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IMPROVING SCHOOL HEALTH PROGRAMMES: BARRIERS AND STRATEGIES

Prepared for:

Health Education and Health Promotion Unit
Division of Health Promotion, Education, and Communication
World Health Organization, Geneva

The School Health Working Group
The WHO Expert Committee on Comprehensive
School Health Education and Promotion



World Health Organization

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The World Health Organization (WHO) is a specialized agency of the United Nations with primary responsibility for international health matters and public health. WHO came into being on 7 April 1948, when the 26th United Nations member ratified its Constitution.

The objective of WHO is the attainment by all peoples of the highest possible level of health. Health, as defined in the WHO Constitution, is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Through WHO, the health professions of some 190 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world a level of health that will permit them to lead a socially and economically productive life.

The World Health Assembly is the policymaking body of WHO and meets in annual session. The Executive Board, which meets twice a year, acts as the executive organ of the Assembly. WHO activities are carried out in six regions, each comprising a regional committee and a regional office. Regional committees meet in annual sessions. The Secretariat consists of a Director-General, six Regional Directors, and such technical and administrative staff as is required.

The first World Health Assembly, held in June 1948 and attended by 53 delegates from WHO's 55 Member States, approved a programme of work that listed its top priorities as malaria, maternal and child health, tuberculosis, venereal diseases, nutrition, and environmental sanitation. In 1979, the World Health Assembly unanimously endorsed the Declaration of Alma-Ata, which stated that primary health care was to be the key to attaining the goal of health for all by the year 2000.

Over the years, the WHO's programmes have responded to, and often anticipated, the major health concerns of Member countries. WHO's ninth general programme of work (1996-2001) fixes goals and targets for the organization's global health action. It focuses on lessening of inequities in health, control of rising costs, the eradication or elimination of selected infectious diseases, the fight against chronic diseases, and the promotion of healthy behaviour and a healthy environment.

Reflecting the concerns and priorities of the Organization and its Member States, WHO publications provide authoritative information and guidance aimed at promoting and protecting health, and preventing and controlling disease.

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Promoting the health of children through schools has been an important goal of WHO, UNESCO, UNICEF, and other international agencies since the 1950s. Since the 1980s, WHO's work in school health has steadily increased. In May 1994, WHO's commitment to and support for school health was further enhanced by the creation of the Division of Health Promotion, Education, and Communication (HPR).

The Director-General of WHO charged the new Division with strengthening WHO's capacities to promote health through schools. He recognized that many WHO programmes have the capacities to provide technical support for a wide range of school-based health promotion, health education, and disease and injury prevention efforts. He also recognized that the support of many WHO programmes is needed to foster the development of integrated and comprehensive approaches to school health, and to provide leadership and direction for a Global School Health Initiative. The new Division established a School Health Team as an integral part of the Division's Health Education and Health Promotion Unit. An interdivisional Working Group on School Health was created through which WHO programmes support the Global School Health Initiative.

The Initiative is designed to improve the health of students, school personnel, families, and other members of the community through schools. Its objective is to increase the number of schools that are "health promoting schools." WHO works in partnership with other organizations to:

- revitalize and enhance worldwide support for promoting health through schools
- build on research and experience worldwide, and particularly on international, national, and local efforts to help schools become health promoting schools
- enable organizations to maximize the use of their resources
- unite the diverse school health initiatives of the United Nations family
- provide full partnership to all organizations involved

The WHO Expert Committee Meeting on Comprehensive School Health Education and Promotion in 1995 serves as the foundation for WHO's Global School Health Initiative. The overall objective of the Expert Committee was to make recommendations for policy measures and actions that WHO, its Regional Offices, other United Nations agencies, national governments, and nongovernmental organizations could take to enable schools to use their full potential to improve health. This document has been prepared to help achieve that objective.

The Global School Health Initiative is founded on partnerships, both within and outside WHO, and fosters new partnerships among organizations with capacities, constituencies, and experience that can help the world's schools become institutions for health as well as education.

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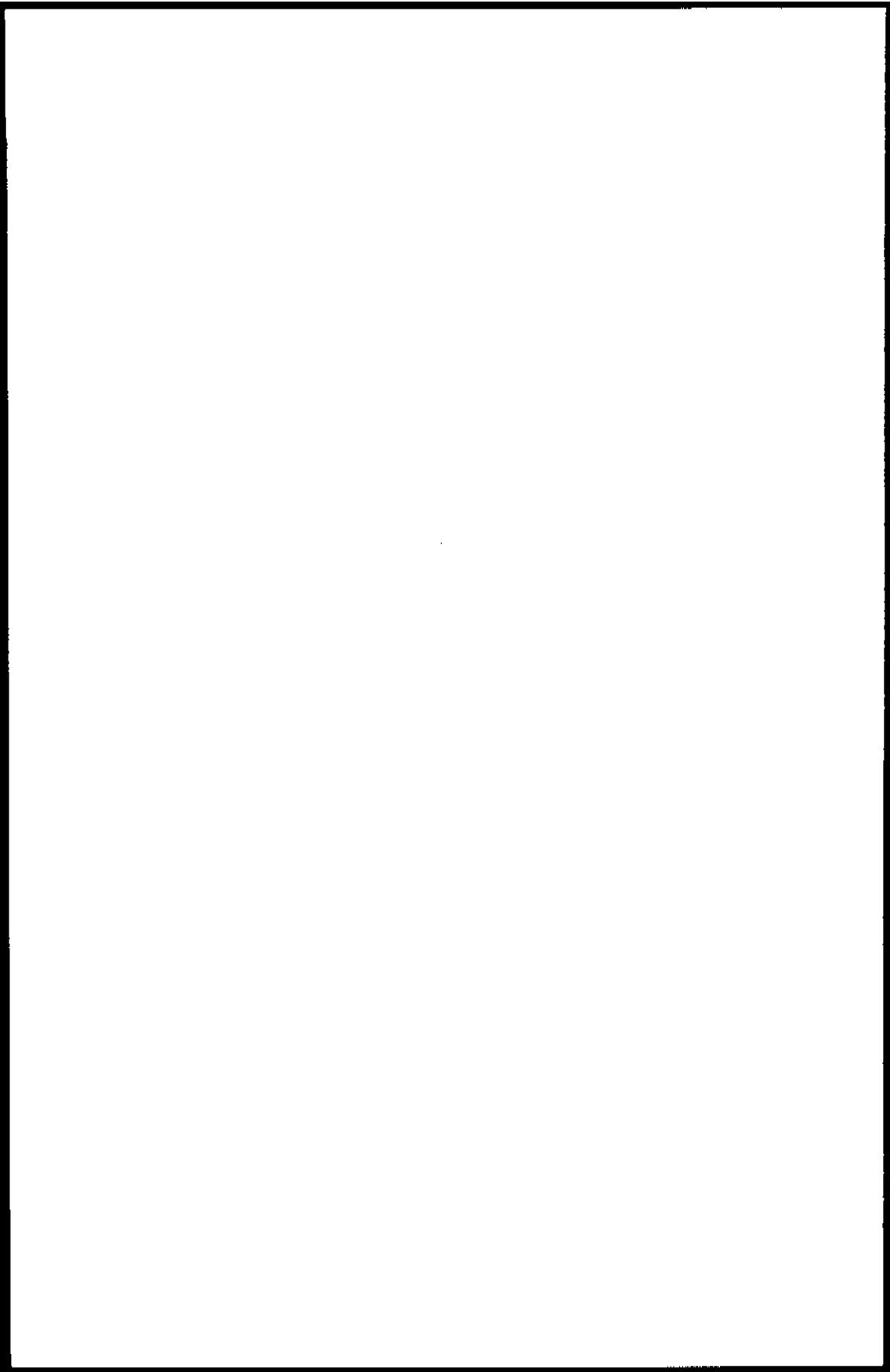
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The Status of School Health (WHO/HPR/HEP/96.1)

