family level.
• How will the curriculum address children and teachers that are already smoking?
• Must have an analysis of stakeholders - including the gate keepers; also need capacity building for schools. See it as extra-curricula as a start.
• Think of building groups of strong advocates. Start a health club or anti smoking club in the schools and gradually increase critical mass and incorporate community. May be able to use the group to approach the legislation... first start to identifying the leaders.
• Concern: there is no space in the curricula for such large curriculum with 15 lessons. Also, do students work to change themselves or work towards changing a group? It should be included into the school curricula, not as extra credit - that way it reaches all not just the ones already interested and the good students.
• How could the Internet be used as a powerful tool for this mobilization?
• Youth involvement: In Europe, delegation coming to the conference on drugs and alcohol must bring young people representatives. One of the messages was that the kids are not the problem, but the Ministries are the ones that are not doing their job. Youth is willing to work together with the Governments and be their advocates and mobilize groups and communities. Use young people for their energy, enthusiasms and advocacy skills. Write in the true participation of young people to make this their process/their own initiative. Look for young people participation. Also, in some countries the democratic process is not existent or strong enough that this would be possible to implement. - However, must be very careful not to put young people at risk. Involving young people is complex.

Anna-Maria Hoffmann-Barthes distributed UNESCO documents and gave introduction/overview

Jack Jones: How UNESCO can help Mega/E-9 countries to address FRESH
- Assist in including FRESH objectives and strategies in National EFA Action Plans
- Provide expertise for planning, implementing and evaluating effective school health programmes
- Assist in the research of funding to support such programmes
- Assist in linking the SHC/MCHPN to the global EFA movement

Amaya Gillespie: HIV/AIDS Global Strategic Framework
- several agencies have come together to put together a concept about HIV/AIDS and education
- three areas to focus on
  - Risk
  - Impact
  - Vulnerability
- tailor responses according to what is important in each community, strategy must be multi-sectoral and consider context, involvement of the medical profession and school health services is part of the program; governments must take leadership and show responsibility, teacher training and support is crucial, teachers are very respected in some parts of the world and have a key role for conveying information, what to do about the children that do not go to school? (they are more vulnerable), it’s important to consider the attitude of teachers, coordination and collaboration is very important

Laura Kahn, CDC: Multi-Risk Factor Surveillance
- meeting on Saturday brought together many agencies - see document from WHO and CDC with summary of surveillance meeting
- goal: over time measure trends in risk behaviors
- not suggesting that CDC system goes global, but it should be similar, developed by interested agencies

Discussion:
- could it be comparable with health survey (HPSC) in Europe?
- where to find out more and join it? updates through the Mega Country Network
- it would be an instrument developed by many agencies collaboratively, hopefully with input from Mega Countries
- countries need to tell if they are interested in conducting this
- why does it focus on risk factors and not on positive factors, e.g. what is good sexual or mental health?
  - answer: risk is connected to mortality and morbidity, but also left some room to include protective factors should appropriate measurement tools become available at CDC
- disseminate the results as much as possible

Hughes Hawes, Child-to-Child: A New Look at School Health Education Content Planning
(see 6.2.2)

UN and International Agencies: How Agencies can support Mega Countries

FAO, Peter Glasauer:
• working on a document which will be available within the next year: Planning Guide for Curriculum Development on Nutrition Education, not focussing on classroom curriculum but involving the whole school and community, taking schools through a planning process to come up with a curriculum that involves the whole school
• approach follows FRESH
• could possibly attract donors to get funding for countries; does have funding for pilot projects (e.g., this document has been pilot-tested in Zambia)
• FAO will (next year) go out and apply the document in countries

**Education International, Monique Fouilhoux:**
• Teacher unions are key partners for ministries of health and education
• strongly convinced of the link between health and education and that schools are key actors to educate adolescents to be responsible for their own health
• unions are ready to work with ministers of health and education
• Monique is part of the EFA follow-up group, will commit herself to ‘push’ recommendations

**WHO, Chuck Gollmar:**
• support for national infrastructure assessment (RAAPP)
• support for school health and guidance (Local Action to promote HPS, materials/publications, website)
• surveillance system

**EDC, Cheryl Vince Whitman:**
• work in partnership with UN agencies and EI, “behind the scenes”:
  • Rapid Assessment
  • HIV/AIDS skills-based training
  • teacher training for pre-service on active methods

**UNESCO, Anna-Maria Hoffmann-Barthes:**
• link FRESH with follow-up to Dakar/EFA; e.g. document on EFA and FRESH
• interact with school networks and see directly how to work together with teachers, including in disadvantaged areas

**World Bank, Don Bundy:**
• financing FRESH; barriers: whether a government requests the funds
• education and health projects can be used to fund FRESH, existing and new requests
• Don Bundy is contact person

**UNICEF, Amaya Gillespie:**
• country offices are the first contact
• EFA: UNICEF is a key partner, can help to make education system stronger, partnering with governments; e.g. ensure that girls are in schools, life skills, etc.
• particular aspects of FRESH that UNICEF can help: skills-based health education; water and sanitation

**Representing World Food Program: Ute Meir**
• support of school feeding programs: can provide resources and know-how
• uses its resources to support girls education
• supports skills training and literacy programs for women
• contact through country offices, website, WFP cooperates with UNESCO

**Suggestions from the Audience:**
• make a list of the representatives of the agencies present: names, addresses, emails
• how to convince people in MoE - put this on agenda
what is the difference between FRESH and HPS and how to link it together? suggestions: leaders are there, need operating mechanisms to link education system and health departments; different persons need to be linked to EFA forum

many donors want to give money, but there is much duplication; FRESH is a good beginning that can help avoid duplication

Russia proposed to plan only one action, but to implement it together. Two years ago Youth-YRBS was proposed and all countries agreed, but not many countries worked in this direction; now a new risk-behavior surveillance has been proposed; proposed to do it together in all Mega Countries, “only one action, but all of us” - WHO to organize a technical group to support this, give material support from World Bank, expertise from each organization, stay in contact

Phyllis Scattergood & Scott Pulizzi (EDC): Policy Workshops
(see 6.2.3 for handouts and worksheets)

Reporting Back:

**Group 1: Mexico & Brazil (“Bramex”)**

Point 1 “Protection for children becoming addicted to tobacco through such measures as the banning of sales to and advertising targeted at children”

- this is already in place in many countries
- law is much better than the social/institutional practice

School Level
- start anti-smoking education at 1st grade of primary school, about addiction in general
- work on a continuous basis, incorporate it in daily school work, not just a campaign
- include preventive education in pre- and in-service teacher training

Ministry Level
- create mechanisms for effective implementation of existing laws e.g. related to advertising
- stricter campaigns to discourage adults from smoking in front of children
- work with media on this
- MoH and MoE could work together on this

Point 2 “Implementation of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster than the rise in prices and income.”

School Level
- develop activities which will show students the cost of smoking; what else could they do with this money, discuss cost-benefit

Ministry Level
- decrease taxes on alternative products to tobacco

Also discussed:
at school level many of the 10 points could be better developed if schools could work with HPS framework

**Group 2: China, FAO, Child-to-Child**

Point 3 “Allocation of a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.”

School Level
- use money from tobacco taxes for school health programs

Ministry Level
- ask government agencies to use more tobacco taxes in smoking control program
- ask government to seek out extra taxes for smoking control
Point 4 “Health promotion, health education and smoking cessation programs.”

School Level
- carry out policy of banning teacher smoking in schools
- organize teacher cessation campaign
- organize parents cessation campaign
- smoke-free school programs
- educate students to know how much it costs when somebody smokes (how much of total income is used for smoking)

Ministry Level
- policy to banish teacher smoking in school
- policy about adolescents

Group 3: Russia, Finland, UNICEF

Point 5 “Protection from involuntary exposure to environmental tobacco smoke.”

School Level
- no smoking on any education/school premises (will need ministerial policy)
- give teachers opportunities to stop smoking - MoE will prepare a special letter to local governments to give teachers an opportunity to stop smoking and do healthy activities
- MoE will recommend to local authorities to organize some funds to help teachers stop smoking (approx. 50% of teachers in Russia smoke) e.g., give them extra money for six months after they stop smoking

Ministry Level
- last week President Putin signed Russia’s first anti-smoking law
- policy to prohibit smoking on school grounds

Point 6 “Elimination of socio-economic, behavioral and other incentives that maintain and promote the use of tobacco.”

School Level
- provide all schools with special curriculum and teacher materials

Ministry Level
- recommend to MoE to prepare some materials for teachers and pupils
- recommend to local authorities to organize teacher training

Also discussed:
-- Importance of national policy and link between national and school level
-- Programs have to be integrated; e.g. cessation services are needed to make a school smoke-free

Group 4: Pakistan & Indonesia

Point 7 “Elimination of direct and indirect tobacco advertising, promotion and sponsorship.”

School Level
- engage students and teachers in anti-smoking campaign
teacher and school staff should act as role models
headmasters not to accept any sponsorship from tobacco

Ministry Level
• produce MoE instruction on school ads on no smoking area
• banning of any ads in school area
• propose to local govt to ban any vendor close to school area

Point 8 “Controls on tobacco products, including health warnings.”

School Level
• post health warnings in every class; e.g. competition for creating warning signs
• surveillance of tobacco products brought to school
• participatory activity for children and parents to discourage smoking

Ministry Level
• advertisements against smoking
• develop curriculum on anti-smoking for early grades
• module on teaching methodology

Also discussed:
-- consistency between local and national message is important (warning labels in school should match those on advertising and TV)

Group 5: Nigeria & India

Point 9 “Promotion of economic alternatives to tobacco growing and manufacturing and sales.”

School Level
• promotion of alternatives to tobacco growing
• parents who work in tobacco to find alternative jobs

Ministry Level
• alternative incentives: offering different incentives to tobacco growers; e.g. different cash crops, food licenses?
• encouraging farmers to produce crops that can be locally marketed
• discouraging any sponsorship by tobacco company, particularly in media
• stringent laws restricting such activities, simultaneously consumer activities for fighting against tobacco advertisements, also in entertainment/stars
• increasing community efforts

Point 10 “Effective management, monitoring and evaluation of tobacco issues.”

School Level
• peer group monitoring
• document the records of use of tobacco by fellow students and verify this over a period of time

Ministry Level
• large scale monitoring and evaluation over time:
• two assessments: 2005, 2010

Questions/Discussion:

Fourth Annual Meeting of School Health Component of Mega Country Network
July 2001, Paris
• children of tobacco farmers could convince parents based on their knowledge: to get their parents to have a retrospective look how many people had problems with tobacco and win them over to farm other cash crops; government should provide incentives for growing other cash crops
• looking at smoking as satisfying a social need; besides banning smoking need to replace what makes people smoke
• Brazil: took the word “Prevention = to prevent action”; whole session was used to discuss this: what positive things can we do
• Finland: smoke-free class competition, ask a class to commit themselves for a year not to smoke and have a prize for them; main prize: one trip for a class to another country; this has been evaluated in Finland and Germany and found to delay the onset of smoking
• Indonesia: children to be active to bring the adults to stop smoking; inside air conditioned rooms smoking is not allowed but people ignore this; young children come in with ash trays and ask smokers to distinguish their cigarettes = school children influencing adults
• GYTS: 50% of youth want to quit, but youth cessation services are not available
• what could be done about teacher cessation; could nicotine patch be an intervention to be made available for teachers?

Chuck Gollmar: Recommendations and Next Steps:

• This is a meeting of the Mega Countries, not the UN agencies. The UN agencies receive technical support from the countries. The function of the agencies is to do whatever they can to support MCs efforts.
• The purposes of the meetings are:
  • to meet the needs of the countries
  • agencies to receive technical assistance from the countries
• These recommendations will form the scope of work for the next year, from now until next meeting. These recommendations need to be considered by UN agencies. There is not a guarantee that they will (all) be completed, what will be done will be written up and sent back and will be our charge.

(please see the finalized recommendations in section 3 of this report)

Dr. Pekka Puska, Closing Remarks

• Thank you for coming. This is important. Children represent the future of the world. Schools are vital settings.
• We asked Mega Countries to come here to tell us what to do. Discuss together what should and could be done and share information and experiences from each other.
• In addition to experience and information sharing, we could agree to do more together (simple things, not to be too ambitious). E.g, surveillance monitoring. Tobacco is very important from a global view, the single most important cause of death. Also, discuss more practical things for collaboration and communication.
• Chuck will be the focal point in Geneva.
• Our partners UNESCO, UNICEF, FAO, WB, EDC, CDC - is a great model for international collaboration.

Evaluation
(participants filled out evaluation sheets; see 6.4)
6.2. INDIVIDUAL PRESENTATIONS

6.2.1. Anna Maria Hoffmann, UNESCO, 15 July 2001

SCHOOL HEALTH AND EDUCATION FOR ALL

Presentation by Anna Maria Hoffmann, UNESCO-HQ

Poor health and malnutrition negatively affects both school participation and learning. But these conditions can be addressed, with appreciable results, through school-based health, hygiene and nutrition policies and programmes targeting students and staff. The background and underlying principles for these statements are described in the THEMATIC STUDY ON SCHOOL HEALTH AND NUTRITION, prepared for the EFA 2000 ASSESSMENT.