Improving School Health Programmes: Barriers and Strategies (WHO/HPR/HEP/96.2)

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1.0 Introduction

More children than ever are attending school, and for longer periods of their lives. In virtually every nation, therefore, schools can do more than perhaps any other single institution to improve the well-being and competence of children and adolescents. Yet evidence suggests that schools around the world have difficulty in addressing these critical physical, mental, and social health needs.

To improve school health programmes and thereby promote health and advance education, schools require support at three levels: international, national, and local. At each level, there are organizations whose support can be instrumental:

- International organizations can be global or regional:
 - Global organizations include United Nations agencies (e.g., World Health Organization [WHO], United Nations International Children's Emergency Fund [UNICEF], United Nations Educational, Scientific and Cultural Organization [UNESCO] and international nongovernmental agencies (e.g., Education International, International Committee of the Red Cross, Rotary International).
 - Regional organizations include agencies like the WHO Regional Offices and the European Union.
- National organizations include:
 - Ministries of health and education.
 - Nongovernmental agencies, such as teachers' unions and national Parent-Teacher Associations (PTAs).
- Local organizations form the broadest category and include:
 - Provincial or state governmental agencies, which in many nations have considerable responsibility for health and education.
 - District or county governmental agencies, which often have responsibility for health and education in the smaller jurisdictions that comprise states or provinces.
 - Schools themselves, which usually are governmental agencies that have some responsibility to ensure the education and health of their students.

At each level, as organizations seek to support the extension and improvement of school health programmes, they may experience specif-

ic barriers and need to implement specific strategies. At the same time, certain other barriers and strategies are common at all three levels.

This paper identifies:

- Specific local, national, and international barriers to improving school health programmes.
- Three general, related barriers that are common across all levels (local, national, and international).
- Examples of specific local, national, and international strategies to improve school health programmes.
- Six general, related strategies that could be implemented at all levels (local, national, and international) to improve school health programmes.

2.0 **Barriers to Improving School Health Programmes**

The specific barriers discussed below were identified by participants in several WHO-sponsored meetings and consultations during the past five years. These gatherings included country consultations, regional inter-country meetings, global consultations, and international conferences.

2.1 **Specific Local Barriers**

2.1.1 ***School Level***

In attempting to improve the health of their students, schools experience a wide range of barriers (see Annexes 1–3). One of the most common is that communities do not perceive such programmes to be a priority for schools. This is compounded in many developing countries, where school workers encounter significant barriers (Annex 2) in providing even the most rudimentary educational experiences for students (1).

In some developed countries, schools face barriers resulting from political and economic changes. In certain countries of Central and Eastern Europe, for example, schools are affected by radical changes in political, economic, and social philosophies (Annex 3). In other countries, such as the United States, schools may be reluctant to implement health programmes (e.g., providing education or services to prevent HIV infection) because these could be seen as politically controversial.

Substantial evidence indicates that health influences learning and that education influences health; increasing evidence shows that school health programmes offer high cost-benefit ratios (2,3); and growing

information pinpoints strategies that schools can use to efficiently implement school health programmes. In many local communities, however, political, social, health, and education leaders, as well as the public at large, lack both sufficient knowledge about the potential impact of school health programmes to make them a priority and information about how to implement such programmes efficiently.

2.1.2 District/County Level

At the district/county level, specific barriers often result from: (1) ambiguous delegation or assumption of authority, responsibility, and resources, and (2) ambiguous jurisdictional boundaries (Annex 4). Education agencies may be delegated or may assume responsibility for protecting and improving their students' health, but lack the expertise and funds that might be available through health agencies. Sometimes conflict exists about which agency should implement a school health programme; frequently neither wants to. Rarely do education and health agencies want to share programmatic responsibility.

To aggravate the problem, at this level the jurisdictional boundaries of education agencies are often different from those of health agencies. Consequently, the health and education agencies may be responsible for different populations of young people and thus have less incentive to share responsibility for implementing school health programmes.

2.1.3 State/Province Level

Many unnecessary barriers experienced at the local and district/county levels result from the often poorly developed capacity of state/province health and education agencies to help their districts and schools implement effective school health programmes. In the United States, state health and education agencies may each have junior-level staff who are independently responsible for helping districts and schools implement fragmented elements of such a programme. One person may be responsible for drug abuse education, another for school-based immunization, another for HIV education, and so on. But rarely do these agencies employ senior-level staff who could work together to more effectively address broad policy and funding issues and more productively integrate the fragmented elements of a school health programme.

2.2 Specific National Barriers

National-level health and education officials have identified a range of barriers; examples are listed by country in Annex 5 (4). Although the

specific barriers may vary widely from country to country, some are experienced more commonly than others. Those most commonly experienced in the Western Pacific Region of WHO are lack of:

- Full recognition by education and health officials of the importance of health to education and education to health.
- Policies and resources to support school health.
- Coordination among the various agencies addressing health in schools.
- Knowledgeable and trained personnel to plan and manage school health programmes (5).

2.3 Specific International Barriers

International efforts to improve school health programmes will require active and effective collaboration among interested nations and relevant international organizations (6). Unfortunately, health and education agencies involved in nationwide implementation of school health programmes usually have few resources for their domestic programmes. These agencies appropriately may be concerned about using some portion of their limited domestic resources to help improve school health programmes globally. Further, some nations may believe that circumstances in their own nation are so unlike circumstances in other nations that it would not be productive for them to collaborate in global efforts.

Experience has shown that most Member States can efficiently learn from the mistakes and successes of others. Moreover, to the extent that health and education agencies worldwide are working to improve school health programmes, it may be easier to implement such programmes within any given nation.

Yet, international organizations also face many barriers in their regional and global efforts to improve school health programmes. Constantly changing political and organizational structures, as well as political and economic crises in countries of greatest need, hamper long-term planning and capacity building. The programmatic strengths and priorities of international organizations such as WHO, UNESCO, and UNICEF differ. To maximize the use of their resources, as well as their potential for success, they must be able to plan and implement programmes in a concerted and complementary manner. Yet cooperation and coordination among international organizations are hindered by many of the barriers cited in Annex 6.

3.0 **Three General, Related, and Common Barriers That Impede Local, National, and International Efforts to Improve School Health Programmes**

Although different barriers must be overcome at each of the levels discussed above, three problems are of overriding importance and priority for action because they cross all levels. These barriers are significant because they are: *general*, that is they may be the root cause of many more specific barriers; *related*, in that they influence each other; and *common*, because they are found among local, national, and international agencies worldwide. They are significant because they present the following problems:

- Inadequate understanding and acceptance of school health programmes
- Inadequate collaboration among the agencies whose expertise and resources are necessary to design and implement effective school health programmes
- Inadequate vision of what school health programmes can achieve and the ability to plan strategically to make that vision a reality

3.1 **Inadequate Understanding and Acceptance**

Neither the core elements of, nor the integration required for, an effective school health programme is adequately understood or accepted by many influential international, regional, national, and local agencies. This is equally true of the public at large. Inadequate understanding and acceptance provide the seeds for controversy, especially because school health education programmes are often explicitly designed to influence behaviour (e.g., delaying sexual intercourse among young people). Such education may be seen as outside the province of an institution whose purpose, some argue, is to transmit knowledge and not to address behaviour change.

Further, some believe that school health programmes divert resources that might otherwise be used for subjects like science and mathematics. Relevant agencies and the public are seldom informed about specific actions they can take to improve school health programmes and ensure they are acceptable to the community.

3.2 **Inadequate Collaboration**

Implementation of effective school health programmes requires active collaboration among relevant governmental agencies, especially health and education agencies. Health agencies have the necessary expertise and mandate to protect health; education agencies have the necessary facilities, organization, and staff. In addition, such programme implementation requires active intersectoral collaboration among relevant nongovernmental organizations, as well as between governmental and nongovernmental agencies. Too often, these agencies neither work effectively with nor support each other.

3.3 **Inadequate Vision and Strategic Planning**

The development and implementation of effective school health programmes require both a modern, evolving vision of school health and an integrated plan that maximizes the resources and strategies for action at each of the three levels. The evolving vision, plan, and strategies should be supported and implemented collaboratively by relevant governmental and nongovernmental agencies at each level. Ideally, the evolving visions, plans, and strategies across the three levels should be complementary and mutually supportive.

No single strategy at any one level, or across all three, will enable all schools in a given country to implement effective school health programmes. Individual countries are at different stages in developing such programmes and have different strengths and experiences on which to draw. That is equally true of different schools within the same country. A combination of strategies is therefore required at each level to develop and sustain school health programmes. Strategies will need to be developed with a view toward the three broad obstacles described above, as well as toward the specific barriers, available resources, and particular circumstances at each given level.

4.0 **Examples of Specific Local, National, and International Strategies to Improve School Health Programmes**

This section focuses on strategies currently being employed by agencies at each level to improve school health programmes. These strategies were chosen not because they are "model" or "best" strategies but because they describe often complementary efforts of agencies working strategically to develop a vision, a plan, and a set of actions for improving school health programmes.

4.1 **Example of a Local School Strategy to Improve School Health Programmes: Katrinedals Folkskole in Denmark**

Situated in a pleasant, residential, middle-class area of Copenhagen, Denmark, the Katrinedals Folkskole has 450 pupils and 36 teachers. The school was built 60 years ago, with classrooms set around a large oval assembly hall. Second- and third-floor classrooms can be reached by long balconies encircling the great hall. The school setting provides easy access to a leisure centre, a library, and school health services.

As early as 1991, planners at this school decided to independently develop school health, using the concept of the "health promoting school;" they were supported by their local school authority. Eighteen months later, they were invited to join the National Danish Network of Health Promoting Schools.

During the developmental phase, they experienced several barriers:

- Not all teachers or parents were supportive or interested.
- Communication, as well as efforts to clarify aims and objectives, proved arduous.
- Those attempting to implement the program tried to work with everybody at once and did not work with small groups or simple goals.
- The process of consultation and discussion undertaken in workshops proved to be too long and did not sustain the interest of participating groups.
- Teachers realized that they needed more theoretical background knowledge about health education and promotion.

To overcome these problems the planners employed several strategies. They created a small, cohesive group within the school to coordinate and lead project activities. They organized separate workshops for teachers and pupils to explore areas of concern and to develop a vision of how their school could be improved. They also created action plans to implement the vision.

The major lessons learned through this experience were to start small, coordinate efforts, consult intensively with key partners throughout the process, and work with the capabilities of those involved.