Education for All – EFA - is an international movement, consisting of governments, international agencies, civil society and local actors involved in education. Its aim is to ensure that all children have access to basic education of good quality, which implies creating an environment in schools and basic education programmes in which children are both able and enabled to learn. The fact that children cannot learn when they are hungry and in poor health was raised already in the first World Conference on Education for All in 1990, which recognized that poor health and malnutrition are important underlying factors for low school enrolment, absenteeism, poor classroom performance, and early school dropout.

The Dakar World Education Forum (2000) ten years later expanded this vision by highlighting the three ways that health interacts with basic education for all: as a condition required for learning; as an outcome of education; as well as a sector to collaborate with in achieving EFA. School health is in this respect a key element in the broad vision of Education for All as an inclusive concept taking into account the needs of the poor and the most disadvantaged, including children, young people and adults affected by HIV/AIDS, hunger and poor health, many of which are girls. The debate over the role of school health in efforts to provide basic education to children and young people has thus been resolved. The Dakar Framework supports the view that policies and practices that ensure that children are healthy and thus able to learn are essential components of an effective education system.

Experiences during the past decade has shown that multiple and co-ordinated approaches to school health are far more efficient than individual approaches. As a response, UNESCO, UNICEF, WHO and the World Bank decided to promote a common vision and a comprehensive framework for school health. The FRESH initiative was subsequently developed by the four agencies and launched at the Dakar World Education Forum (2001) in order to jointly raise the awareness among the international education community on the value of implementing an effective school health programme as one of the strategies to achieve EFA. It was launched in collaboration with Education International in order to underline the important role of teachers in making school health truly efficient, and we are happy to note that since its inception in April 2000, many other agencies and associations are joining the FRESH initiative, such as UNAIDS, Roll Back Malaria, EDC, CDC, WFP, FAO etc.

FRESH STANDS FOR Focusing Resources on Effective School Health. Improving the health and learning of school children through school-based health and nutrition programmes is not a new concept. Many countries have school health programmes, and many agencies have decades of experience. However, common experiences suggest an opportunity for concerted action by a partnership of agencies to broaden the scope of school health programmes and make them more effective. FRESH is subsequently based on positive experiences by the supporting agencies suggesting that there is a core group of cost-effective activities which could form the basis for intensified and joint action to make schools healthy and child friendly, and so contribute to an investment in a country’s future and in the capacity of its people.
THE FRESH FRAMEWORK, actively endorsed by all the supporting agencies, is the starting point for developing an effective school health program, and as such it is intended as a basis from which individual countries can develop their own strategy to match local needs. The FRESH framework proposes four basic core components of a school health programme should be made available together, in all schools, supported by intersectoral partnerships.

Health-related school policies that prevent exclusion and violence, that encourage healthy lifestyles. Provision of safe water and sanitation as a first step to provide a healthy, safe and secure learning environment that, for example, reinforces hygienic behaviors and provides privacy to girls in order to promote their participation in education.

Skills-based health education that focuses upon the development of knowledge, attitudes, values, and life skills needed to establish lifelong healthy and active practices and reduce risk behaviors.

School-based health and nutrition services that are simple, safe and familiar, and address problems that are prevalent and recognized as important within the community.

These four components are proposed to be made available together since experiences show that multiple coordinated strategies produce a greater effect than individual strategies. They are proposed to be implemented together in all schools - a starting point with which each school can identify with, adapt, implement and build upon according to their resources and problems.

As highlighted in the Dakar Framework for Action, there are three ways that health interacts with education for all: as a condition required for learning; as an outcome for children; and also AS A SECTOR TO COLLABORATE WITH EDUCATION IN ACHIEVING EFA. This crucial multi-sectoral partnership is highlighted within the FRESH framework at three levels:

FIRSTLY, the success of school health programmes demands an effective partnership between Ministries of Education and Health, and between teachers and health workers. The health sector retains the responsibility for the health of children, but the education sector is responsible for implementing, and often funding, the school based programmes.

SECONDLY, promoting a positive interaction between the school and the community is fundamental to the success and sustainability of any school improvement process.

THIRDLY, children and youth must be important participants in all aspects of school health programmes, and not simply the beneficiaries.

These components are proposed to be made available together in all schools and supported by inter-sectoral partnerships.

Let us look at the core elements one by one…

**FRESH Core Component #1: Health-related school policies**

Health policies in schools, mandating a healthy, safe and secure school environment, guaranteeing equal rights and opportunities and regulating the provision of skills-based health education and health services, are the blueprints for action necessary to harness the potential of health to improve education. The process of developing and agreeing upon such policies draws attention to the link between health status and educational outcomes and encourages the participation of a wide array of community-based partners.

Health officials and providers are necessary partners in this endeavour, but experience has shown that the education sector must lead, and retain overall responsibility for the development, implementation and enforcement of health policies in schools. This requires the allocation of both human and financial resources. FRESH recommends that responsibility and authority for school health programmes must be designated at every level of education planning and administration possible. This is the essential first step toward a successful school health program.

Once policies are in place, they must be effectively monitored. School administrators and teachers should be trained to implement the policies. Students, parents and community members at large must know and
understand the policies. Mechanisms for enforcing policies, and for evaluating their effectiveness, are necessary to ensure the compliance and support of those the policies are intended to benefit.

**FRESH Core Component #2: Provision of safe water and sanitation: first steps toward a healthy learning environment**

Unsanitary, unsafe school environments may damage the health and nutritional status of schoolchildren, in particular if they increase their exposure to hazards such as infectious disease carried in the water supply. Schools that lack appropriate toilet facilities are almost certainly exacerbating the spread of parasites, and thus harming not only children’s health, but also the health of the community as a whole. The fact of girls abandoning or being withdrawn from schools that fail to provide separate toilets, particularly around the age of onset of menses, is well documented.

The provision of safe water and appropriate sanitation facilities are thus basic first steps in the creation of a healthy physical learning environment. By providing these facilities, schools can reinforce the health and hygiene messages delivered in education programmes, and serve as an example to both students and the wider community. This, in turn, may lead to a demand for similar facilities in other parts of the community. Sound construction policies will ensure that facilities address issues such as gender access and privacy. Sound maintenance policies will ensure the continuing safe use of these facilities.

**FRESH Core Component #3: Skills-based health education**

Health promotion and the prevention of important health problems are at the core of skills-based health education. Modern approaches to skills-based health education, based on documented research findings and recent programme experience, go significantly beyond the delivery of scientific information about disease processes. Skills based health education helps young people acquire beliefs, attitudes, values, life skills and services they need for emotional and psychosocial well-being as well as physical health.

Quality skills based health education helps young people to acquire communication, critical thinking, conflict resolution, refusal and other life skills in the context of developing specific skills needed to practice a healthy life style, such as healthy eating, and to avoid risks, such as tobacco smoke. In addition, it contributes to the development of attitudes and values that promote respect for one-self and for others, tolerance of individual differences and peaceful co-existence. It results in the adoption of habits that reduce risk-taking behaviour associated with HIV/STD infection, premature pregnancy, drug and alcohol abuse, violence, injury, etc. Armed with such important health-related knowledge, attitudes, values and skills, individuals are more likely to adopt and sustain a healthy lifestyle not only during their school years, but also for the rest of their lives.

**FRESH Core Component #4: School-based health and nutrition services**

For a variety of reasons, including population growth, reduced infant and child mortality and the success of efforts to improve access to schooling, more children than ever before, in countries the world over, are now enrolled in basic education programmes. This is a situation of tremendous potential for governments endeavouring to eliminate poverty by enhancing the productive capacity of their citizenry.

Unfortunately, this potential is threatened by health and nutrition problems among school-aged children that exclude them from schools, prevent them from remaining in school for a sufficient number of years or interfere with their learning while there. Girls and members of other disadvantaged groups, populations recognised in the Dakar Framework as priority targets for renewed efforts to achieve Education for All, are likely to be the least healthy and most malnourished of new school enrollees. To protect their investment in efforts to increase access and improve the quality of educational services, national governments must undertake the delivery of basic health and nutrition services in schools.
Fortunately, a great deal of experience in recent years has shown how this can be accomplished in safe and cost-effective ways. Effective school health programmes and services link the resources of the health, education, nutrition and sanitation sectors in an existing infrastructure, the school. They take advantage of an existing skilled workforce (teachers and administrators) that is already working with individual and organisational partners in the local community. They address problems that are prevalent and recognised as important in the community. When these criteria are met, the “learn-ability” of students is enhanced, and the community as a whole views the school and school personnel more positively.

Many studies have already documented the positive reaction that community members have to school-based health services. In particular, deworming, malaria treatments, micronutrient supplementation and school feeding programs that provide free or low cost breakfast and/or lunch, were perceived as a substantial added benefit of schooling and thus improved enrolment and attendance. As one teacher put it: “Now parents want their children to go to school because at school their health is taken care of.”

**HOW DOES FRESH HELP EFA?**

Six goals are described in the Dakar Framework for Action – adopted at the Dakar World Education Forum in April 2000, together with 12 strategies for action

(EFA Goal #1: Expand and improve comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.

EFA Goal #2: Ensure that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality.

EFA Goal #3: Ensure that the learning needs of all young people and adults are met through equitable access to appropriate learning and life-skills programmes.)

These three goals, which seek an improvement in access, retention and learning outcomes for children and youth at the pre-school, primary and secondary school levels, are directly supported by FRESH initiative activities that bring more children into schools, reduce absenteeism and drop-out, and enhance pupils’ “learn-ability.” Girls and members of other disadvantaged groups will particularly benefit from the policies, programmes and services supported by FRESH.

For example, school policies that protect children from molestation or abuse on school grounds would help to allay parents’ fears about the safety of their children, particularly girls, at school. In many countries, this is known to be a reason for which girls leave or are withdrawn from school, especially during the important transition from primary to secondary school. Policies that guarantee the continued education of pregnant and parenting teens would also help to ensure that girls do not end their education prematurely, thereby protecting the public investment in education during the early and primary school years. Unless schools develop and enforce health-related policies that guarantee a safe, sanitary and equal opportunity learning environment, as proposed in FRESH component #1, efforts to increase access to education, especially those targeting girls and other disadvantaged groups, may not produce the hoped-for results.

Appropriate water and sanitation facilities – FRESH component #2 – will ensure that schools do not increase students’ exposure to disease and thus increase absenteeism or the cognitive impairment associated with parasite infection.

Through skills-based health education – FRESH component #3 – schools can help young people acquire the knowledge, beliefs, attitudes, values and skills needed to protect their health and their futures. This reduces absenteeism, academic failure and dropout associated with preventable conditions like HIV infection, premature pregnancy, drug and alcohol abuse and intentional or unintentional injuries.

Fourth Annual Meeting of School Health Component of Mega Country Network
July 2001, Paris
Attendance and “learn-ability” are also improved when schools provide snacks or meals to students who are malnourished, or when they offer treatment for basic health problems like vitamin and iron deficiencies (especially common among girls), parasite infection (the most common cause of illness among children in developing countries), and malaria (the most important reason for school absenteeism due to ill health.) This is FRESH component #4.

By developing partnerships with parents, the private sector and community organisations, as proposed in the FRESH initiative supporting strategies, schools can do all of these things in low-cost and highly effective ways.

EFA Goal #4: Achieve a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.

Though FRESH initiative activities focus primarily on the provision of health and nutrition education and services in schools, the FRESH approach depends on, and seeks to benefit, the community as a whole. As schools become not only more “child-friendly,” but also more “family-friendly,” they can become centres for learning not just for children, but for the community as a whole. The FRESH supporting strategies describe how parents, students and the community at large can participate in this effort.

EFA Goal #5: Eliminate gender disparities in primary and secondary education by 2005, and achieve gender equality in education by 2015, with a focus on ensuring girls’ full and equal access to and achievement in basic education of good quality.

The goal of achieving gender equality cannot be attained without addressing the many social, cultural and economic factors and traditions that prevent girls from enrolling and staying in school or achieving their educational potential. FRESH advocates a variety of activities to remove obstacles that range from the practical to the psychosocial. For example, the lack of separate toilet facilities in many schools is known to contribute to high dropout rates among girls, particularly at puberty when they begin to menstruate. Thus, the FRESH initiative emphasis on the construction and maintenance of appropriate sanitation facilities. At the other end of the spectrum, FRESH addresses the negative effects of pervasive and enduring gender discrimination through policy development and skills-based health education that promote girls’ access to, and exploitation of, educational opportunities.

EFA Goal #6: Improve all aspects of the quality of education and ensure excellence of all so that recognised and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

Tragically, efforts to improve literacy and numeracy skills may come to naught if essential life skills are not also developed. In countries the world over, the learning and education potential of a growing number of children and adolescents is compromised by unhealthy social and behavioural factors that impair their health and impoverish their lives. The loss of productive capacity that many nations are now experiencing as the result of the AIDS epidemic is a relevant example of how the education and development efforts of many years may be thwarted by the failure to attend to individuals’ need for life skills education as well as academics.