4.2 Examples of National Strategies to Improve School Health Programmes

4.2.1 *The United States of America*

In 1993, the U.S. Secretary of Education and the U.S. Secretary of Health and Human Services issued a Joint Statement on School Health that outlined steps to be taken by the two departments to improve school health programmes in the United States. The two Secretaries established:

- A federal Interagency Committee on School Health that includes representatives from nearly 40 federal agencies (e.g., the Departments of Health and Human Services, Education, Agriculture, Justice, Labor, and Defense).
- A National Coordinating Committee on School Health that includes representatives from nearly 40 national nongovernmental organizations interested in improving school health in the United States (e.g., the American Cancer Society, the American Medical Association, the National Association of State Boards of Education, and the National Education Association).

The two committees are co-chaired by high-level representatives of the two Secretaries. The committees meet several times each year to plan ways to improve school health programmes in the United States.

Numerous federal agencies are implementing specific activities to improve school health programmes. As listed below, the U.S. Centers for Disease Control and Prevention (CDC) has established seven long-term, integrated strategies to help achieve that goal (7). Roughly half of the strategies employed by CDC focus on implementing programmes, and roughly half focus on conducting research to assess and improve the impact of those programmes. CDC has created an operating unit to improve school health nationally. In 1988, CDC established a Division of Adolescent and School Health to: (1) identify and monitor the most serious health problems among young people, (2) implement national prevention strategies, and (3) evaluate the impact of those strategies. This division employs staff who are experienced in implementing and conducting research about school health programmes. These staff work together daily to carry out the following interactive strategies:

- *Conducting surveillance to define and monitor outcome and process objectives*—CDC has facilitated a national strategy to monitor and improve priority health outcomes among youth; health behaviours that most influence those outcomes; knowl-

edge, attitudes, and skills (KAS) that affect relevant behaviours; and school policies and programmes implemented to improve specific KAS and behaviours.

- *Providing support for states to help local schools to implement effective programmes*—CDC provides support for each state to establish a senior policy position in the office of the state superintendent of education. This person provides leadership and helps local school districts improve and integrate all elements of the school health programme (e.g., comprehensive school health education, school health services, school nutrition services). In addition, CDC provides support for each state to establish a senior policy position in the office of the state commissioner of health. This person employs the various resources of the state health department to help local school districts improve school health programmes (e.g., through immunization programmes, maternal and child health programmes). These senior staff not only enable the state education and health agencies to plan and implement efforts to improve various components of the local school health programme together, but they also provide each state with the capacity and flexibility to determine and pursue its unique interests, needs, and actions.
- *Providing support for national organizations to help local schools to implement effective programmes*—To create direction and support for national, state, and local efforts to improve school health programmes, CDC provides fiscal and technical support for more than two dozen national nongovernmental education (e.g., National School Boards Association), health (e.g., American Medical Association), and social service (e.g., American Public Welfare Association) organizations, many of which have working affiliates at the state or local level.
- *Convening relevant groups to collaboratively help plan and implement strategies*—Periodically, CDC convenes representatives from five types of organizations to collectively analyze, plan, and implement strategies to improve school health programmes. These organizations comprise: every state department of education, department of health, and department of social services; nongovernmental organizations; federal agencies; organizations that represent higher education; and philanthropies.
- *Conducting evaluation research to assess programme effectiveness*—CDC conducts three types of research to evaluate and consequently improve the impact of school health programmes (8):

intervention research, to develop and evaluate promising theory-based interventions designed to reduce health risk behaviours among youth; dissemination research, to assess the impact of various efforts to help schools implement interventions they have chosen; and programme evaluations, to evaluate and consequently improve the impact of state efforts to help schools implement effective programmes.

- *Conducting syntheses of research and its application to improve programme—effectiveness* In its efforts to assess programme impact, CDC has initiated research registries and meta-analysis databases in order to compile and synthesize results of research conducted to reduce each of the priority risk behaviours. CDC has launched a system to identify school programmes that have credible evidence of effectiveness in reducing specific risk behaviours, and it is also developing research-based guidelines for school health programmes to reduce tobacco use and addiction, physical inactivity, and dietary patterns that cause disease.

4.2.2 **Bulgaria**

In 1992, Bulgaria was undergoing rapid economic and social transitions. Education and school health service structures were in urgent need of reassessment; school buildings needed repairs; and teacher training programmes and school curricula needed revision.

For assistance in addressing these needs, the Bulgarian Ministries of Education and Health sought to join the European Network of Health Promoting Schools (ENHPS). The ENHPS (described in greater detail in Section 4.3.1) is a joint project of the Commission of the European Communities, the Council of Europe, and the World Health Organization's European Regional Office. Its objectives are to include health education in the curricula at all grade levels in Member States, encourage cooperation among Member States, and support and disseminate the results (best practices) of demonstration projects.

As is required for ENHPS membership, an agreement was signed between the ministries and the ENHPS. A National Coordinator was selected; the National Centre for Health Promotion was designated as the National Support Centre for the project; and a small team of educational psychologists and health professionals was established.

Together, these individuals and institutions provided leadership, coordination, and technical assistance to a network of 10 project schools chosen on a competitive basis. Each project school was required to demon-

strate commitment to and understanding of the project; each was also required to obtain consensus for the project from the relevant local municipalities.

Located in mountain villages, small towns of less than 50,000 people, and large cities, the 10 schools represented a wide spectrum of educational, social, and economic circumstances in Bulgaria.

Because so many schools wanted to participate in the project, a three-level system was created. The 10 schools selected were designated Level One. Fifty-eight additional schools, which had also participated in the competition, were designated Level Two; these schools established a Bulgarian National Association of Health Promoting Schools and continued to work to develop individual school health programmes using the health promoting school concept. Level Three schools were those that wanted to work on a specific issue—such as preventing alcohol and drug use, sex education, or promoting healthy eating—rather than seeking immediately to implement the full health promoting school concept.

The Bulgarian National Health Promoting School Project is functioning well; its achievements are listed in Annex 7. Funding of the national network is a problem, however, and changes in government have reduced some of the continuity and motivation of the national support team. Nonetheless, the government has recognized the Bulgarian National Health Promoting School Project for its leadership in improving school facilities, curricula, and teaching.

4.3 **Examples of International Strategies to Improve School Health Programmes**

In different regions of the globe, countries are working together to learn from each other and to propel forward a movement to promote health through schools. Countries in Europe and the former Soviet Union have been most progressive in networking with each other. Similarly, international agencies have joined together in cooperative ways to provide leadership, guidance, and resources.

4.3.1 ***Example of a Regional Strategy: The European Network of Health Promoting Schools***

The European Network of Health Promoting Schools (ENHPS) is an innovative regional strategy for improving school health. The Commission of the European Communities (CEC), the Council of Europe (CE), and the World Health Organization's European Regional Office (WHO/EURO) each make technical, financial, and political con-

tributions to the project. The partnership has been identified as an excellent example of agencies working together at the international level (9).

The ENHPS Network is organized at the international level by an International Planning Committee, including representatives of CEC, CE, and WHO-EURO. Each participating nation ensures intersectoral cooperation between education and health authorities and establishes a national coordinator and a national support centre.

In each nation, approximately 10 schools are selected and work to become "health promoting schools." In each school, a school project manager and a school project team are appointed to help the school strive to:

- Provide a health promoting environment for working and learning through its buildings, play areas, catering facilities, and so on.
- Promote individual, family, and community responsibility for health.
- Encourage healthy lifestyles and present a realistic range of health choices for school children and staff.
- Enable all pupils to fulfill their physical, psychological, and social potential and promote their self-esteem.
- Establish clear aims for promoting the health and safety of the whole school community (school children and adults).
- Foster good staff/pupil and pupil/pupil relationships and solid links between the school, the home, and the community.
- Exploit the availability of community resources to support action for health promotion.
- Plan a coherent health education curriculum with educational methods that actively engage pupils.
- Equip pupils with the knowledge and skills they need both to make sound decisions about their personal health and to preserve and improve a safe, healthy physical environment.
- Take a wide view of school health services as an educational resource that can help pupils become effective health care consumers.

As of May 1995, 34 countries throughout Europe were full members of the network (9). They work cooperatively, sharing information and new initiatives, running cross-border workshops and seminars, and providing

visiting speakers at major health promoting school national meetings in neighbouring countries. The ENHPS epitomizes a cohesive network of countries working within a common framework while still retaining their national identities and autonomy. WHO Headquarters is planning activities to expand the concept at the global level.

4.3.2 Examples of Global Strategies: WHO, UNESCO, UNICEF, and Education International

The strategies discussed in this section exemplify ways in which capacity is built at the global level. They are drawn from the experience of WHO, UNESCO, UNICEF, and Education International (EI). Building capacity at the global level is important because it can be used to support both national- and local-level strategies.

International organizations need to develop means by which they can draw on the full potential of their resources and with which they can work with other organizations. Two strategies to develop such means involve establishing a working group, one within the organization and the other between organizations.

Establish an Intraorganizational Working Group

In establishing the new Division of Health Promotion, Education, and Communication in WHO headquarters, the Director-General of WHO charged the Division with strengthening the Organization's capacities for school health. He recognized that many WHO programmes have the capacities to provide technical support for a wide range of health promotion, health education, disease and injury prevention, health care, mental health, and environmental health interventions in schools. He also recognized that the support of many WHO programmes is needed to foster the development of integrated, comprehensive approaches to school health and to provide leadership and direction in launching a successful Global School Health Initiative.

To meet the Director-General's charge, the Division established a structure to bring together all of the WHO units that are concerned with schools and school health to:

- Establish direction and assist in the formulation of priorities for international, regional, national, and community actions to improve school health.
- Improve collaboration and support among international, regional, national, and community agencies to improve school health.

- Strengthen international, regional, national, and community capacities to plan, implement, and evaluate school health programmes.

Establish an Interorganizational Working Group

As an example of an interorganizational working group, an interagency group for school health has been developed as a part of WHO's Global School Health Initiative. Such a group brings together the expertise of diverse agencies and contributes to both their individual and their collective ability to improve children's health and education. WHO works with EI, UNESCO, Education Development Center, Inc. (EDC), the Dutch Center for Health Promotion and Education, the International Union for Health Promotion and Education, the National Education Association, and United Nations Global AIDS Programme (UNAIDS) in an ongoing interorganizational working group to promote school health.

In addition, three fundamental strategies are implicit in the work of many international agencies: advocacy, resource mobilization, and capacity building. Each of these is discussed below, with brief mention of their application to the work of WHO, UNESCO, UNICEF, and EI.

Advocacy

WHO works through the School Health Working Group and its Regional Offices to consolidate expert opinion about the nature and scope, effectiveness, and potential of school health programmes and health promoting schools and to develop arguments and tools that can help countries improve these programmes.

UNICEF advocates school health programmes through its strength in generating commitment and mobilizing technical and societal resources necessary to achieve goals and standards for children's health and education.

UNESCO plays an important advocacy role by serving policymakers, administrators, teachers, students, and others concerned with education, nutrition, and preventive and health education. Strategies include promotion of awareness-raising action, innovative approaches adapted to the sociocultural context, and preventive education through the media.

EI, as one of the world's largest trade secretariats, advocates improving the role of educators and their ability to promote health and education.

Resource Mobilization

Aimed at mobilizing organizational resources in support of school health programmes, WHO's strategies involve identifying organizations with

the constituencies and capacities to strengthen school health programmes, establishing alliances among organizations, and fostering collaborative or complementary actions to fortify such programmes. In applying these strategies, WHO works with partners to establish regional networks of health promoting schools that link individuals responsible for developing and improving school health at international, national, and local levels.

UNICEF mobilizes the technical and societal resources required to achieve relevant goals and standards. Through its strong field presence, it helps build grassroots support for implementing programmes to improve the health and well-being of children and youth.

UNESCO promotes strategies and educational materials that can be adapted to specific sociocultural contexts. It conducts field assessments of child nutrition, health, and primary school participation to support the development of school health programmes.

EI works through its country affiliates to build the capacity of teachers' unions, associations, and other representative groups to work productively with the ministries of health and education and with other agencies and institutions. It provides support through training, meetings, a newsletter, and other publications.