The skills-based approach to health, hygiene and nutrition education promoted by FRESH focuses upon the development of knowledge, attitudes, values and skills needed to make and carry out positive health and lifestyle decisions. Health in this context extends beyond physical health to include psychosocial and environmental health issues. Skills-based health education promotes the adoption of socially-relevant attitudes, such as those related to gender equity, respect for human rights and tolerance of individual differences, and social and civic responsibility, and uses teaching methods that encourage the development of specific skills, such as dealing with peer pressure. Thus, it supports the achievement of EFA goals related to academic achievement, gender equity and life-long learning.
Mobilise strong national and international political commitment for education for all, develop national action plans and enhance significantly investment in basic education.

Through FRESH, a collaborative effort sponsored by UNESCO, UNICEF, WHO and the World Bank, a significant international political commitment to helping nations achieve Education for All has already been made. The school-based health, nutrition and sanitation services proposed by FRESH will help to bring more children to school, reduce absentee and drop-out rates and solve health problems that interfere with students’ ability to learn. Such services, in and of themselves, therefore represent a significant and necessary investment in basic education.

Promote EFA policies within a sustainable and well-integrated sector framework clearly linked to poverty elimination and development strategies.

FRESH advocates the integration of resources managed by the education, health, sanitation and environmental sectors to achieve Education for All. Poverty elimination and development goals cannot be realised without attending to the health and life skills needs of the population on which such goals depend. The havoc currently being wreaked by the AIDS epidemic in many countries is a relevant example of this. The sponsors of the FRESH initiative believe that skills-based health education and basic health services should target children and youth throughout their development years and that schools are among the most available, most cost-effective venues for the provision of these services.

Ensure the engagement and participation of civil society in the formulation, implementation and monitoring of strategies for educational development.

While the benefits of education take many years to materialise, the benefits of improving children’s health are immediately apparent to parents and community members. Where schools are perceived as taking a leadership role in safeguarding the health and well-being of children, families and community members will be inspired to collaborate with schools. To ensure that school-based health programmes are relevant to local needs and implemented in cost-effective ways, FRESH maintains that administrators, teachers, parents, community organisations and students must participate in all phases of planning and administration of such services.

Develop responsive, participatory and accountable systems of educational governance and management.

The Dakar Framework places fresh emphasis on the need to involve community partners in efforts to achieve Education for All. To implement the school-based health education and services advocated by FRESH, policy-makers and administrators at every level of education are encouraged to engage the front-line staff (school administrators and teachers) who will implement programmes, and the beneficiaries (students, parents and community members) who such programmes seek to benefit. FRESH calls for the development of policies regulating school health services that 1) respond to identified needs, 2) encourage participation of local people and organisations with vested interests and resources to contribute, and 3) contain enforcement and evaluation provisions to ensure accountability.

Meet the needs of education systems affected by conflict, natural calamities and instability and conduct educational programmes in ways that promote mutual understanding, peace and tolerance, and that help to prevent violence and conflict.

Populations affected by conflict, natural calamities and instability pose a very difficult problem for governments attempting to achieve Education for All. On the one hand, children who are sick or hungry,
physically maimed or psychologically traumatised, orphaned, homeless or living in temporary shelters, are unlikely even to come to school, let alone take full advantage of the education offered. On the other hand, school buildings and school staff are not immune to conflict and disaster. Will there be a school for children to come to? Will there be teachers and administrators in sufficient number and adequately trained to handle emergency situations?

All four of the FRESH initiative components address the special and significant needs of education systems affected by conflict and calamity. Policies and procedures are critical for the successful management of catastrophic situations. Before disaster strikes, schools should develop and practise emergency response plans. Potable water and sanitation facilities on school grounds will be particularly needed, and valuable to the whole community, if other facilities have been contaminated or destroyed. Skills-based health education can address the roots of violence and intolerance and promote conflict resolution and peaceful co-existence. And a variety of health services that can be offered in schools, especially first aid, food services, information and referral services and counselling, will be particularly needed to keep children coming to school and learning during emergency situations.

*Implement integrated strategies for gender equality in education which recognise the need for changes in attitudes, values and practices.*

The wording of this EFA strategy and other statements included in the Dakar Framework point to the need for action on multiple fronts to change the underlying attitudes and values that perpetuate the unequal treatment of boys and girls, and men and women, in educational systems and society at large. The FRESH initiative offers a blueprint for just such an integrated approach.

Each of the FRESH core components offers solutions to problems that prevent girls from enrolling in school, staying in school or achieving on an equal basis with boys the benefits of education. Under component #1, for example, schools might develop a policy that protects girls from harassment and abuse on school grounds. Or, implement a policy that provides for the continued education of pregnant and parenting teens. Component #2 covers the provision of proper water, hygiene and toilet facilities, which is known to be of particular relevance to girls. Under component #3, FRESH advocates skills-based health education to change attitudes, values and practices that perpetuate gender stereotypes and gender inequality. Component #4 calls for the provision of basic health services to ensure that students, especially girls, are not too sick, hungry or physically impaired to make the most of their educational opportunities. By implementing such strategies, schools can become models of gender equality and a force for change in the community at large.

*Implement as a matter of urgency education programmes and actions to combat the HIV/AIDS pandemic.*

Until there is a vaccine to prevent transmission of HIV, efforts to combat the AIDS pandemic will remain wholly dependent on preventive health education that results in behaviour change. The skills-based health education recommended in FRESH core component #3 uses participatory learning techniques to help individuals identify risky situations, make decisions that protect their health and well-being and carry through on their decisions. Research has confirmed that skills-based health education is an effective means of producing behaviour change that reduces the spread of HIV and the discrimination that complicates prevention, detection and treatment of this disease.

FRESH component #1 is also relevant to this strategy. As the number of teachers, students and parents who are infected or affected by HIV/AIDS grows, the education sector is forced to address issues that are deeply personal, culturally sensitive and potentially divisive. Policies help to ensure that difficult issues are addressed in rational, humane and uniform ways. If developed through a process that invites participation and respects the basic needs and rights of all, they can also be a means of raising community awareness of the AIDS epidemic and building consensus about how to deal with it.

*Create safe, healthy, inclusive and equitably resourced educational environments conducive to excellence in learning, with clearly defined levels of achievement for all.*
The wording of this strategy highlights the link between student health, the school environment and educational achievement. It reminds us that learning outcomes depend not only on the excellence of the education provided, but also on the quality of the context in which learning is expected to take place. If parents refuse to send their children to school because they fear for their health or safety; if students are too hungry to pay attention to their teachers or too cognitively impaired by micronutrient deficiencies to understand what they are being taught; or if they are frequently absent due to illness or drop out altogether because they feel discriminated against, because they get pregnant or become infected with HIV, learning will not occur. FRESH component #1 encourages the development of policies that regulate the school environment. Component #2 calls for the provision of safe water and sanitation facilities as first steps toward the establishment of a healthy educational environment. Components #3 and 4 address the need for health education and basic health and nutrition services.

**Enhance the status, morale and professionalism of teachers.**

The success of the school-based health education programmes and services proposed under the FRESH initiative depends, in large part, on teachers. Their morale and professionalism is particularly critical to their role in carrying out activities under FRESH component #3 (skills-based health education) and #4 (school-based health services.) As a first step to implementing this strategy, FRESH recommends that professional standards and administrative responsibility for teacher training (both pre- and in-service) and evaluation be clearly defined in policies at all levels of education. Beyond this, FRESH will support the goal of enhancing teacher professionalism, in particular for teachers who provide skills-based health education and/or health services, by offering assistance in a variety of forms. For example, each of the FRESH sponsoring agencies offers technical expertise on a broad range of health and education issues, and FRESH will develop and disseminate materials to help schools implement all four of the FRESH initiative core components.

Teachers are not, however, only implementers under the FRESH framework; they are also expected to be beneficiaries. As schools become safer, healthier environments, more responsive to the needs of students and staff and better supported by the community at large, teacher morale improves automatically. Training in the use of skills-based health education methodologies improves teaching practices overall. Professionalism is further enhanced by involving teachers in the development of policies to address issues that undermine their efforts to teach. And a documented result of school-based health services is enhanced teacher status in the eyes of parents and other members of the community.

**Harness new information and communication technologies to help achieve EFA goals.**

Modern information and communication technologies offer an important new vehicle for sharing resources and experiences. In the short run, however, the equipment needed to access these resources will not be universally available. Therefore, the FRESH initiative sponsors intend to maximise the potential of both new and traditional communication channels (e.g. email, CD-ROMs, the World Wide Web and Internet as well as radio, television and printed materials) to facilitate a broad exchange of information and material related to school-based health education and services. FRESH encourages national governments to develop policies that ensure that education planners, administrators and teachers, at the local as well as national level, can participate in and benefit from this exchange.

**Systematically monitor progress towards EFA goals and strategies at the national, regional and international levels.**

Based on scientific research and the experience of its four sponsoring agencies, FRESH offers a systematic approach for both implementing and monitoring school health activities designed to achieve progress toward the EFA goals. By incorporating objectives that address each of the FRESH core components into their national action plans, governments will strengthen their effort to achieve Education for All in two ways: first, by committing to a specific course of action for dealing with student health problems known to interfere with educational efforts; and second, by ensuring that investments in one area of student health improvement will not be undermined by a lack of attention to critical needs in other areas.
A very basic monitoring mechanism supported by the FRESH framework is the establishment and maintenance of student health records by schools. By assessing children’s health status when they first enrol in school and tracking changes over time, education planners and administrators gain essential information about current needs, trends over time and the impact of health issues on educational outcomes. Without such information, it is difficult to determine priorities or evaluate strategies for future planning.

In addition, efforts are currently underway to establish a global multi-risk factor surveillance system to document and monitor the state of adolescent health within and across national boundaries. Participation in such a system will enable governments to collect and analyse data about the prevalence of important risks among students over time and thus strengthen national capacity for planning and monitoring school health interventions. Each of the FRESH sponsoring agencies is contributing to this effort, and the FRESH framework focuses attention on key areas of risk and intervention that the proposed system will monitor.

*Build on existing mechanisms to accelerate progress towards education for all.*

Where health and nutrition problems interfere with learning, solving such problems will automatically accelerate progress towards education for all. The FRESH initiative brings together the existing resources of all four sponsoring agencies and provides a mechanism for schools, communities and governments to share information and materials related to school health.

The FRESH supporting strategies, which describe the context in which implementation of the core activities will produce the greatest success, call for partnerships among institutions, groups and individuals that all have resources to contribute. For example, in the planning and implementation of specific health services, the education sector should take advantage of the existing expertise and resources, including trained health workers at the local level, of the health sector. Community groups, private sector enterprises and even individual community members could help schools to construct and maintain appropriate water and sanitation facilities. Parent involvement and support is essential to ensure that efforts to improve student health are relevant, accepted by the community and reinforced in the home. Even students have something to contribute: their needs should guide policy development and the determination of health education curricula and health services; they are the critical link between schools and parents, and they can help to make the school a safer, cleaner and more supportive environment. By encouraging the development of partnerships, governments can ensure that school-based health education and services, undertaken to accelerate progress towards Education for All, are low-cost, effective and sustainable.
THE PARTNERSHIP RECOGNIZES that good health and nutrition are not only essential inputs but also important outcomes of basic education of good quality - children must be healthy and well-nourished in order to fully participate in education and gain its maximum benefits – and education of good quality can lead to better health and nutrition outcomes for children. THE PARTNERSHIP AGREES THAT to be fully efficient, school health programmes must be comprehensive, taking into account the school environment as well as instruction part, and present a framework in which several health issues can be treated. THE PARTNERSHIP ALSO UNDERLINES the importance of inter-sectoral co-operation to make school health comprehensive. IN THIS RESPECT, THE FRESH PARTNERSHIP REPRESENTS a common understanding concerning underlying principles for school health and priority fields of action, as well as an agreement to speak with one voice in order to underline the importance of school health and to jointly work towards the same goal.

FRESH HAS THE AIM to improve learning and educational achievement by improving the health and nutritional status of school-age children, and thus contribute to the twin goals of achieving Education For All and Health For All. IT PROPOSES an effective school health programme that ADDRESS the adverse effects of poor health and malnutrition on education, which may indeed jeopardize children’s readiness to enter school, their ability to learn and the duration of their schooling - effects that are directly hindering many countries’ efforts to provide effective learning opportunities to all their children.

AT THE INTERNATIONAL LEVEL, FRESH offers promise for strengthening the links between health and education, with a shared vision, a commitment to act, a pledge to work collaboratively, and a global effort to acquire and share information.

Poor health and malnutrition are primary causes of poverty meaning that “it must be tackled first and foremost through political leadership and political commitment”. In this respect, FRESH is a call on countries to include the development and implementation of effective school health programmes to improve learning and schooling and the health and well being of students and teachers in their national plans of action, notably their national EFA plans of action currently being elaborated as a follow-up to the Dakar World Education Forum. The challenge is to provide an impetus for action at national levels, triggering political commitment while at the same time promoting school level action, underlining that if the quality and quantity of school health programs are to increase, the education authorities at all levels must take a lead role.
6.2.2. Hugh Hawes, Child To Child, 17 July 2001

A New Look at School Health Education Content Planning
Dilemmas and some ways forward.

The study: rationale, background and limitations.

This presentation reflects the outcome of a study on the curriculum of Health Education for Primary Schools undertaken at end of a working life which has concentrated on both primary school curriculum and health education with working experience spanning many countries in Africa and Asia including Nigeria, India, Pakistan and Indonesia.