Capacity Building

WHO works through the School Health Working Group and its Regional Offices to increase knowledge, skills, and technical capacities and to develop financial and technical resources for school health programmes. In applying this strategy, WHO also works with partners in selected countries to help them obtain technical and financial support for strengthening school health programmes. In addition, WHO works to foster increased interest and investment in school health and to develop leadership skills to buttress school health programmes and help schools become health promoting schools.

UNICEF's School-Based Interventions Technical Support Group (TSG) is an example of strategy to empower educators and health workers to implement activities that are feasible; that are likely to have relatively rapid, measurable results; that can reasonably be expected to be taken to scale; and that can contribute to the health and development of youth. In its efforts, UNICEF draws on the experiences of representatives from selected country programmes, as well as key organizational and technical partners (including WHO and UNESCO) that can contribute to the acceleration of national-level programming. For example, UNICEF

works closely with WHO to develop means of enhancing life skills and is working with TSG members to consider improving the health and learning capacity of school-age children (e.g., providing micronutrients, antihelminthics, clean water, and sanitation), creating links with health services and organizations outside the school (e.g., school health clubs), and exploring the potential role that schools can play as community resources for improving young people's health and development.

UNESCO empowers health and education professionals by working with them to collect data on which effective programmes can be based. By drawing on its resources in education, social and human sciences, natural sciences, culture, and communication, UNESCO assists in the creation of multisectoral, multidisciplinary programmes. Empowerment is also fostered by framing social and economic development in people-centred, equitable, sustainable terms.

EI, as one of the largest International Trade Secretariats (representing more than 18 million education professionals) pursues the empowerment of educators as a primary goal. It intends to help unions mobilize their unique capacities and constituents to help strengthen school health and education programmes worldwide.

5.0 **Six General, Related, and Common Strategies That Could Be Implemented to Improve School Health Programmes**

The review of specific local, national, and international barriers in earlier sections led to the identification of three general, related, and common barriers that must be addressed. Similarly, the review of strategies at each level, discussed above, leads to the identification of six strategies that can be used by interested international, regional, national, and local agencies to overcome those barriers. In fact, organizations and individuals should be involved in adopting these strategies at their own levels, as well as participating in developments across levels. The ultimate aim of all strategies should be to help the local school implement effective school health programmes. Therefore, it would be ideal for local schools to participate in the global initiative to improve school health programmes.

If Member States and agencies at every level can carry out these strategies, substantial progress can be made in developing, implementing, and advancing school health programmes. Without reliance on these strategies, such progress is likely to be much harder to achieve.

The six critical strategies are:

- Identifying responsible organizational staff/units.

- Developing an evolving strategic plan.
- Implementing activities to achieve the plan's objectives.
- Monitoring achievement of the objectives.
- Establishing an intraorganizational working group.
- Establishing an interorganizational working group.

Each of these strategies is discussed below.

5.1 **Identifying Responsible Organizational Staff/Units**

If efforts to improve school health programmes are to be institutionalized, ongoing, and effective, qualified agency staff must be assigned to help plan, implement, and coordinate these efforts. WHO's Division of Health Promotion, Education, and Communication has identified staff in its Health Education and Health Promotion Unit to comprise an ongoing School Health Team. UNICEF and UNESCO have also identified staff to work on school health issues. Similar assignments need to be made in all WHO Regional Offices, in ministries of health and education, and at state/province, district/county, and school levels.

5.2 **Developing an Evolving Strategic Plan**

An evolving strategic plan is necessary to ensure that scarce agency resources and the activities they support are designed to have maximum effect. The WHO Expert Committee on School Health Education and Promotion, for which this background document was prepared, will recommend ways to improve school health programmes. International, national, and local agencies will need to develop strategies to act on such recommendations. The six critical strategies described here should be considered by all agencies interested in developing plans to improve school health programmes.

5.3 **Implementing Activities to Achieve the Plan's Objectives**

Priority activities need to be implemented to achieve the strategic plan objectives. Important ideas can be drawn from a range of WHO publications that summarize some of its school health programmes (e.g., *Comprehensive School Health Education: Suggested Guidelines for Action* [1992] (11); *Advancing the Status of Girls and Women: A Shared Goal* [1995] (12); and *WHO Guidelines for Strengthening School Interventions to Reduce Helminth Infections* (13) [in press]).

The WHO Expert Committee on School Health Education and Promotion, for which this document was prepared, provides 10 recommendations that should be considered by all agencies interested in improving school health programmes. The 10 recommendations focus on activities that, if implemented, will have a significant influence on improving the health and learning of young people through schools.

WHO Headquarters and several WHO Regional Offices have also organized a series of conferences to help improve school health programmes (e.g., meetings of Regional Advisers in Health Promotion and Education: planning Meetings for the Expert Committee on School Health, November 1994, in Geneva); meetings with international nongovernmental organizations (e.g., EI and UNESCO Conference on School Health and HIV/AIDS Prevention, July 1995, in Zimbabwe); and meetings with Member States (e.g., country consultations with China, Oman, Sri Lanka, Argentina, and Cameroon). As part of the Global School Health Initiative, WHO is considering working with five to seven of the most populous Member States to: (1) intensively help them implement effective school health programmes; and (2) consider integrating such efforts to improve school health programmes as part of the WHO Fourth International Conference on Health Promotion.

5.4 **Monitoring Achievement of the Objectives**

Monitoring the activities designed to achieve strategic plan objectives is essential not only to understand whether objectives are achieved but also to provide for mid-course correction as the activities proceed. Thus, objectives should be written with the monitoring process in mind. In the mid-1960s, the International Bureau of Education and UNESCO conducted a comparison of health education programmes in the primary schools of 94 nations. For those nations interested in building the capacity of the education system to promote healthy development and learning, WHO is currently developing a Rapid Assessment and Action Planning Tool (RAAPT) to strengthen school health. This tool—a collaboration among WHO, PAHO, Education Development Center, Inc., and government agencies and nongovernmental organizations in Bolivia and Costa Rica—will provide information that can be used by national and local organizations, as well as international organizations, to develop strategic plan objectives. The tool, if used periodically, will help monitor progress toward the planned objectives, including the six strategies described herein, and/or other indicators of progress in improving school health programmes.