The current research contains field studies of just three countries, one of which, India, is here represented, but I believe it to be very widely relevant. It certainly is to my own country, England. Moreover although my experience and the research focuses on the basic cycle of education many issues raised have implications for secondary schools and for teacher education at every level.

Why the Content of Health Education is important

You may have noticed that the term content is used here in preference to curriculum the latter word comes with too much baggage. Curriculum development largely a matter of judgment and common sense, has acquired a vocabulary and mystique which is often unproductive.

All of us here today would agree the importance of choosing and delivering appropriate content as a vital part of comprehensive school health promotion for it is apparent to us that by helping students master basic health knowledge and skills and building upon these we enhance the quality of learning as well as the health of individuals and communities. But it may be that we have not fully understood how complicated and difficult this process of choice and delivery is.

Common Concerns about School Health Education

As I have read about, talked about and taken part in content planning for health education over the past years, I have detected a considerable consensus over three issues:

1. The importance and priority accorded to health education as a content component in the primary school has risen and its definition greatly widened.
   All see both the teaching of basic knowledge and the development of skill based health education as vital. Gone is the time when health was equated with hygiene and nutrition to be inculcated in children.

2. There is widespread concern, and with reason, that the planning of health education in and for primary schools is frankly inadequate and inefficient.
   There are two broad reasons for this: first is lack of conceptual clarity of the task to be undertaken. The terminology used is still poorly understood; the meaning of ‘skill based health education’ still needs to be clarified and related to methodologies used in and out of the classrooms. Moreover the special nature of health education and the ‘active learning’ associated with it still needs to be recognised. For health is in many ways different from other school subjects. You learn health by practising it and you practice it...
now and at home and not at examination time in school. Hence a methodology which links home and school is essential.

The second reason is that the process of curriculum planning is still in most countries, rigidly subject based and syllabus orientated and lacks adequate planning machinery to coordinate cross cutting themes like health and environment. The result of this is that there is much duplication and some omissions in programmes. Moreover different content elements such as syllabuses, textbooks and examinations which contain health content (and these include Language, Science, Social and Environmental Studies, Physical Education, Work Experience and Home Economics) may present different and sometimes even conflicting approaches and even out-of-date messages.

3. Gaps between the content planned centrally and the content delivered in most average schools remain wide.

Here health education suffers badly. In the first place it is not an examination subject though certain questions may figure in science paper. Hence it is neglected at school level. Even if some health content is examined no attempt is made to achieve mastery. Children can pass a Science examination containing health questions by scoring over 50% even if they have no knowledge of such vital issues as how HIV/AIDS is spread or the link between faeces, hands, food, and diarrhoea.

Secondly health understanding and the development of skills need to be built up through discussion, problem solving, action and discussion of action taken. In a textbook dominated classroom climate where children are not allowed to communicate, where children’s questions and discussion are not encouraged and where school learning and home action are kept separate, Health as an area of experience cannot flourish. In certain situations too the situation is exacerbated by language problems since the mother tongue is discouraged as a medium of communication and hence children stumble to express their ideas in a language such as English or Bahasa Indonesia which is not used by the folks at home.

Ways forward
Over the study a number of practical actions have been identified and recognised as providing a way forward towards more effective planning. Some are relatively easy to achieve; some more difficult; some very difficult indeed but all are recognised as important and timely. Let me offer twelve of these; four in each category:

Category 1. Relatively easy.

1. Group together all current health education content in current curriculum documents and issue them separately preceded by a set of national health objectives and followed by some suggestions on the teaching and learning of health related content. Hence a national Framework of Health Education for School Aged Children could be issued.
2. Agree and issue a set of minimum competencies for health knowledge and skills which all school leavers should master.. thus creating a sort of Facts and Skills for Life for Children. As with 1 (above) this statement could be issued jointly by the ministries of health and education. It might also be possible encourage the issue of locally based mastery tests leading to some form of health proficiency badge on the lines of those given by the Red Cross, Red Crescent or youth organisations such Scouts or Guides.

3. The production at national level of a bank of teaching learning units based on priority health themes at various levels which could contain a series of linked lessons designed to present key health issues at different levels, link them with enquiry and action at home, teach them simply in a way that develops skills rather than rote knowledge and is reinforced in different subjects across the curriculum, particularly language and mathematics. Such a bank could be continually revised and augmented in the light of use in the field.

4. The production of resource books linked with and regularly used in programmes of both initial and in-service training of teachers so that gradually a new approach to health education could be fostered.

**Category 2 More Difficult**

5. The production of a scope and sequence chart for health as a cross-cutting theme across the curriculum which could be used with great effect as a planning document in times of curriculum revision to ensure complementarity between subjects and also as an aid for textbook writers and teacher educators. Such a chart might profitably be divided into age bands e.g. lower, middle and upper primary, rather than into grade levels.

6. Emphasis on content planning at school and community level linked with the emergence of a policy whereby individual schools and groups of schools emphasise comprehensive school health promotion and produce action plans based on local priorities.

7. Action at local and national level to clarify concepts and goals and to identify actions towards meeting them. Specific action is needed to clarify the meaning and implications of skills based health education and of an effective school health programme particularly as they apply to schools with resource constraints.

8. Review of current textbooks in health related subjects and the way in which they are chosen, planned and written leading towards the issuing of guidelines to ensure that new books better meet criteria to promote more active and skills based health education.

**Category 3: Very Difficult**

9. Review of the nature and management of curriculum centres and the curriculum development process to ensure that essential cross cutting areas of experience such as
health education the environment (including disaster preparedness) and living together (e.g. issues of discrimination, violence and gender) may be better planned and integrated.

10. Review and gradually change of the culture of primary education so that school and classroom practices which inhibit skills based education are gradually changed and schools move closer to communities and reflect their health needs.

11. Augment the level of relevant expertise in curriculum centres, training programmes, and international projects particularly to include personnel with greater knowledge of the needs of younger children and of school and classroom practices at elementary level. Currently much of the expertise which exists, and it is everywhere spread thinly, has been secondary and tertiary rather than primary experience. This is an issue which goes far beyond health education.

1. Review the planning of health content at local level so that the concept of a community curriculum where school and adult, formal and non-formal education move closer together to reinforce each other.
6.2.3. Scott Pulizzi & Phyllis Scattergood, HHD/EDC, 18 July 2001

**Tobacco-Control Policy Workshop:**

**Goal:** to introduce Mega-Country leaders to an effective policy framework for tobacco control and to develop skills to promote policy implementation.

**Objectives:** As a result of this workshop participants will;
1. Be able to identify key elements of tobacco control policies at national and school levels;
2. Develop a prototype to use at the ministry level for an effective tobacco control policy for schools;
3. Develop advocacy skills to promote tobacco-control policy implementation.

**Date:** Wednesday, July 18, 2001

**Time:** 13:00 – 16:45

**Materials:**
- Research synthesis fact sheet
- Policy benefits fact sheet
- Policy outline
- Checklist: 10-point program for successful tobacco control
- Framework Convention on Tobacco Control: A Primer
- WHO Information Series on School Health: Tobacco Use Prevention
- Sample tobacco-control policies
- Activity work sheets
- Reporting work sheet

**Methods:**
- Presentation
- Large group discussion
- Small group, participatory activity
- Demonstration/role play, summary of results & next steps

**Introduction (5 minutes)**
- Purpose of the workshop is to introduce Mega-Country leaders to an effective policy framework for tobacco control and to develop skills and strategies to advocate for successful implementation.
- Output is to develop a prototype through consensus that will provide participants with a systematic approach to develop tobacco control policies in their own countries.
- Methods include presentation and small-group role playing with report back

**Overview – public policy and FCTC (10 minutes)**

A.) Framework Convention

**Framework Convention on Tobacco Control (FCTC)**

- **What is the FCTC?** The Framework Convention on Tobacco Control (FCTC) will be an international legal instrument that will circumscribe the global spread of tobacco and tobacco products. This
instrument will be developed by WHO’s 191 member states. The FCTC will establish legal parameters and structures, the foundation of a tobacco-control public health tool.

- **How will the FCTC help international tobacco control?** The FCTC and related protocols will improve transnational tobacco control and cooperation by establishing guiding principles to inform the policy makers and standardize policy objectives. Additionally, the FCTC will mobilize national and global technical and financial support for tobacco control; raise awareness among ministries as well as various sectors of society; strengthen national legislation and action; and mobilize NGOs and other members of civil society in support of tobacco control.

- **Can international agreements affect the behavior of states?** An international agreement can provide supporters within national governments with additional leverage to pursue the treaty’s goals, articulate laws and establish review mechanisms that hold States up to public scrutiny.

  (Adapted from: *WHO Framework Convention on Tobacco Control: A Primer*)

B.) Public policy:

“Public Policy is essentially an aggregate of governmental decisions, rules, and programs expressed in the form of laws, local ordinances, court opinions, executive orders, the whole reflecting certain long-range objectives that society wants to pursue.”

*(American Public Administration: Concepts and Cases)*

“National and provincial laws establish a base for local policies—local policy focuses on implementing and enforcing existing laws.” (Northeast CAPT)

Similarly, international treaties can establish a base for national policies.

3 components of policy:

- **Policy choices** – using public power to affect the lives of citizens, for example, to control tobacco

- **Policy outputs** – putting choices into actions, for example, passing laws to ban advertising around schools, training staff to enforce laws, and conducting public education campaigns

- **Policy impacts** – the effects of policy choices and outcomes on citizens, for example, fewer smokers and more smoke-free public spaces

  (Adapted from: *American Public Policy: Promise and Performance*)
The Public Policy Process:

1. **Identify the Problem** – tobacco is the leading cause of preventable death

2. **Design the Course of Action** – laws, programs, and taxes to prevent tobacco usage, help users to quit, and protect nonsmokers from second-hand smoke

3. **Mobilize Support** – advocacy for government agencies, NGOs and the public to support the policy

4. **Establish Guidelines and Rules for the Course of Action** – funded, feasible, monitorable, enforceable, and sustained over time

5. **Implement and Enforce the Course of Action**

6. **Evaluate** – the policy outputs: laws, programs, tax schemes

7. **Reform** – the policy outputs based on lessons learned

(Adapted from: *American Public Administration: Concepts and Cases*)

**Outputs of policy:**

- **Law** – to place warning labels on tobacco products, to ban sale of tobacco to minors
- **Services** – education and training programs, cessation services
- **Money** – grants to districts that comply with tobacco control policies
- **Taxation** – sales tax on tobacco products
- **Suasion** – an influential leader or agency makes a moral, public interest argument against tobacco

(Adapted from: *American Public Policy: Promise and Performance*)

**Benefits of Tobacco-Control Policy:**

- Policy provides a framework for establishing priorities, goals, and programs for tobacco control
- Policy is a guide to practical decision-making for staffs of schools and ministries
- Policy articulates common vision for tobacco control
- Policy can set national standards for tobacco control that can be enforced and measured
- Policy influences the environments in which choices about tobacco are made

*Policy helps give children a real chance to grow up tobacco free*

(Adapted from: *WHO Information Series on school Health #5: Tobacco Use Prevention*)
Elements of Effective Tobacco-Control Policy (10 minutes)

Core Areas of Tobacco Control:

- Preventing the initiation of tobacco use, especially among your people
- Helping users of tobacco to quit
- Protecting of nonsmokers from second-hand smoke
- Identifying and eliminating disparities related to tobacco use and its effects among different populations

(Adapted from: CDC Best Practices for Comprehensive Tobacco Control Programs)

School Tobacco-Control Strategies That Work:

- Higher tobacco taxation – to make tobacco unaffordable for the young
- Marketing restrictions – to ban advertising directed at youth
- Prohibition of sale to minors – to make it difficult for youth to access tobacco products by establishing a minimum age to purchase tobacco
- Protection from environmental tobacco smoke – to reduce exposure and reinforce the message that smoking is harmful

Policy experts agree that a combination of these strategies should significantly reduce tobacco use by youth, provided they are sustained over time, strictly enforced, and adequately funded.

(Adapted from: WHO Information Series on school Health #5: Tobacco Use Prevention)

“National and local policies and commitments can maximize the success of local efforts to prevent and reduce tobacco use through schools. In addition, schools themselves can help foster supportive polices”

Smoke-Screen: How Tobacco Tries to Buy Legitimacy (5 minutes)

Educators and policy makers should not collaborate with the tobacco industry on any programs for tobacco control. The tobacco industry’s practice of marketing to kids has been well documented. Most users start during adolescent years. Unless this strategy stops, all joint tobacco-control efforts will be compromised, and will serve to strengthen the tobacco industry’s position in the public, political, business and legal arenas.

Funds the tobacco-industry allocates for tobacco control is simply a smokescreen; they are trying to buy legitimacy by partnering with credible agencies. It is ultimately not in their interest, and explicitly against their marketing strategy, to stop youth addiction. Accepting money from the tobacco industry will serve only the short-term monetary goals at the great cost of compromising your ministry’s credibility and integrity to advocate for the public good.
The tobacco industry philosophy is: get them early and they will be customers for life.

Stop marketing its tobacco products to kids:
- a ban on vending machines;
- a ban on ad campaigns that are successful with youth, e.g., the Marlboro Man
- a ban on all tobacco ads in magazines with significant youth;
- a ban on outdoor ads near schools and areas frequented by youth;
- a complete ban on all brand name sponsorships of teams, sports, entertainment and other events;
- stronger and more visible warning labels on all tobacco packaging and ads.

(Adapted from: The Tobacco Industry's Youth Anti-Tobacco Programs: Campaign for Tobacco Free Kids)

Brainstorming Activity (90 Minutes)

A Ten-Point Program for Successful Tobacco Control

1. Protection for children becoming addicted to tobacco through such measures as the banning of sales to and advertising targeted at children
2. Implementation of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster that the rise in prices and income
3. Allocation of a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4. Health promotion, health education and smoking cessation programs.
5. Protection from involuntary exposure to environmental tobacco smoke.
6. Elimination of socio-economic, behavioral and other incentives that maintain and promote the use of tobacco.
7. Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8. Controls on tobacco products, including health warnings.
9. Promotion of economic alternatives to tobacco growing and manufacturing and sales
10. Effective management, monitoring and evaluation of tobacco issues.

( WHO Information Series on School Health)

Purpose: For participants to develop strategies to address each of the Ten Points, from the outline listed above, at both the ministry and school level.

Materials: 10-point program, worksheet, report form, and sample policies
Brainstorming Activity Instructions:

- Convene in small groups
- Each group will have a facilitator and should identify both a recorder and reporter.
- Each group will be assigned two points that they will present to the plenary. Groups should be prepared to spend 5-10 minutes reporting highlights.
- Each group will address each of the Ten Points using the questions below and record their answers on the Reporting Worksheet
- Each group will use the Reporting Form to report their findings with the two points they have been assigned
- Group responses will be synthesized into a single prototype that addresses each of Ten Points. In other words participants will draft the contents of what should be in a national policy that addresses tobacco control in an education setting.

Key Questions for the Activity 1

1. What can be done at the school level to address each of these ten implementation issues?

2. What can be done at the ministry level to address each of these ten implementation issues?

Example:
Point # 1. Protection for children becoming addicted to tobacco through such measures as the banning of sales to and advertising targeted to children.

1. There will be no advertising, distribution, or promotion of tobacco products permitted on school property.

2. No school that permits tobacco advertising or promotion on school grounds will be eligible to receive funding from the ministry of health/education.

Building the prototype (30-45 minutes):

- report back
- synthesis
- comments, questions, and summary

Advocacy (Introduction -10 minutes)

Building on Cheryl’s presentation, we will highlight tobacco-specific issues for advocacy:

Advocacy Issues to Promote Tobacco-Control Policy Implementation:
Examples of Advocacy Objectives:

1. Raise public awareness about the importance of tobacco prevention.
2. Advocate for governments to include tobacco prevention in national, provincial, and local policies.
3. Secure technical and financial support for implementation.
4. Educate leaders and community members about the importance of tobacco prevention efforts.
5. Promote public awareness of the need for school-based tobacco prevention initiatives.
6. Advocate for the provision of training for education personnel.
7. Establish coordinated training programs with national institutions, such as universities, to train all education personnel.
8. Join forces with other international, national, governmental, and non-governmental, i.e., Framework Convention (FCTC)

Building Advocacy Skills to Promote Policy Implementation:
Role-play & Practice (50 minutes)

- Small group activity to practice advocacy skills to persuade decision-makers to develop effective tobacco-control policy.
- Report/demonstration to large group.

Building Advocacy Skills to Promote Policy Implementation Instructions:

Using brief case studies, participants take turns developing arguments to successfully advocate for the development of tobacco control policies.

- Assemble in small groups.
- There should be an advocate, a decision-maker, and few observers to provide peer-feedback.
- Rotate roles as time allows.
- Prepare a 5-10 minute demonstration and report of results.

Summary and Closure (5 minutes)
Health Promotion School in the Municipal of Rio de Janeiro/Brazil

The major school health achievements from 2000 to 2001

Carlos dos Santos Silva

Health Promotion has been taking place in different schools of the public educational system of Rio de Janeiro Municipality through several initiatives which involve a variety of professionals and the scope of the Municipal Health Department and the Municipal Educational Department. Such initiatives have been being led toward subgroups or the totality of school community and also include daily actions which are already incorporated to pedagogical practice, curricula, schools routine, risk or protective situation identification, diagnoses and demand analyses, among others.

The partnerships are important subjects to enlarge the Initiative, for example with Municipal Environment Department at the level of the appointments of Agenda 21 and with the academic area to evaluation, to survey and technical training.

The Health Promotion School Project is sponsored by the Municipal Health Department of Rio de Janeiro with financial sources from the Municipal Health Funds and for its accomplishment it was formed 10 initial teams with educational and health area professionals. So, we are working with some important strategies to implement health promotion through schools, for example: diagnosis and local, regional and general demands survey; teachers technical training program; working groups formation, accomplishment of workshops in the communities; production and publication of technical-scientific pedagogical material support; and multiplying agents formation: teachers, adolescents and community leaders.

Since last meeting we established Health Promoting Schools network in collaboration with Department of Health and Department of Education; analyzed data about children and youth risk behaviors and probably to identified protection factors in potential for children and adolescents; trained teachers in school health promotion; produced new materials (including manual for teacher training in school health) and produced a website for school health (http://www.saude.rio.gov.br), evaluated Health Promoting Schools in Rio; proposed local intersectorial project for HIV/AIDS prevention among children and youth. At this time we are planning new investments in prevention and control of tobacco use and school with partnership of Health Ministry (INCA).

In Brazil we have some progress too, including a federal level: the Health Ministry and Education Ministry did a Government regulation about a especial working group that must think and work together for health promoting school politics. Particularly with the municipal of Rio de Janeiro, it is probable to consolidate a partnership with the Health Promotion Project of Policy Secretariat of Health Ministry just to implement a school health promotion network and to enlarge teachers training associated with National Public Health School (ENSP/Fiocruz).

1 Dr. Pediatrics Master. Manager of School Health Program of Municipal Health Department of Rio de Janeiro
Health Promoting School in the Municipal of Rio de Janeiro/Brazil

The major school health challenges from 2000 to 2001

Carlos dos Santos Silva 1

The Health Promotion through School Initiative in Rio de Janeiro municipal area intends to support, remodel and enlarge the developing activities in this area integrating Health Area discussions and acknowledgment to the Basic Curriculum Nucleus Multi-education, developed in municipal school system. The consolidation of this Initiative requires a whole process which presupposes dialogue, creativity and daring, success eagerness, involved professionals disposability and agreements among Institutions.

We're sure that one of the existing challenges is to maintain the development of actions for school health promotion and to foment local real action in the school communities. Such a process is to be developed into medium and/or long periods, so it's important to look for an institutional goal. The activities must be developed in regional and local levels and all of actors involved must know, believe and wish that the proposals of Health Promoting School will be better for the quality of their life. So, it is very important to have resources and more investments: a) in the technical training of human resources, so much in health promoting school as in the management subject, methodology and planning to form leaderships and multiplier agents, b) to give conditions to their actions and help them to improve local projects; c) to supply educational materials that subsidize activities in accordance with themes and demands of community with large editions; c) to improve news partnerships, mainly with the local health services; d) the Education Department needs to work with the proposal that Health Promoting School must be in their curriculum and pedagogical program and it's not extracurricular activities of classroom; e) exchange experiences between schools, among professionals and communities, regular meetings and a interactive website which can stimulate the effective health promoting schools network.

Since the last meeting, those iniquity conditions still persist because the social and economic politics remain and they don't guarantee a better distribution of income. The external causes continue to affect in an important way the children's and adolescents' mortality. The drug traffic has been contributing to elevate the use of drugs, to increase risk factors. The violence subjects are more intense and serious, cause they have been representing a challenge to the health promotion.

Another challenge is to revert the adverse conditions of the population, who lives in risk situations, with committed life quality, by quite unfavorable social indicators and without access to the essential services and basic needs, which they have as rights. The investments are not enough to consolidate an effective politics of health promotion so it's very difficult to guarantee improvement of the life quality of the population with more justice, equality, and peace and without violence.

We expect and need to stimulate more dynamically the school community to actively participate of the constructing process of health life and through this way to stimulate the active local action toward sustainable development.

1 Dr. Pediatrics Master. Manager of School Health Program of Municipal Health Department of Rio de Janeiro
Along years the Health Promoting School implementation process in Rio de Janeiro municipal area have been configured by actions in the school community through sexuality issues, as adolescence pregnancy, sexually transmissible diseases and aids prevention. These demands were accompanied by the discussion and the reflection on the risks of tobacco, alcohol and other drugs use and school, situations which usually put in risk the quality of children's and adolescent's life. One of the basic strategies to introduce those themes in the school was the teachers' and students' training. The proposal was to form multipliers agents, who could create new work groups and to expand the actions of health promotion through the municipal educational system universe and, mainly to work with adolescent to adolescent.

Some Projects, like "Alive Being", "Aids and School!", "Educarte", "At This School I Stay", among others, oriented to the integral development of the adolescents, with sexuality issues, reproductive health and drug use emphasis have been being done together with the Municipal Health and Education Departments! The Adolescent Health Program, School Health Program and DST/AIDS Prevention Program integrated to Health and Environmental Education Project which created the Sexual Orientation and Drug Use Prevention Program. Another important point was the creation of the Multiplier Adolescents Nucleus at municipal schools, firstly linked to the Educarte Project. Both envisage to capacitate teenagers to work with other young people. Currently there are 55 Multiplier Adolescents Nucleus which interact in their schools and in the community. The creation of the adolescent nucleus at school is coordinated by teachers who are available with a double regency to enlarge their works and activities through stimulating the protagonist adolescent action who really is responsible for the actions. Today, these Multiplier Adolescents Nucleus stands for at about 2,000 adolescents between 12 to 18 years old and they develop many actions with other children and adolescents from the school community like promoting meetings, plays and games, creating and writing poem and songs, theatre dramas and other kinds of activities about sexuality and STD/Aids and drugs use prevention. These Multiplier Adolescents Nucleus are emphasizing auto - esteem, protagonist action, life's valorization, responsibility, construction of knowledge, health and environment healthy inter alia. The Healthy Adolescent program implanted at municipal health services Projects like Green Signal and Wear Condom, which invest in a integral health support and stimulate the condom wearing and guarantee condom access in health services.

This year we are planning more investments against tobacco use and we're programming to introduce this theme firmerst at Health Promoting School and at Schools which have the Multiplier Adolescents Nucleus.
6.3.2. China

**Major School Health Achievement and Challenges (2000-2001) in China**

Dr. Yan Jun, Assistant Consultant, Dept. of Diseases Control, MOH, China  
Dr. Liu Yexun, Officer, Bureau of Education of Anhui Province, China

From June 2000 to July 2001, the Major School Health Achievements in China are as follows:

1. **National Conference of Health Promoting School**

   National Conference of Health Promoting School was held from Oct. 17-19, 2000, by Department of Diseases Control, Ministry of Health and the Department of Physical, Health and Art Education, Ministry of Education, organized by the National Institute of Health Education Research, technique sponsored by the Institute of Child and Adolescent Health Research, Peking University and the Chinese Academy of Prevention Medicine. We would like to thank WHO for providing finance supporting to the conference. The total participants are 134 coming from local governments, bureaus of health and education, stations of health and epidemic control, health education, primary and secondary school student’s health care, some schools and universities and mass media units in 28 provinces, municipal cities and autonomy regions. Some experts from WHO, UNICEF, CDC, of US and the Hong Kong Association of Health Promotion joined in the conference.

   The conference achieved the following agreements:
   - The guideline of health promoting school to encouraging the work of promoting school to improve health based on the real Chinese status and the experience of pilot studies should be co-developed by health and education sections.
   - The program of creating health promoting school should be expanded step by step in whole country.
   - The work of health promoting school should be combined with the regular work of school health to keep it sustainable.
   - Both sections of health and education should be working together, but the responsibilities of each section should also be defined clearly in order to make the work effectively.
   - Except for carrying out health inspecting in school, the health sections were asked to provide technique guiding and services of how to implement health promoting school program for education section and schools.
   - For improving the knowledge and skills of health promoting school, workers, managers and teachers in health and education sections and schools should be trained with the theories and practices of health promotion.

   After the conference, the Municipal Bureaus of Health and Education of Beijing and Shanghai launched the local programs of health promoting school in which the health promoting school is considered as an important strategy to improve school health and is combined into the regular work of school health.

2. **Carrying out the final evaluation of the national strategy plans of comprehensive prevention and control of common diseases for students and developing the next 10 years national strategy plan of promoting student health.**

   In the end of year 2000, MOH and MOE have organized the final evaluation of the national strategy plans of comprehensive prevention and control of common diseases for students to check the progress of the national strategy plans during the past 10 years using the uniform standards developed by both Ministries. Field inspection will be taken in this September by officers and experts from health and education sections of the National Institutes of Health Education and Research and the National Institutes of Health Education and Research of the USA.
education sections of center level and province level. The sum-up and award meeting will be hold in early of next year.

The national strategy plan of promoting student health in the year of 2001-2010 has been drafted by experts this year, organized by both Ministries. Because China is a large country with different status between region and region, the new strategy will apply the theories of health promoting school into school health. Each province will be asked to define the priority problems what affect student’s health and then select and implement their intervention. The next 10 years strategy plan will be issued in the end of this year.

3. The national programs of improving the status of child and adolescent’s physical fitness and health

In August 2000, the national program of improving the status of child and adolescent’s physical fitness and health approved by the State Council has been launched by MOH, MOE, the Ministry of Agriculture and the State Bureau of Sports. The projects cover the following areas:

- **School Milk Program** is focus on primary and middle school students of urban areas and is co-operated by 7 sections such as the Ministry of Agriculture, MOH, MOE, etc. In the year of 2000-2001, the first stage of project is carried out in Beijing, Tianjin, Shanghai, Guangzhou and Shenyang cities.

- **School Soybean Milk Program** is focus on primary and middle school students of rural areas and is co-operated by MOE and the Ministry of Agriculture. In the year of 2000-2001, the project covered Heilongjiang, Jilin, and Liaoning provinces in north areas of China

- **School Lunch Program** is initiated in 1980’s and is formally launched as national wide project by the State Commission of Economy and Trade in 2000.

- **Food Fortification Program** focus to fortified white flour and soy sauce with iron to treat anemia of farmer including child and adolescents in poverty areas. The project is co-operated by MOH, the State Bureau of Food and the National Institute of Economy Research and is supported by UNICEF and the Asia Bank. In the year of 2000-2001, the project is just in initial stage.

- **Adolescent Sport Club Program** aims to promote physical activity among students through providing enough physical activity spaces and instruments. The project is operated by the State Bureau of Sports. Up to now, almost 100 clubs have been set up in 16 provinces.

4. Surveys on the student’s physical fitness and health and on the school nutrition status

- **Surveys on the physical fitness and health of Chinese Students in the year of 2000.** According to the regular five years survey rule in the physical fitness and health of Chinese Students, MOH, MOW, the State Bureau of Sports, the Ministry of Science and Technology, the State Nationalities Affairs Commission conducted the survey of 2000 within whole country. Up to now, data collection and draft analysis is finished, whole report will be finished in the end of this year.

**Survey on school nutrition status.** The survey organized in July 2000 by MOE supported by UNICEF, is to collect information about nutrition in school what including knowledge of nutrition, food consumption style, facility of school kitchen, parents attitude of food sever in school, etc. The finding will be report in end of this year.

5. Promoting mental health of students

- **China/WHO School Contest on Mental Health for World Health Day 2001.** Answering the WHO initial program, China organized Chinese School Contest from Dec. 2000 to April 2001 by MOH and WHO Representative in China and printed the Collection of Winning Essays and Drawings after contest. More than 50 primary and middle schools in 11 regions participated in the contest. The essay titled The Injured Butterfly wrote by Tang Shuwei, 14 years girl student from Shenzhen Experimental School, Guagdong Province, won the Globe First Prize (10-14 years old) of the contest.
Training Program of Mental Health for Psychology Teacher in School. The program organized by MOH and MOE supported by Eli Lilly Asia, will start at July 2001 and train school doctors, nurses and psychology teachers to increase their knowledge and skills of mental health and communicative methods with students and to help them to find early and treat properly the student with problem behaviors related mental disorder. The problem willing to find a suitable way to combine the experience of clinic finding into the school based intervention action.

6. Continuing action of the regular annual school health examination to strengthen implementation of the Act of School Health Work

From 1991, according to the Act of School Health Work the regular annual school health examination has been conducted by the MOE and carried out each year by every provinces, municipal cities and autonomy regions. The contests of examination include 6 areas: health framework and it’s management, health circumstance and finance, school doctors or nurse and health care setting, health education, public health and student’s common diseases and communicable diseases preventing and control and situation of student’s health. The excellent schools and universities have been awarded every 5 years by MOE.

7. Health education and communication projects and activities

The health education and communication projects and activities in some special areas had been carried out as follows:

- World Tobacco Day (31st May) in 2001 with topic: Second-hand Smoke Kills, Let’s Clear the Air
- National Iodine Deficiency Disorders Elimination Day (15th May) in 2001 with topic: Continuing Elimination Iodine Deficiency Disorders
- National Teeth-Loving Day (20th September) in 2000 with topic: Dental Health is Care, Avoid Dental Injuries
- Health promoting school projects focus on smoking control and nutrition and the health promoting university program organized by MOH supported by WHO
- School-based HIV/AIDS prevention project in some regions organized by MOE supported by Save Children
- School adolescence health, oral health and cleaning body project in some regions organized by MOH or MOE supported by Unilever or P & G or Colgate-Palmolive.

Major Challenges:

1. Although the policies and standards related school health has been established in China, there are still in shortage of sufficient resources to keep the work going, especially in western China where the poverty provinces, municipal city and autonomy regions locate in.
2. Because more and more student’s health problems related with behaviors of child and adolescent, regular child and adolescent behaviors surveillance or survey should be established in addition to the annual reporting system for school health.
3. Needing experience and technical guide in the areas of mental health, adolescence health and behaviors surveillance.
6.3.3. India

National Policy On School Health – India

The School Health Programme in India is run mainly in the secondary schools where usually students in the age group of 4-18 generally are available. The main objectives of School Health Programmes are as follows:

a. Promotion of positive health of school going children.

To achieve this, following activities are undertaken:
1. Health appraisal of school children and school teachers.
2. Preliminary screening of all the pupils by the school teachers.
3. Six monthly medical examination by a doctor.
4. First Aid and Treatment of Minor ailments.

In addition to the general approach as described above, there are two issues where focused attention is being given - Tobacco Use and AIDS Education.

2. Tobacco Use & Schools
2.1 In India, several studies amongst school going children/teenagers have been carried out to gauge levels of tobacco use prevalence, attitude and knowledge, their exposure to ETS etc, in various parts of the country. The results of the same are alarming.

2.2 In a survey done in Bihar, it was found that among high school students, the overall prevalence of any current tobacco use was as high as 59%. Here, smokeless forms of tobacco (55.8 %) were the most prevalent among students. The overall prevalence of any smoking was 19%. Cigarettes (8%) were the most prevalent type of smoking, followed by bidi (5%) and other forms of tobacco smoking (2%).

2.3 A recent study done in Punjab to assess the extent of use of smokeless forms of tobacco like “gutkha” among middle school children, revealed similar results.

2.4 Shockingly, about two-thirds (66%) students admitted their addiction to gutkha without any hesitation. Earlier, a similar study conducted in the schools of Hissar in Haryana had revealed that more than 50% students from class sixth onwards were addicted to gutkha. One of the major causes of this is free availability of chewing tobacco at roadside vends, tea-stalls, paan shops, grocery stores, booksellers and stationers. Also, the cost of a pouch of gutkha is only Rs 1, which even ordinary school children can easily afford from their pocket money.

2.5 In light of the above facts, the Ministry Of Health is taking stringent steps to protect this vulnerable segment of school children from the tobacco initiation and addiction. In India, the main challenge is dissemination of anti-tobacco awareness among to schoolchildren at various levels within the school system, which is varied and diverse across the country.

2.6 This information dissemination is being done through a three-pronged approach:

[a] Inculcation of the Anti-tobacco message in the school textbooks:
Efforts are being made to ensure that the school syllabi and textbooks are developed and revised by the National Council of Educational Research & training (NCERT) to include educational material on tobacco at all levels i.e. primary, middle and high school. Through this process, anti-tobacco information will be drilled into the student’s young mind right from primary school since all his books on subjects like Science, History and Geography will impart some knowledge about the ill effects of tobacco on health, society, environment etc.
[b] Inculcation of the Anti-tobacco message through extra-curricular activities in schools:
Through various programs being carried out by schools and organizations like Nehru Yuva Kendra & Deptt of Field Publicity; anti-tobacco information is being disseminated by organizing Painting competitions, Debates, Quiz contests etc on the topic amongst schoolchildren. Children are encouraged to learn more about tobacco and its ill effects through these activities, which are held outside the realm of formal education. Innovative techniques like magic-shows are also being used to give out the information in an entertaining way to schoolchildren in tribal/fisherman belts of Kerala.

[c] School Based interventions:
The Govt. is extending support to various NGO’s who are carrying out school-based interventions for preventing tobacco use among school children. These NGO’s contact the students within school hours to spread anti-tobacco awareness through detailed discussions, game-books, posters etc. Once the students are fully aware of the consequences of tobacco use, they are encouraged to involve their families and communities in the activity. Student Parliaments and street plays are conducted by the students on the topic to ensure that the child develops holistic view of the tobacco menace and as a result does not indulge in tobacco use even in his adulthood.

2.7 Legislation banning sale of tobacco to minors:
In addition, there is a legislation in the states of Goa & Delhi, which bans sale of tobacco products to minors. This clause has also been included in the Tobacco Control Bill, 2001; which is currently under review in the Parliament, to ensure that tobacco is not legally available to young people under the age of 18 anywhere in the country.

3. SCHOOL AIDS EDUCATION PROGRAMME
3.1 Young people are specially vulnerable to HIV and other sexually transmitted diseases (STDs). They are also vulnerable to drug abuse. Even if they are not engaging in risk behaviours today, they may soon be exposed to situations that put them at risk. Very often they cannot talk easily about AIDS or about the risk behaviours that can lead to HIV infections at home or in their community. Young people generally find it difficult to reach services where they can discuss questions related to sexual health.

3.2 At the same time, young people can be a positive asset in helping prevent HIV and STDs. As they are still developing behaviour and experimenting in sexual matters, they can adopt safer practices from the outset. Young people can also exert a strong influence on one another. Young people can be used positively in AIDS Education programmes to spread messages on safe and high risk behaviour as regards to HIV/AIDS.

3.3 It is estimated that globally almost 60% of all new HIV infections are among 15-24 year olds. In India, young people in the age of 15-24 years comprise 20% of the total population. In 2000, the total HIV prevalence in the country is estimated at 3.86 million.

3.4 The National AIDS Control Organisation has adopted a two pronged strategy for integrating AIDS Education in the school activities. These include:

a. Inclusion of information on HIV/AIDS in the curriculum in Class IX.
b. Integrating HIV/AIDS activities with ongoing life skills education and extra curricula activities in schools.

3.5 In collaboration with NCERT, information on HIV/AIDS has been included in the NCERT books for Class IX CBSE schools. The NCERT is also collaborating with the SCERT in the State for inclusion in the curricula of the state schools.

4. EVALUATION
The evaluation of the activities is carried out on sample basis at the national and state levels through established organizations. Of late, NGOs are also being used to evaluate and assess the performance through questionnaires and also through personal contacts.
6.3.4. Indonesia

**Indonesia 2001**

**School Health Program**

**Mayor Achievement**

1. Scheduled National School Health Coordinating Board Meeting (SHCB) held in Jakarta 13-15 November 2000, attended by 24 out of 26 provincial SHCB shows that the National Commitment in guiding School Health Program are still very high. (2 politically unstable provinces of Maluku and Aceh were unable to participate).

**Among the important recommendations are:**

a. The need of Presidential decisions/decrees to further strengthen the 4 (four) ministerial commitment currently being use as a legal basis for school health program implementation.

b. Identification of mayor SHCB program activities to include:
   - Prevention of drug abuse
   - Pregnancy, sexual behavior, and child abortion
   - Prevention of smoking cigarette and alcoholic drink
   - HIV / AIDS prevention
   - Child violence prevention
   - Safe school facilities

2. **Expansion of School Supplementary Feeding Program**

Following the political system changing toward decentralized government, the initial school feeding program supported by central government budget was also discontinued; meanwhile school milk program which cover approx. 500,000 primary school student is to be expanded to cover 6 other provinces. Mean while alternative food preparation are being tried out such as snack noodle, fortified biscuits, bean porridge; to prepare for the implementation of Food for Education initiatives currently sponsored by USDA and going to be the new initiatives of FAO.

3. As part of continuous implementation of Health Promoting School, a yearly school health competition has been conducted. In the year 2000 besides primary school, for the 1st time junior secondary school level also involved in the activities and President of the Republic of Indonesia personally presented the award for the winners during the National day celebration.

4. Healthy life skill education to cover wide range areas such as anti smoking campaign, child violence, HIV/AIDS prevention etc, was initiated and had produced modules for different level of education and implemented in a number of provinces.
6.3.5. Mexico

**ACHIEVEMENTS AND CHALLENGES IN HEALTH**

The Mexican population grew more than 7 times in the 20th century, from 13.5 million in 1900 to 97.5 million by the year 2000, in this same period, the rate of total mortality declined from 3.5 to 4.5 annual deaths per 1000 population, and the rate of infant mortality in the same period, decrease from 200 deaths to 26 per 1000 registered newborns.

Mexico currently has a population of 2 million children under 1 year old; 8.8 million children of one to 4 years and 11 million children from 5 to 14 years giving a total of 21.8 million, the majority of them are being served by the National Health and the Educational National Systems in order promote healthy lifestyles and disease prevention.

Among the effort to diminish the child mortality is the high immunization coverage that include 95% of this population. An important result of this initiative is that since 1990 cases of poliomyelitis have not occurred in our country.

The analysis of others cause of death in children demonstrate an important reduction infectious pathologies such us mortality associated with intestinal infections diminishing from 3.6 deaths by 1000 newborns in 1990 to 1.1 in 1996; moreover mortality from pneumonia and influenza was reduced around 30% during this period.

Similar patterns of mortality were observed among the children of one to four years old, and those from five to fourteen, in these groups the intestinal infections decrease to 60% and pneumonia and influenza diminished to half.

Within the leading 10 causes of mortality in children under 1 and of one to four years, nutritional deficiencies occupy the fifth place, while in children under one year of age it occupies the seventh place.

Favorable changes had occurred in the nutritional situation of children under 5, an example of this, is the prevalence diminish of low weight in this age group 5, from 14.2 in 1988 to 7.5 in 1999, which means that during the past decade there was a reduction of almost 50%, however, we still have the challenge of reducing the prevalence until reaching levels of around 2%, to achieve in a healthy and well fed population.

The prevalence of anemia in this age group in 1999 was of 27.2, during the second year of life of these children almost 50% and almost 33% in children from 2 to 4 years old, therefore consider that in Mexico should be a priority public health problem to attend.

Among of overweight and obesity boys and girls the prevalence was 4.7% in 1988 and of 5.4% in 1999.; the increase in the prevalence of overweight and obesity is alarming given the close relation of these problems to the chronic degenerative diseases.

In addition, food consumption behavioral has been improving gradually in mexicans, including adequate protein intake and ‘folic acid’, as well as moderate consumption of energy are observed and vitamin A. However, we still have a deficient iron and vitamin C intake. Results from researchers are being considered to design programs of nutrition and good feeding habits.

Mexico needs to redouble efforts to reduce prevalences of ‘malnutrition’ and avoid the growing problems of anemia and obesity.

In this regard, by law, the Government of Mexico has created and implemented since 1995 the Education, Health and Feeding Program (PROGRESA), which is targeted to boys and girls under 5 years old and school-age as well as, to pregnant women and mothers in period of lactation, living in areas of extreme
poverty, this program carries out actions of education, primary health care and food supports to reduce 'malnutrition' and promote health as well as to improve its quality of life.

Joined together to this the Ministry of Health sets up the program for basic health care oriented to the beneficiary families of the PROGRESA in order to promote a better utilization of the health services involving both, the families as well as the service providers.

Among the schoolchildren and preschool children causes of death the accidents are gaining greater importance up to occupy the first places; It represents a challenge for our country to face this problem we are developing specific programs to prevent in this population through the National Council for Accident Prevention.
Major school health achievements

Mtro. Armando Sánchez Martínez
Ministry of Public Education, MEXICO

In the context of the curriculum reform of 1993 and the actions of the Ministry of Public Education, the promotion of health was recognized as a subject of vital importance in elementary education. Settled as a priority in education, health issues considered in the curriculum include the functioning and care of organ systems, nutrition, personal and food hygiene, prevention of diseases, accident and addictions, first aid, safety and sexual education.

The main health related topics in primary education are considered in the subject Natural Sciences. The approach adopted intends to contribute to the integral education of children who attend six years of primary education (aged 6 to 12). The purpose is to overcome the anatomic and physiological perspective that has prevailed in educational practice. Health education intends to promote the development of a good self-image and the responsibility of individuals for their own bodies.

The subject policy for Natural Sciences recognizes as a priority the promotion of health and this concern has been reflected in the elaboration of the new official free textbooks and books for teachers which are distributed by the Ministry of Education in primary schools. These materials include a wide variety of activities and information which first aim is to promote the acquisition of knowledge of personal relevance and the development of skills and healthy habits and attitudes. In the scholar year 2000-2001, 14,808.3 millions of students and 545,717 teachers received their correspondent free textbooks or books for teachers (See table 1 for detail).

<table>
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<th>Table 1. Primary education: Students, teachers and schools</th>
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<td>Students (millions)</td>
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<td>Teachers (thousands)</td>
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<td>Schools (thousands)</td>
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The content of health related lessons mainly points to the integral education of children and to reinforce prevention attitudes and behavior, in order to allow pupils to take care of themselves in a responsible and healthy manner. The study of health related topics in primary education intends to emphasize the promotion of health, as a basic human right and a necessary condition for individual and social development.

Health promotion actions have continuity in the three years of secondary education for adolescents (aged 12-15), particularly in the subjects Biology and Civic and Ethic Education. The study of health and sex education topics in secondary schools is based in textbooks, which are produced by private editors and supervised by the Ministry of Education. The Ministry of Education has produced several materials to support teacher’s work in the field of health promotion such as the books for teachers correspondent to the mentioned subjects and other titles as:

- Build your life without addictions. Teacher’s manual and workshop guide
- Origins and effects of addictions. Anthology
- Sex education, gender equity and addition prevention. Study guide for teachers
- Schooling for change: Reinventing Education for Early adolescents (Andy Hargreaves et al.)
- Child and adolescent development for educators (Judith Meece)

New educational materials (free textbooks, books for teachers, videocassettes, etc.) are being used in initial teacher training. Several in-service teacher training programs have been implemented. Parents and teachers have welcome educational materials and actions to reinforce health and sex education. In the last year the Ministry edited a collection of books for parents to initiate a specific program for them.
Major school health challenges

In Mexico, as in many other developing countries, education of youth occupies a significant place among the priorities of government. As far as health promotion have become a central issue in educational policy, curriculum and educational materials, the Ministry now face challenges as:
- To continue the revision and improvement process of educational materials permanently
- To reinforce its action concerning initial and in-service teacher education, particular attention is being given to teaching strategies and efficient use of textbooks for the study of health issues.
- To maintain and strengthen co-operation with the Ministry of Health in the actions for curriculum and educational material development, teacher education and detection of health problems in schools.
- To design actions to assess the use and effectiveness of textbooks and books for teachers in the study of health issues in schools. Until now, the analysis of letters sent by students and teachers has provide elements to know about the interest and relevance level of the content of these materials.

The main concern and challenge continue to be the improvement of current teaching practices. They must go beyond the transmission of knowledge concerning health matters and emphasize the development of decision making skills related to healthy attitudes and lifestyles that would promote the health and well-being of students.
6.3.6. Nigeria


Introduction
School health services have been in existence in Nigeria since the pre-independence era. While the first era of national governments in the 1960s laid significant emphasis and gave attention to strengthening the services, the political dynamics of the country vis-à-vis the long period of military governance of the country and the associated declining national economy have resulted in an overall deterioration of various basic social services, including school health services. The return of Nigeria to democracy on 29 May 1999 marked the beginning of efforts to strengthen various social services. With specific reference to school health, the last 12 months (July 2000 to June 2001) have essentially been a period of laying the foundation for the re-invigoration of the services. The major achievements and challenges in the period are highlighted below.

Major Achievements

National level
Inter-sectoral committee on comprehensive school health programme (CSHP) in Nigeria was established. The committee, whose mandate is to oversee the overall integration of school health services in the country, has membership from a wide group of stakeholders. These include the following Federal Ministries: Health, Education, and Information. Other members include UNICEF, WHO, UNFPA, JHU/CCP, the Nigerian Educational Research Development Council (NERDC), and the national body of the Parents-Teachers Association (PTA).
The committee held regular meetings and has developed a draft questionnaire for conducting the Rapid Assessment and Action Planning Process (RAAPP). Sites were selected as well as sampling plan for schools to be involved. Draft questionnaire to conduct situation analysis in schools in the selected sites was developed.

State level
Various State governments have initiated efforts to improve the health of the school-age population. These include:
- Free school-based nutrition services launched in one State
- Operationalisation of population and family life/sexuality education in 13 states
- Strengthening linkages between the school system and the primary health care services
- Training of school-based counsellors in adolescent reproductive health counselling
- Periodic deworming of students in some States.

Major challenges
- Organisational challenge
- Funding constraints
- Securing and sustaining political support and goodwill of relevant stakeholders
- Ensuring sustainable linkages of all key stakeholders involved in the delivery of school health services
6.3.7. Pakistan

ACHIEVEMENTS OF SCHOOL HEALTH SERVICES IN PAKISTAN

Pakistan has a population of 140.5 million making it the seventh most populous country in the world. Each year another 3.2 million people are added to this number. The number of school age children (6 to 16 years of age) is approximately 42.15 million. The literacy rate has improved from 26.2% in 1981 to 49% in 2001. The primary school gross enrolment rate has increased from 52% in 1987 to 71% in 1998-99. At the primary level the number of institutions is 165,775 with 338,398 teachers at middle the number is 18,806 and teachers 95,195 and at the secondary level the institutions are 12,852 with 162,006 teachers. During 2000-1 the total education budget was Rs. 72,237 million which is approximately 2.06% of GDP.

Although the subject of provision of health services in schools has always been taken care of by the district health services, School Health Services in Pakistan were formalized in the 1980’s with the creation of posts of medical officers all over the country.

Schools have been a partner institution with the health staff during the National Immunization Days held for Polio Eradication. During and before these nationwide campaigns health education messages and social mobilization messages have been disseminated through schools.

The nation wide National Programme for Family Planning and Primary Health Care currently has more than 45,000 female workers all over the country. These community based workers provide health care services to a population of approximately 1,000 each. In addition to health promotion in their catchment areas, these workers also deliver health education messages at least once a month in all the schools in their catchment areas concerning sanitation, hygiene and other health problems of the school age children. These health workers have also been equipped to test vision and refer cases to the nearest health facility for further treatment.

Recently, Hepatitis B awareness campaigns have been carried out on a pilot basis in some schools and children have been immunized. A pilot school Health Services project is being run in the Islamabad Capital Territory with collaboration of WHO. In this project, schoolteachers will be trained for basic health care of school children. The students have also been given an opportunity to visit hospitals and observe the provision of health care.

Recently work on the Global Youth Tobacco Survey has been initiated in the country. This will be a nation wide survey with a sample size of approximately 2000, assessing the behaviors of the youth regarding tobacco.
MAJOR CHALLENGES FOR SCHOOL HEALTH SERVICES IN PAKISTAN

The expenditure on Education sector is 72,237 million (2.06% of GDP), which is quite short of the recommended minimum of 4% by UNESCO for developing countries. Furthermore, the expenditure on health sector is 24,281 million rupees (0.7% of the GNP). This resource constraint has severely restricted the activities required for an effective school health service.

The main problems are rising poverty levels which has led to a very high school drop out rate at the primary level (50% drop out). The available infrastructure for both health and education departments is insufficient and this hampers the ability to conduct and manage an efficient school health service.

Many of the medical officers recruited for the school health services have been assigned other duties and thus there is a shortage of staff available. Resource constraints also severely constrain the movement of the staff.

The major challenge in the field of school health service is the availability of staff to cover the schools. Furthermore, there is an urgent need for advocacy of school health services at all levels.

There is a plan to devolve powers to the district level in the country in August 2001. The challenge will be to get the district governments on board for effective school health services and to enhance the allocations for the health and education sectors.

There is an option to retrain the education staff for school health services and for the health department to provide technical support but the teacher to student ratio in the primary schools is currently one teacher for every 56 children with the distribution being unequal in the urban and rural areas of the country.
SALIENT FEATURES OF PROHIBITION OF SMOKING IN ENCLOSED PLACES AND PROTECTION OF NON-SMOKERS ORDINANCE, 2000.

A) BACKGROUND INFORMATION
Smoking is a serious health hazard for health. Smoking is responsible for increased mortality such as 90% of lung cancer deaths, 75% of bronchitis deaths and 24% of Ischemic Heart Disease deaths under 65 years of age. Non-smokers are also equally at risk due to involuntary inhaling of smoke emitted by smokers.

In view of the health hazards of tobacco smoking, legislation to control tobacco use has become a necessity.

B) PURPOSE
The purpose of the ordinance is to protect the health of the nation by banning smoking in enclosed public places in order to eliminate the risks of passive or involuntary smoking and to protect the right of non-smokers to a smoke free environment. Another purpose is to restrict tobacco advertisements.

C) SALIENT FEATURES
Smoking will be prohibited in public and enclosed places such as public transport, schools, hospitals, offices, work places etc.
No person shall advertise in any place and in any public service vehicle, which may promote smoking or sale of cigarette etc.
No person shall sell cigarettes or any other smoking substance to any one who is under the age of 18 years.
No person shall himself or by any person on his behalf store, sell or distribute cigarettes or any other smoking substances within an area of one hundred meters around any college, school or educational institution.
Owners or managers or in charge of every place or public work shall display boards of “No smoking zones” and that “Smoking is an offence”.

PAKISTAN’S NATIONAL HEALTH POLICY REGARDING PREVENTION OF HIV/AIDS AND RELATED DISCRIMINATION IN SCHOOLS

Youth, in Pakistan has remained a relatively ignored area as far as the prevention of HIV/AIDS and other related discrimination is concerned. Although, a School Health Service System has been in place since last many years yet it could never be utilized to its full potential due to a myriad of factors. Moreover, due to low literacy rate and other associated social practices, health education on the reproductive health issues mostly remained a difficult area for the planners and public health professionals.

Since launching of the National AIDS Control Programme in 1987, the youth emerged as an important area and interventions were initiated but remained limited mainly to the health educational seminars. A teachers training programme was initiated with the collaboration of Ministry of Education and a number of such activities were held in various schools. A significant number of schools could still not be covered on account of economic constraints.

Presence of a number of vulnerabilities and threats and the changing national and international scenario made it prudent for Pakistan to re-write its HIV/AIDS agenda. Fully cognizant of the fact, the National AIDS Control Programme through consultative efforts, has recently strategize an expanded national framework in collaboration with the UNAIDS Pakistan. The priority areas have been defined in light of a sound “Situation and Response Analysis” which is a product of consensus between all national and international stakeholders. During the exercise, it was seriously felt that in order to reduce their vulnerability to HIV/AIDS, there is an urgent need of the policies that promote the healthy development of children and young people and respect and fulfill their rights. Youth, therefore, emerged as one of the nine priority areas identified as a result of the country’s strategic framework.

The framework that has been formally endorsed in the inter-provincial meeting of Health Ministers on 20th March 2001 provides the foundations for an expanded, concerted and well-coordinated response to the AIDS threat. The framework is now being transformed to action plans involving all partners and mechanisms are being devised to approach and address the needs of this important group.

INSTRUMENTS FOR SCHOOL HEALTH PROGRAMMES

Data regarding school health services is fragmented and lack of a regular management information system is one of the main drawbacks. However, The Health Services Academy being a school of public health identified this problem and has been working on it. There have been a lot of research projects carried out by the Academy and one of these specifically focused on the availability and functionality of school health services. The findings of the survey are summarized as under.

When the school teachers were interviewed regarding the existence of school health services, 18/20 had never heard of that while 2 of them had some of the clues of these services about 10-12 years back. One of them had seen the incidence of medical check up of students at schools once in her lifetime about 12 years back. According to her, the students were screened for different health problems at that time and those requiring referrals were also referred. The team had given them referral cards. Those students were never followed up and the team never turned up again in that school. She did not know what were the reasons of withdrawal of these services. Another teacher at boys school told that once in 1987-88, when he was transferred to one of the schools of rural area, he saw some of the health proformas lying in a cupboard, but none of them was ever used and later they were discarded.

None of the respondents at schools was satisfied at the existing situation regarding medical care in schools. All of them strongly recommended setting up of proper school health services as they were facing many problems due to absence of these services. The problems were particularly faced during emergencies, as 70% of the schools did not have even an emergency box.

Recommendations for Improvement of School Health Services
For every 1000 students, there should be one doctor, who must visit the school once in a week. During the visit, the doctor should screen one class each turn by turn. He should also give lectures on general hygiene and common diseases. The teachers, as well as the students must attend this lecture.
In every school, 2-4 teachers should be trained regarding first aid management and recognition of important common diseases. Qualified doctor, who may visit the school once in a month, must supervise these
teachers. During his visit, he should examine those children, who are already screened by the trained teachers.

There should be a compulsory medical check up of the students at the time of admission to the school. In this check up screening for auditory or visual defects should be done. Those having problems should be preferred, their record maintained and regularly followed by school doctors.

There should be at least annual detailed medical check up; the results of which should be entered on the report card. The records of these check up should be maintained and comparisons should be done with standards milestones.

The doctors of school health services should issue referral cards to those needing specialized treatment. The referral centers should allocate specific days or specific timings for attending those students, in order to save wastage of time of the students.
6.4. PARTICIPANT EVALUATIONS


SUMMARY OF RESPONSES:

1) How do you feel the meeting prepared you to perform the following objectives:

Respondents felt that the objective they were most well prepared for was identifying the four components of FRESH and at least one way the UN and international agencies can help implement FRESH. In addition, the resources for Mega Countries were received favorably. Although respondents did not specify which resources they found most useful, they reported that they plan on using the resources as guide and planning for teacher training, implement EFA action plans using FRESH strategies, modify current policy, evaluate existing programs, and to spread knowledge and information within their country. The fifth objective, analyze the content of school health policies and have a model to develop or improve school policies in country, was seen as least favorable.

2a) What was the most useful part of the meeting?

The one aspect of the meeting that respondents described as most useful was the opportunity to learn more about FRESH, EFA and RAAPP through the presentations and workshop in order to address School Health issues in their country. Respondents also appreciated the opportunity to network and exchange experiences with each other and experts from international agencies and the interactive and practical exercises. Respondents also found useful the opportunity to agree on common direction, the advocacy exercises, the World Bank’s presentation on financing School Health programs, and the Tobacco Curriculum policy/workshop.

2b) What was not useful in the meeting?

The most common complain that respondents had about the meeting was that there was too much information, workshops and/or items on the agenda. This prevented important issues to be discussed in depth and accounted for long evenings. Respondents also mentioned the location being inadequate for the meeting, some presentations being redundant (on FRESH), introductions (for a returning participant), and lack of clarity about how international agencies will assist countries and the HIV/AIDS presentation. Some respondents didn’t feel anything was not useful.

2c) What would you change for future meetings?

Respondents would like to see a more structured and better organized agenda. The most common suggestions were to allow more time for countries to present experiences and challenges, analyze and discuss specific countries’ situation, and exchange information among them. Other suggestions included having more frequent contacts (i.e. a mid-year meeting in addition to annual meeting), have Mega countries host meetings, and to make meeting/sessions longer.

3) When you go back to your country, how will you use the information and resources that you obtained at this meeting?

The most common next steps that people reported were:
• Disseminate information by meeting/contacting colleagues, decision-makers, staff and representatives of other Ministries and UN agencies in their country
• Plan and/or begin implementation of FRESH strategies and modify current School Health Programs/policies
• Apply resources and knowledge gained at meeting in their current work

4) Please provide any additional comments you may have:

In this section people reiterated points made above such as the usefulness and need for more network opportunities for country representatives including social gatherings, and more time for countries to present their experiences. In addition people asked for better logistics (i.e. transportation to site, hotel accommodation) and better space accommodation (i.e. like at UNESCO on Sunday), for agenda to be circulated beforehand, and for time to express reservations.
**RESPONSES:**

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<th>Respondents</th>
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<td>Marina Valdao</td>
<td>Brasil</td>
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<td>P.K. Mohanty</td>
<td>India</td>
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<td>Patwardhan G.R.</td>
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<td>Carlos Silva</td>
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<td>Jun Yan</td>
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<td>Yexun Lin</td>
<td>Indonesia</td>
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<td>Armando Sanchez Martinez</td>
<td>Mexico</td>
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1) How well do you feel the meeting prepared you to perform the following objectives? Please rate.

   | 1 = Not at all | 2 = Somewhat | 3 = Neutral | 4 = Better | 5 = Very well |
---|----------------|--------------|-------------|------------|--------------|
| a) present strong arguments for improving health and school health policies | 0 | 0 | 4 | 8 | 4 | 16 |
| b) identify the four components of FRESH and at least one way how UN and international agencies can help implement FRESH | 0 | 0 | 1 | 4 | 10 | 14 |
| c) describe the EFA Framework and its school health and health components | 0 | 1 | 1 | 7 | 7 | 16 |
| d) identify concrete steps to take in your country upon your return to support EFA | 0 | 0 | 5 | 9 | 2 | 16 |
| e) analyze the content of school health policies and have a model to develop or improve school policies in your country | 2 | 0 | 4 | 6 | 3 | 15 |
| f) To what extent do you think the resources for Mega Countries (website, Model School Tobacco Curriculum, UNAIDS policy on HIV/AIDS, etc.) will be of value to you? | 0 | 0 | 0 | 11 | 4 | 15 |

Please describe briefly how you expect to use the presented resources:

- To develop: Guidance, model of service/activities, model of training, in my country
- Improve and modify the current policy
- To promote school health more effectively and implement EFA action plan
- Use ###, guide teacher training
- Website: to place relevant information, to seek info.
- Integrate all resources including funding into on set of strategy plan to reach EFA using FRESH strategies
- Evaluation of different forms of activity in Health Promoting Schools
- They are to some extent already under process in my country.
- Quite a lot:
  a) It will help in sharing
  b) Understand and know success stories
  c) Help in replication
  d) Restructure and use resources in focused planning
- 1) Giving the information about them to people responsible for these programs and for local action (also to people at the Public Health Schools)
  2) Using them in the planning of teacher’s training program
- To change experiences
- A Guide for teacher training

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>g) To what extent do you think that the steps we have delineated as recommendations to be undertaken by WHO to support the SHC will be of value?</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>h) To what extent do you think the next steps you have delineated for your country will make a difference?</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>2</td>
</tr>
</tbody>
</table>
Fourth Annual Meeting of School Health Component of Mega Country Network
July 2001, Paris
2a) What was the most useful part of the meeting? Please be specific.

- Exchange info.
- Knowing direction we agree upon together
- Understanding new methodology in school health
- Commitment taken from recommendation
- Advocacy to decision makers in my country
- The whole exercise was very useful
- Practical exercises
- To know with more detail FRESH
- To know the RAAPP Proposal
- To know the School Health leaders of the E-9 Countries
- To be back on board; with the encouragement to participate even more actively in the future
- Having presentations of FRESH, RAAPP, EFA and the interactive sessions
- The discussion parts were useful, especially the “arguments” exercise
- How to develop the teaching material addressing the priority issues of Health
- FRESH Framework
- Information about EFA and FRESH
- Contacts with representatives from UNESCO, World Bank, etc.
- The opportunity that I have about reinforced my work in Rio de Janeiro/Brazil
- Integrating expertise of International Agencies like UNESCO/UNICEF
- Presentation of Anna Maria explaining FRESH
- Presentation by Mr. Don Bundy on sourcing finance for School Health Programs
- Policy/workshop/Tobacco Curriculum
- To know with more detail FRESH
- To know the RAAPP purpose
- To know the School Health leader of the Mega Countries

2b) What was not useful in the meeting?

- Repeat → Repetition of the topic of presentation (FRESH) in same School Health class # bigger one
- Too many workshops
- Repetition and duplication of quite a few sessions
- The agenda was plenty
- The presentation/workshop on HIV/AIDS was not clear for me (purpose, expected outcome)
- Too many important issues were cramped into the short meeting periods which therefore dropped on late into the evenings
- Nothing really
- Not
- Its not very clear like the agencies will help the SHPC in our country.
- The preliminaries—since I had participated in similar expositions in my tenure in the Ed. and Health Ministry. But they must have been useful to new comers.
- Nothing special
- The funding for FRESH
- Lack of discussion in some themes because the agenda was plenty
- Bad place to flexibilize the sessions (Monday-Wednesday)
2c) **What would you change for future meetings?**

- The program and arrangement
- Discussion time
- Country presentation to share to other countries
- In addition to annual meetings, we should also hold mid-year review meetings of Mega Countries
- To host meeting in one of the Mega Countries
- Frequent contacts
- More structure and organized meeting
- To involve more the Mega Countries (E-9) experiences
- Change the experiences the other countries
- Devote more time
- If possible increase the time for sessions, so we don’t end up missing out planned activities
- Not
- It is very useful to have more information about experiences of Mega-Countries in details
- We need to change experiences between Mega Countries members
- The difficulties different countries have in implementing the program. I sincerely feel that there should be more discussion among the experts (WHO, UNICEF, etc.) and country representatives.
- Review each E-9 countries on the next step and strategies adopted for this
- Make some country presentations and analyze them in depth (different dimensions and aspects that count)
- To involve more the Mega Country experiences
- To discuss more less points

3) **When you get back to your country, how will you use the information and resources that you obtained at this meeting?**

- Put into plan of action and budget proposal
- Share them with members of School Health team/Board
- Share with decision makers
- Report to the upper level
- To promote school health and implement EFA action plan
- Apply my knowledge in the policy of Health Promotion and School Health
- To reduce in country as a brief ## in Ministry
- Follow up on contacts started here with the EFA Anchor person for Nigeria in UNESCO.
- Develop a team with MOE and ensure implementation of FRESH in collaboration with Health.
- Since the MOE representative could not attend, I’d get in touch with him and also get the key people in MOE (where names have been giving by our Ambassador to UNESCO) to work together, to actualize EFA and FRESH goals.
- Report to the leaders of two ministries
- Combine the think into the national plan of School Health
- I intend to organize meetings and consultations with Deputies of MOH and MOE
1. Yes! Here in the conference I began with some representatives offices of my country
2. I will first meet representatives of UNICEF, WHO, UNESCO, WB, etc. to find if the contents of their approach have good reflection in our programs.
3. Rebuilding and consolidating the existing School Health Program for next 5 year plan starting 2002
4. I will use them in the work in which I am involved in this moment: Preparing the contents for an “in service” training program of teachers (on School Health)
5. First, to define with my Health partner how to continue the program. Second, inform in detail to my authorities the importance of enhanced it. Third, to establish priorities in order to define how to use FRESH components.

### Please provide any additional comments you may have:

<table>
<thead>
<tr>
<th>Please make social gatherings to get to know each other more</th>
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</thead>
<tbody>
<tr>
<td>Very little support available for logistic like pick-up transportation to the meeting venues; hotel arrangements need much to be desired</td>
</tr>
<tr>
<td>The meeting is very important but we need more contact with MOH in countries</td>
</tr>
<tr>
<td>It was very interesting to know people from other Mega Countries</td>
</tr>
</tbody>
</table>

1. Agenda should have been circulated earlier.
2. There was not much scope for airing our reservations
3. It appears that there were time constraints- countries should be allowed more time to say what they feel about their difficulties

### Agenda should have been circulated earlier.

More information about existing programs in each E-9 countries. Maybe presentation by each would have helped in understanding (by every E-9 country)

It’s important to have decent physical conditions. It’s better to work in rooms as the UNESCO in which we stayed on Sunday.