5.5 **Establishing an Intraorganizational Working Group**

As noted in Section 4.3.2, in establishing the Division of Health Promotion, Education, and Communication in WHO Headquarters, the Director-General charged the Division with strengthening the Organization's capacities for school health. A key element in carrying out that charge has been the development of a multidisciplinary School Health Team, a School Health Working Group, and a Core Group on School Health. The School Health Team serves as the secretariat to both the Working Group and the Core Group. The Working Group and the Core Group serve as the means to organize WHO's capacities into concerted efforts to strengthen school health and to explore avenues of resource development and cooperation with United Nations agencies, intergovernmental organizations, nongovernmental organizations, donors, and professional and scientific organizations worldwide. They serve as mechanisms to enable all WHO programmes with an interest in school health to share their experiences and work together. All organizations interested in effectively using their full potential to improve school health should consider developing an intraorganizational working group to plan and act concertedly in support of school health programmes.

5.6 **Establishing an Interorganizational Working Group**

The WHO Global School Health Initiative will require collaboration with a variety of other institutions and agencies to achieve the maximum effect of improving school health programmes. UNESCO, UNICEF, UNFPA, WFP, UNDCP, and UNEP, as well as the World Bank and UNDP, all have interests and roles to play, as do such nongovernmental organizations as UICC, the Alcohol Council, IUHPE, EI, and national teachers' organizations. To reduce duplication of efforts and maximize the availability and use of resources, organizations at all levels should be involved in interorganizational groups.

The report and recommendations of the WHO Expert Committee on School Health Education and Promotion should serve as an important starting point for developing a vision, guidelines, and standards for school health that could be used by interorganizational groups as a basis for action. Such guidance from WHO and other international organizations working in an interorganizational group could offer assistance to Member States and groups at the national and local levels as they seek to adapt and implement relevant suggestions.

6.0 **Conclusion**

The world's children, no matter in which nation they live, are our children. We are all responsible for them. They are the future and hope of humankind.

School health programmes can provide one of the most effective means available for improving the health of young people in every nation. To implement such programmes within each of our own nations, as well as in other nations around the globe, is a challenge both worthy and formidable. If we can unite our abilities and commitment, and if we can involve the schools of our respective nations as part of such a global initiative, we might help each other ensure that all our young people learn what they need to grow healthy and prosper. And in so doing, we additionally might teach our young people that they too share responsibility for ensuring the well-being of future generations of humankind.

Acknowledgments

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Annex 1: Factors Influencing Local Priority for School Health

The extent to which schools give priority to improving health is often related to:

- An understanding of the relationship between health and education.
- Managerial direction and support, including delegation of the responsibility and authority for school health.
- Financial support for programme development.
- Community support for addressing health and sensitive health issues, such as sexuality and decisionmaking.
- Incentives for school personnel.
- Ability to implement interventions affecting health, including health education, health services and environmental modifications, health promotion for staff, and other components of a school health programme.
- Training for teachers and other school personnel.
- Teaching/learning materials and resources.

Annex 2: Barriers Faced in Developing Countries

Schools in developing countries face substantial and overwhelming barriers, such as:

- Lack of classrooms and furnishings.
- Lack of safe water and sanitary facilities.
- Lack of electricity.
- No trained teachers or other school personnel.
- Hazardous buildings and grounds.
- Malnourished, diseased, and disabled students and staff.
- Lack of local health services, nongovernmental organizations, volunteer and community groups, and other fundamental community resources.
- A population tired by efforts to survive in poverty and squalor.
- Competition for funding between primary schools and schools of higher education.

Annex 3: Barriers Faced by School Project Managers Participating in National Health Promoting School Projects in Europe

School project managers in schools participating in the European Network of Health Promoting Schools face many barriers to improving school health:

- Many school administrators lack the confidence to introduce change into school management structures. Traditionally, many schools have become hierarchical institutions with a top-down system of management.
- Teachers often have great difficulty in adapting to new educational methodologies.
- Maintaining local momentum and creating sustainability of health promotion in schools—particularly financial viability in individual schools—is difficult.
- Negotiating acceptable changes in local school policies to create a more supportive environment for health (e.g., nonsmoking policies/ safety standards and regulations for the school) takes a long time.
- A democratic form of education is often lacking whereby pupils can adopt peer learning responsibilities and be encouraged to develop opinions about, and social attitudes toward, their school and community.
- The communication gap between school personnel, parents, and community members can be wide. Schools need to be supported in their capacity to act as change agents to create closer links between all parties.
- It is not uncommon for school personnel to believe that, even with training, they lack the capacity to undertake different forms of research and to assess the quality of teaching, management practices, curriculum development, and community involvement in school life.

Annex 4: District/County/Province/State Barriers

- The responsibility for school health is sometimes delegated from one level to another without consideration of resource needs at the level receiving the responsibility.

- School district authorities and health authorities, which, respectively, have responsibility for education and health within their own jurisdictions, do not always share a common jurisdiction—a situation causing difficulties in planning coordinated approaches between national, district, and local education and health authorities.

Annex 5: National Barriers to Improving School Health Programmes: Examples from Southeast Asia

Bhutan

- Limited national resources in terms of skilled manpower and communication materials.
- Inadequate attention allocated to health in the academic period and in the school timetable.
- With health as an integrated subject, limited infusion of it into the school curricula.
- Coordination between the concerned departments in need of further strengthening.

Indonesia

- Limited national resources in terms of skilled personnel, training, and teaching/learning materials.
- Low priority on the government list of development activities.
- Low image of schoolteachers, especially those teaching health and physical education.

Maldives

- Scarcity of trained people to implement health programmes in schools.
- Inadequate supply and production of health materials.
- Rapid turnover of health and education personnel.
- Difficulty in coping with the fast-growing school populations.
- Shortage of funds to train health personnel.
- Transportation difficulties in serving schools on more than 200 islands.

Nepal

- Inadequate coordination between health and education sectors to initiate and facilitate school health activities.
- Lack of well-defined national strategies for the promotion, support, coordination, and management of school health programmes.
- Lack of research and infrastructure in the school health programme.
- Seeming lack of implementation rather than planning in order to accelerate the development of school health education.
- School health activities—implemented by government and non-government institutions—that vary in scope, intent, and depth; inadequate resources, lack of coordination, and reluctance to recognize health as a school priority.
- No adequate opportunities within the present national curriculum for students, particularly of higher grades, to learn about health.
- Limited availability to obtain higher education credit hours for health teaching, in turn limiting the justification for sanctioning a post of health teacher in the school system.
- In the absence of a subject teacher, health teaching at school has become everyone's responsibility and no one's business.
- Financial resources allocated by the Ministries of Education and Culture that are insufficient to help expand and improve the school health programme.
- Lack of trained teachers: only 38 percent of the country's 76,800 teachers are trained in health education by the Faculty of Education.
- Inadequate training in the school health programme of those health workers who are given responsibilities for conducting health education activities in schools.

Sri Lanka

- Lack of funds allocated for health education training programmes at regional levels.
- Lack of awareness of the importance of health education among decisionmakers at regional levels.

- Lack of monitoring, follow-up, and evaluation of current programmes.
- Only two periods of 40 minutes per week allocated for health education in grades 6–8 and, in other grades, the absence of a definite time allocation, creating variability in the level to which health is integrated—a serious disadvantage in implementation of the school health education programme.
- School personnel expected to have a high degree of competency and commitment to carry out school health education on a comprehensive basis, but lack awareness of relevant and current health issues, communication skills, leadership qualities, and confidence.
- Lack of teaching/learning materials.
- Greater emphasis among school health personnel on correcting defects than on implementing preventive measures.

Annex 6: Barriers Faced by International Organizations

International organizations face many barriers to helping national and local organizations strengthen their school health programmes such as the following:

- Lack of alliances, coordinated efforts, and collaboration between international organizations and other relevant organizations working in health education and promotion to advocate the concept of the health promoting school as a combined initiative.
- Lack of a common vision of what school health and a health promoting school should or could be; difficulties with fund raising and an inability of international educational and health organizations to share knowledge and resources that would provide technical support for international networks to be effective.
- Duplication of effort by various international organizations or intergovernmental organizations/nongovernmental organizations in presenting differing concepts in health education and promotion at a national level, thereby leading to confusion and division of effort.
- Failure of national governments to recognize the political, educational, health, and social benefits of participating in international networks that offer countries the ability to twin, exchange information, and learn from each other's experience.

- Governments not always seeing the potential of conceptual design, such as the concept of the health promoting school, as a means of developing and directing new educational and health policy reforms.
- Conflict between different national education and health systems that makes international coherence and consensus difficult to achieve.
- Lack of recognition by governments that improvement in the education status of a community leads to a corresponding improvement in health, thereby making the school an ideal setting for increased investment and return.
- Lack of an effective partnership with a common vision of what a health promoting school should or could be, making fund raising with both government and private organizations difficult.
- Inability or lack of commitment of international educational and health organizations to share knowledge and resources that would provide technical support to an international network.

Annex 7: Achievements of the Bulgarian National Health Promoting School Project

During its first two operational years, the Bulgarian National Health Promoting School Project has:

- Developed good working relationships and communications with the two ministries involved.
- Created a National Steering Group composed of senior education and health personnel to advise the coordinating team on technical and bureaucratic matters and to offer political endorsement of new initiatives.
- Organized regular workshops for project school teachers to upgrade their training in areas such as planning and evaluation, project management, and specific curriculum topics (e.g., sex education/crisis intervention in the school).
- Organized lectures on different aspects of the health promoting school approach to parents, members of local communities, and journalists from the print and broadcast media.
- Negotiated with national teacher training institutions to include health education and promotion theory in their training courses.

- Developed “National Health Promoting School” days that have coordinated the activities of all health promoting schools in the country.
- Developed a relationship with other health promoting school networks in neighbouring countries, to the extent that they now share their newfound knowledge and experience by giving input in Romanian and Albanian national workshops organized by their colleagues within the ENHPS.
- Organized twinning and exchange programmes for teachers and students both within the national network and within their neighbouring countries.
- Placed the issue of health promoting schools firmly on the political agenda in Bulgaria.

This is not to say that huge changes have been made, but by developing a good working relationship with the national mass media the Bulgarian National Health Promoting School Project has ensured a steady flow of news items, documentaries, and talk-show interviews with national and international figures that keep the issue of school health reform in the public eye.

Selected WHO Publications of Related Interest

Price (Sw.fr.) / Price for Developing Countries

School Health Education to Prevent AIDS and Sexually Transmitted Diseases. A Resource Package for Curriculum Developers Issued Jointly by the WHO Global Programme on AIDS & UNESCO, 1995 (275 pages) 18. / 12.60

School Health Education to Prevent AIDS and Sexually Transmitted Diseases. WHO AIDS Series, No. 10, 1992 (v + 79 pages) 12.60

Accidents in Childhood and Adolescence. The Role of Research. edited by M. Manciaux and C.J. Romer, 1991 (xiii + 217 pages) 35. / 24.50

The Health of Young People. A Challenge and a Promise, 1993 (x + 109 pages) 23. / 16.10

The Narrative Research Method: Studying Behaviour Patterns of Young People by Young People. A Guide to its Use, 1993 (38 pages) 8. / 5.60

AIDS Prevention Through Health Promotion. Facing Sensitive Issues, 1991 (viii + 78 pages) 16. / 11.20

Guide to Planning Health Promotion for AIDS Prevention and Control WHO AIDS Series, No. 5, 1989 (iv + 71 pages) 14. / 9.80

Prevention in Childhood and Youth of Adult Cardiovascular Diseases: Time for Action. Report of a WHO Expert Committee. Technical Report Series, No. 792, 1990 (105 pages) 12. / 8.40

Health Education in the Control of Schistosomiasis, 1990 (61 pages) 11. / 7.70

Hookworm Infection and Anaemia. Approaches to Prevention and Control Z.S. Pawlowski, G.A. Schad, and J. Stott, 1991 (vi + 96 pages) 19. / 13.30

Further information on these and other WHO publications can be obtained from Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland.