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Active Living: An Essential Element Of A Health-Promoting School

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WHO Global School Health Initiative

FOREWORD

Investments in schools are intended to yield benefits to communities, nations and individuals. Such benefits include improved social and economic development, increased productivity and enhanced quality of life. In many parts of the world, such investments are not achieving their full potential, despite increased enrolments and hard work by committed teachers and administrators. This document describes how educational investments can be enhanced, by increasing the capacity of schools to promote health *as they do learning*.

For better or worse, health influences education. Healthy children learn well. If children are healthy, they can take full advantage of every opportunity to learn. But, children who cannot attend school because of poor health or unhealthy conditions cannot seize the opportunities that schools provide. Similarly, schools cannot achieve their full potential if children who attend school are not capable of learning well. Poor health and unhealthy conditions jeopardize the value of school attendance.

This document is part of the technical series on school health promotion prepared for WHO's Global School Health Initiative. Because Active Living creates personal resources, vigor and health for students -- schools, families and the community also benefit. A health promoting school strives to offer developmentally appropriate, motivating, sufficiently supervised and safe opportunities for all students to be active. Through policies and practices that promote physical activity, recreation and sport, along with complementary actions in support of healthy lifestyles, the health promoting school fosters social growth and maturation, as well as mental and physical health.

WHO's Global School Health Initiative is a concerted effort by international organizations to help schools improve the health of students, staff, parents and community members. Education and health agencies are encouraged to use this document to promote Active Living as part of the Global School Health Initiative's goal: to help all schools become "health promoting" schools.

Although definitions will vary, depending on need and circumstance, a "health promoting" school can be characterized as *a school constantly strengthening its capacity as a healthy setting for living, learning and working* (see box).

The extent to which each nation's schools become health promoting schools will play a significant role in determining whether the next generation is educated and healthy. Education and health support and enhance each other. Neither is possible alone.

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Fostering Active Living in Schools: An Important Element of A Health Promoting School

1. Introduction

This document is written to help authorities and private citizens to improve health of children, youth and school personnel by using Health Promotion strategies. The document is based on the recommendations of the Ottawa Charter for Health Promotion (1986). It will help individuals and groups apply a renewed approach to improving peoples' health. This process creates on-going development that creates conditions conducive to better health and well-being, as well as to a decrease in existing health problems.

1.1. Why did WHO prepare this document?

The World Health Organization (WHO) has prepared this document to help people take control over and to improve their health. It provides information that will help people strive for and implement measures that will foster conditions for Active Living and for its adoption in schools.

1.2. Who should read this document?

This document is written to:

a. Policy- and decision-makers, programme planners and coordinators at local, district (provincial) and national levels.
b. Officials and institutions responsible for planning and implementing the measures described in this document, especially those from the health and education sectors on all levels.
c. Programme staff and consultants of international health, education and development programmes who are interested in promoting health through schools.
d. Community leaders, school personnel, health workers, service providers, media representatives and members of organized groups, e.g. sports and public health organizations, interested in improving health, education and well-being in the school and community.

1.3. What is meant by "Active Living"?

Active Living is a way of life in which individuals make useful, pleasurable and satisfying physical activities an integral part of their own daily life. Active living is based on individual preferences and choices but in general active choices are the preferred choices. In some forms Active Living is accessible and should be accessible to everyone, everywhere, at all times, and it includes both the actual doing and the experiences related to it. Active Living has the potential of being conducive, depending on its content, to physiological, emotional, mental, spiritual, esthetic, moral, and social benefits of physical activity. In communities Active Living is an important part of the culture that is reflected in e.g. health and well-being of the people, in the modes and opportunities for physically active recreation and commuting, in various aspects of the environment, and in the attitudes and values concerning the above mentioned issues.

1.4. To what extent does Active Living affect education and health?

Active Living is conducive to better health and increased life energy, and these give more personal resources for necessary tasks and optional achievements. The direct effects of activity may not always be great on the individual level and in short term. However, in groups and populations and in the long run the differences in activity are likely to make a sizeable difference to the amount and quality of achievements including those of teachers and students. In addition to the direct effects of physical activity, it has the potential to influence favorably the social environment of the school and consequently the spirit and behaviors that are important for successful work and well-being of both students and teachers. An active school is a healthier and better performing school and a better place to work. Adoption of Active Living in schools offers opportunities to improve health and effectiveness of education of most young people at low costs in most countries and circumstances.

1.5. Why focus efforts on promoting of Active Living through schools?

There are two main reasons. First, schools themselves benefit from Active Living because it creates personal resources, health, and vigour for the students and staff. Secondly, schools make a favorable setting for promotion of Active Living. A great part, and in most countries the vast majority of every young generation, attends school. Physical activity in various forms is popular among the students. Physical activity in schools is managed by responsible teachers, who know the children and have pedagogic training. These conditions offer more effective, efficient and equal opportunities than any other setting or time to get young people interested in Active Living and to give them the necessary skills, knowledge, experiences, and confidence to practice continuously some physical activities. The results of the efforts may not be limited to the students and staff, because there may also be important reflections in the attitudes and practices of, e.g. parents and sport clubs. Schools have the potential to extend physical education given to the children as part of school curriculum to active living practiced by the children as part of life curriculum. Thus, schools may be the most influential agents

to work for Active Living especially in societies where their role in creating health and resources for life is not yet fully recognized.

1.6. How will this document help people to promote health?

This document provides a framework for the promotion of Active Living that creates health. It is designed to help people address the broad range of factors that must be changed to increase physically active life style in and through schools. The document is based on the best scientific evidence and practical experience of the promotion of health and physical activity. It will help you and others to:

a. Create Healthy Public Policy: This document provides information that you can use to argue for increased local, district and national support for conditions favoring Active Living in schools and school health efforts. It also provides a basis for justifying the decisions to increase such support.
b. Develop Supportive environments: This document describes the environmental changes that are necessary for Active Living in schools and how those changes can be made at the lowest possible costs.
c. Reorient Health Services: This document describes how current health services can be changed to seize the new opportunities afforded by schools resulting from the development of more effective school health promotion programs.
d. Develop Personal Skills: This document identifies the skills that young people need to adopt and maintain an active way of life. It also identifies skills needed by others to create conditions conducive to Active Living and health through the school.
e. Mobilize Community Action: This document identifies essential actions that must be taken by the school and community together to make Active Living possible; identifies ways in which the school can help to mobilize the community to implement such actions and to strengthen school physical education and health programmes. It also provides arguments and facts that can be communicated through the mass media to call attention to the necessity to increase attention to as well as conditions and resources for Active Living in schools.

2. Convincing others that efforts to foster Active Living among students and staff will be beneficial to education as well as health.

This section provides information that you can use to convince others that, by improving the results of school work as well as health, physical activity and sports in schools are important to both students and teachers. The arguments presented in this section can also be used by policy- and decision makers to help them justify their efforts and decisions to implement measures promoting Active Living in schools.

2.1.

Positive influence on the school milieu. Physical activity offers possibilities for open and natural communication and helps to lower the barriers and inequalities of interaction in the school milieu. Physical activity is one of the best ways to create contacts between people having different roles and characters. This is especially true regarding those who are most difficult to get in confidential contact with. Physical activity can make an important contribution to the school atmosphere by creating experiences of togetherness, acceptance and success, and by influencing the self-esteem positively.

2.2.

Essential counterbalance for sitting and mental work. Continuous sitting and concentration on mental work is contrary to human nature and may lead to tension, anxiety, restlessness, lack of interest on school work, somatic and nervous symptoms and consequently to poor performance and eventually to undisciplined behavior. These risks are greatest among younger children and among those who have lower than average capacity or interest in school work and achievements. Active breaks and sufficient amount of adequate physical activity and sports are natural and necessary antidotes and remedies to these problems. Frequent bursts of physical activity during the school day can be a good investment in effective and enjoyable school work.

2.3.

Possibilities to widen and integrate teaching. Physical activity has been and still is, a natural human function and need in all cultures. Physical activity relates directly and indirectly to many school subjects and learning tasks, such as biology, physics, chemistry, zoology, geography, ecology, economics, arts, and naturally, health education. Features of physical activity can be used to illustrate important issues in these subjects in an interesting and easily understandable and concrete way. Vice versa, the deep meaning and real significance of Active Living for health, functional capacity and well-being can be illustrated in many places of the school curriculum. Physical activity is concrete action that gives easy and equal opportunities for interaction between people from different backgrounds. Therefore, physical activity is well suited to be part of Healthy Schools activities, and it may be one of the best "icebreaking" activities in the initiation phase.

2.4.

Possibilities to maintain and improve current health and fitness. Many symptoms such as backache, musculoskeletal and gastrointestinal pains, headache, feelings of tension, stress, tiredness and fatigue are not uncommon among school age children. These symptoms are due to various causes, insufficient daily physical activity being one of them. Obesity among children and adolescents is an increasing, serious health problem in both developed and developing countries, and part of it is due to inactivity either in absolute terms or in relation to food intake.

In part of the children and youth, physical fitness is likely to be poor as a direct consequence of insufficient physical activity, but lack of reliable research data exclude definite conclusions of the status or trend in this regard.

It is obvious that daily physical activities, Active Living, have much to offer: they decrease the extent and prevalence of the disturbing symptoms of school children both directly and also indirectly by alleviating psychosomatic ailments and by decreasing the likelihood of adoption of unhealthy measures and behaviors producing these ailments.

2.5.

Possibilities to decrease future health risks. Childhood and youth give possibilities not only to have better current health and well-being but also to lay the foundations for better health in the future. It is e.g. likely that youth is a unique time to acquire the strongest possible bones. This may be an advantage in old age in decreasing the risk of bone fragility (osteoporosis). It is also known that avoidance of obesity in childhood and youth is important, because once attained, it tends to continue in adulthood. Increasing evidence indicates that some of the prevalent diseases such as cardiovascular diseases can begin already in childhood. Many of the biological characteristics, such as blood pressure and blood lipids that increase the risk of acquiring these diseases in later life tend to take an unfavorable course due to inherited susceptibility or unfavorable living habits already in childhood. The development of important future health risks can thus be counteracted by healthy living habits, including physical activity in childhood. The schools have a crucial role in responsibility for helping young people to adopt an active lifestyle from childhood on and to maintain it uninterruptedly until adulthood and onward!

3. Convincing others that it is important for schools to foster Active Living

This section provides information that you can use to convince others of the importance of the promotion of Active Living, especially through schools. It also contains arguments to help policy and decision-makers justify their decisions to increase such support.

The following arguments strongly support the importance of the promotion of Active Living as part of school's functions and the need for increased investment in the conditions for Active Living.

3.1. Optimal time. **School age is the optimal time of life to adopt Active Living!**

School age is optimal and even unique time to benefit of the effects and influences of physical activity for biological, mental, moral, ethical, esthetic and

social growth and maturation. This time is also optimal for learning and adopting the skills, rules, and norms of exercises and sports as well as for gaining favorable experiences related to physical activity, all of which are important prerequisites for the adoption of Active Living as a sustained way of life. The time is optimal because the growth, adaptation and learning potential of the young people in response to physical, mental, cognitive, and social stimuli included in, or related to physical activity are at their peak. Very importantly, the spontaneous interest and natural enjoyment of a wide variety of physical activities is greatest during the early school years. The soil is at its best for harvesting the biggest crop!

3.2. Best coverage and most equal opportunities.

No other setting than school offers the opportunity to reach so great a proportion of every successive age class and to familiarize them with important aspects of Active Living under qualified guidance. No other setting than school offers these opportunities on as equal basis. Without physical activity and physical education offered by schools there would be a risk that part of the children and adolescents would be highly active in sports clubs, while the rest, those less interested and less talented as well as those with illnesses or disabilities or without adequate family support would become physically inactive and possibly remain so through out their life. When the aim is to influence the current and future health and well-being of the entire population, schools are in a unique position.

3.3. Mandate and responsibility. **Schools have been given the mandate and responsibility for enhancing all aspects of development and maturation of children and youth. This includes teaching the basics as well as ways and means of Active living to all students.**

The responsibility of the schools for fulfilling this task is to offer developmentally adequate, motivating, sufficiently supervised and safe programs that allow participation of all students and that enhance biological, moral and social growth and maturation. Physical activity and sports offer great possibilities for positive social and moral development but they come true only on the condition that the activities are practiced in the spirit of high morals. Schools with their professionally qualified teachers are an ideal setting for using physical activity and sports to enhance psychosocial and moral development of children and adolescent.

Schools usually have the most resources for adequate physical activity and physical education, and the schools also have the responsibility for striving for resources to accomplish this task. Further, each teacher and each school is accountable for the standard of work. All these conditions make schools superior to any other setting in providing opportunities for adequate physical activity for children and youth.

3.4.

Popularity. In all parts of the world physical activity is one of the most popular school subjects especially among the young children. Thus, physical activity need not be taught or practiced "up-stream" against the motivation of the students. On the contrary, physical activity and sports add to the variety, enjoyment, challenges and achievements of the school work.

3.5.

Opportunities for collaboration and coordination in communities. Schools have good opportunities to collaborate with parents, sport and other voluntary organizations, community officials, health care providers etc. in organizing physical activity and sports. Schools are also in the best position to coordinate in an effective and responsible way the gathering and use of the community resources for Active Living of children and youth. Schools can thus greatly increase the availability and variety of physical activities while at the same time maintaining their accessibility and educational qualities on high level.

4. Planning efforts to foster Active Living

Once the importance of Active Living and the feasibility of its promotion through schools become understood by citizens, school officials and policy- and decision-makers, the next step is to plan promotion measures. This section describes important steps that should be considered in the planning process. It includes conducting a situation analysis, obtaining community commitment and support, and setting goals and objectives.

4.1. Situation analysis

4.1.1. Purpose of conducting a situation analysis

Policy- and decision-makers will want a strong basis for their commitment and support, especially when their policies and decisions involve the allocation of resources. Accurate and up-to-date data and information can provide a basis for discussion and justification for action. Data are also essential for planning measures that foster Active Living.

The need for adequate situation analysis on national, regional, local and school levels regarding physical activity is accentuated by several reasons. There is increasing competition of curriculum time at all school levels in all countries. It is easy to convince the planners and decision-makers of the importance of academic subjects e.g. supporting technological and economical competitiveness. The importance of and continuous need for physical activity is much more difficult to prove. However, it can be done on the basis of reliable scientific evidence, and it has to be done in order to win high level political commitment and support.

It is well accepted that especially the amount of moderate and vigorous activities as part of daily living has continuously decreased, first in industrialized but gradually also in non-industrialized countries. It may be claimed that this decrease in activity is compensated by increased participation in organized sports. This may be true in a limited part of the youth population in a few countries. However, for the majority of children and youth physical activity in school is even more important than previously to fulfil the basic need. This is true especially for those who are most in need of activity, e.g. the children belonging to underprivileged and minority groups, or having diseases or disabilities.

4.1.2. Information needed

It is important to show in what degree, quantitatively and qualitatively, the present level of physical activity meets the goals and standards set to adequate activity. Most of the basic data are easy to collect by questioning the teachers and school administrators.

The information should include the number of hours devoted to and used regularly for physical activity and sports, description of the content of these hours (activities and sports practiced, active time during the lessons, participation rate, criteria for exemption and proportion of exempted students from active participation, competitiveness etc.) and of the available resources in the schools and elsewhere in the community (number and qualifications of the personnel, and information of space, equipment, dressing rooms, transportation etc.).

It is also useful to have information on the adequacy of the clothing, personal equipment and other prerequisites for active and adequate participation. The attitudes and activities of parents, school health services, sport and other organizations, municipal authorities etc. as regards physical activity in schools and in the community are also important to know. Attitudes, preferences and experiences of children are important to know, because the content of and experiences brought by present activities have to correspond sufficiently to the expectations and needs of the children in order to give them motivation for continuous activity.

At school level this information can be obtained by direct questioning from the respective sources. However, in planning programs and resources at national, regional and even municipal levels, more formal approaches selected on the basis of expert consultations are advisable in order to secure feasible programs and effective use of resources.

4.2. Community commitment and support

Realization of physical activity in schools needs community commitment and consequently support in order to be allocated the necessary time during the school day and the resources for planning, teaching, sites and other requirements.

The current trends in many industrialized countries show that the time and resources devoted to school physical education are decreasing indicating lack of commitment. This seems to be due to increased emphasis on subjects that improve directly the competitive power of a nation on world market. In many non-industrialized countries school physical education has not yet gained broad commitment nor resources for its realization due to many serious and actual problems. Thus, there is a need to work for more acceptance of the value for individuals and societies of school physical education in most countries around the world.

Realization of adequate school physical education calls for commitment, and support of many parties at national, regional and local levels. Commitment of only one or few parties is usually not sufficient to create substantial change and consequently support. Partnerships and alliances are needed in order to gain more awareness, visibility and credibility for school physical education, and to make a bigger impact on a larger number of people. The potential partners include representative individuals, groups and organizations from numerous sectors such as political, public, education, health, business, communication, recreation, voluntary, service, and even religious sector.

The main goal of the actions of the partners is to work for policies, laws, and regulations that support creation of social and physical environment conducive to opportunities for continuing physical activity in schools. One of the most important functions is advocacy for physical activity by approaching individuals, groups and populations by way of personal contacts and the media. The success of this work depends greatly on how well the messages and their presentation are tailored to meet the interests, priorities, comprehension, and language of the target audiences. As a consequence, different partners are needed for different tasks in the advocacy work. The role of parents as the eye witnesses of the value of physical activity for their children, and of the students themselves as subjects of physical activity is worth emphasizing.

4.3. Goals and objectives of Active Living in schools

The main goal of school physical activity is to lay the foundations for a lifelong physical activity by strengthening its most important internal prerequisites, i.e. good motivation based on favorable experiences, and sufficient skills and confidence to practice disciplines that are suitable for continuing practice.

The second goal is to maintain and increase current well-being of the students by preventing symptoms due to one-sided mental activities and indoor sitting, and by offering enjoyment, fun and social interaction.

The third goal is to prevent future health risks. This goal can be attained only by reaching the first one because none of the health-related effects of physical activity are retained, if it is discontinued.

Several health-related objectives for school physical activity can be set on the basis of the effects of physical activity. The objectives can be expressed in somewhat quantitative way if the amount, intensity and type of activity to attain the effects are known, and if the occurrence of various risk factors or health

problems related to insufficient physical activity are known. There is paucity of both sets of data even in countries where they are best known. The optimal amount and intensity of physical activity needed to confer the health benefits in young people is not currently known. Furthermore, the prevalence of health risks and problems vary greatly in different countries, depending not only or mainly on physical activity but also on, e.g. nutrition and other living habits. Thus, presently the health-related objectives of school physical activity can be set only broadly and any quantitative objectives have to be set country by country.

A recent US consensus statement recommends that "all adolescents.... be physically active daily or nearly every day, as part of play, games, sports, work, transportation, recreation, physical education or planned exercise, in the context of family, school, and community activities" and that "adolescents engage in three or more sessions per week of activities that last 20 minutes or more at a time and that require moderate to vigorous levels of exertion".

This recommendation has been developed further, still pointing out the lack of convincing data, in an international symposium on young people and health-enhancing physical activity: "All young people (all those under the age of 18) should participate in physical activity of at least moderate intensity for an average of 1 hour/day. While young people should be active nearly every day, the amount of physical activity can appropriately vary from day to day in type, setting, intensity, duration, and amount. As part of the recommended 60 minutes of physical activity, young people should participate at least twice per week in physical activities that enhance and maintain strength in the musculature of the trunk and upper arm girdle. Strength promoting activities that are appropriate for young children include playground activities that involve climbing, gymnastics, and "exercises". It is further recommended that the activities characterized above be developmentally appropriate from both physiological and behavioural perspectives.

It is noteworthy that the recommendations cited above include active living (as contrasted to formal physical education) as an essential and even major part of the recommended total activity.

5. Integrating Active Living efforts into various components of a Health Promoting School

A Health Promoting School can be characterized as a school constantly strengthening its capacity as a healthy setting for living, learning and working for the students and the staff. The functional components of health promoting schools include the creation and implementation of policies and practices supporting health, cooperation between the schools and the communities, creation of healthy school environment, inclusion of health education in the curriculum, organization of health services for the students and staff, involvement of the whole school personnel in health promoting activities, serving healthy food, and organizing extracurricular activities that promote physical, mental, and social health and well-being.

The success of the efforts to promote active living in schools depends largely on how effectively the various functions that have health promoting potential can

be used to support the adoption and maintenance of physical activity. The following information describes how efforts promoting active living can be integrated into relevant health promoting components.

5.1. Supportive school policies and practices

Policies provide formal and informal rules, preferably in written form, that guide schools in planning, implementation, and evaluation of efforts aimed at promoting active living. The formulation of policies should incorporate input from various partners, e.g. school and community administrators, teachers and other school and community personnel, health care and recreation sectors, public health professionals, sport and other voluntary and service organizations, parents and students.

One of the most important policy issues is to require several hours supervised physical education weekly. That should be instructed by qualified, responsible teachers in the way that the activity meets the needs and interests of all students by taking into account the differences in e.g. gender, developmental and health status, skills, and motivation.

The exact content of the policies has to be formulated on the basis of the national and local traditions, needs, and possibilities. It is worth emphasizing that both in terms of realistic possibilities and the promotion of the development of independent active lifestyle, only part of the recommended physical activity can materialize as formal physical education. However, that part should be the responsibility of teachers who work with the students for longer periods and get to know them, and who have pedagogic training. It is advantageous to begin guided physical activity as early as possible, already in kindergarten. This way children can be socialized into physical activity and sports, and they learn and internalize the rules and norms. Through physical activity and sports children are also socialized into some important aspects of life.

Because a major part of the need for physical activity can not be met by formal physical education, schools should adopt policies and practices that increase the opportunities for physical activity during the breaks, before and after the school hours, and in commuting to and from school. Encouraging and creating possibilities for physical activity during breaks is mainly an internal matter of the schools depending more on willingness and imagination than on resources. Offering opportunities for physical activity during out-of-school hours requires collaboration with school and community administrators and workers, sport clubs and other voluntary organizations as well as with parents. Vast experience shows, that this goal is not easily reached. This finding actually demonstrates, that there may be large amount of incompletely used resources for health promotion due to insufficient cooperation. The main prerequisite for physically active commuting is the possibility to use safe walking and bicycle roads from home to school. This may require long-term and intensive lobbying and collaboration with many parties, e.g. community and traffic planners', and decision makers in order to persuade them to accept that the use of human muscle power instead of engine power is profitable for both the citizens and the nature.

5.2. Cooperation between schools and the community

Schools and communities have great mutual interests regarding the administration, effectiveness and resourcing of the schools. This also applies to physical activity. In many countries the communities are the most important partners for schools, and the communities should give their full support to schools by providing funding for qualified instruction and for use and construction of accessible and safe sites for physical activity. In return these investments yield healthier, fitter and more energetic citizens.

In order to secure a continuing and open exchange of information between schools and communities, it is important to establish organs in which school administrators, teachers, and parents as well as the community planners, administrators and decision makers are represented.

5.3. A healthy school environment

The physical and social environment of the schools should encourage and enable the students and the staff to participate in enjoyable and safe physical activities during, before and after school hours and also during weekends and vacations. In community planning schools should be a priority location for exercise and sports facilities. Special care has to be taken to minimize environmental hazards and risks in the use of these facilities by meeting or exceeding all safety standards regarding the location, design, installation, equipment, and maintenance of the exercise and sports facilities. The safety issues related to climatic conditions (heat, cold, air quality), water, constructed or natural obstacles, lighting, surfaces, and violence are all the more important, the less adult supervision is provided. Special care has to be taken to meet the requirements regarding the access to and the use of the facilities by persons who have disabilities. The best way to handle many environmental issues related to physical activity is by definite rules, regulations and laws.

The social environment determined, e.g. by the type, intensity and spirit of the activities, their guidance and supervision by adults or peers, the selection and matching of the teams, and compliance with rules and norms has great influence on the experiences and risks of the practiced activities. Negative experiences due to any reason have to be especially avoided, because they decrease the motivation for, and confidence in participation in physical activities. These risks can be decreased by appropriate instruction, guidance and supervision, by matching participants in, e.g. team sports according to size and abilities, by modifying rules to meet the skill level and equipment of the participants, and to eliminate unsafe practices. The schools have the best possibilities and greatest responsibility to ensure a positive and safe social environment for physical activity.

5.4. Physical Education, Recreation and Sport

The formal part of the efforts to promote Active Living in schools, physical education, offers the greatest possibilities to influence in a planned, sequential, and developmentally appropriate way the major determinants of the adoption and

maintenance of physical activity, namely motor and behavioral skills, knowledge, attitudes and self-confidence.

Physical education should be fun and social, it should bring positive experiences and feelings of mastery, success and self-confidence in order to work for its primary goal, that of laying the foundations for lifelong physical activity. Therefore, it is important to teach motor skills that enable the practice of potentially lifetime activities such as swimming, bicycling, hiking, cross-country skiing, dancing and some racket games, e.g. badminton.

A great part of the students is most interested in team ball games. These have to be part of the physical education program, but not at the cost of potential lifetime activities. The same principle applies to competition. It is a natural and enjoyable part of sports, but especially an uneven and unsuccessful competition is likely to decrease seriously the interest of especially the less talented students, and not only in the respective sports, but also in physical education and activity in general.

It is also important to teach behavioral skills that help to begin and continue suitable physical activities. These skills include self-assessment of abilities and readiness for various physical activities, goal setting, decision making, self-monitoring, and communication related to physical activity. Some of these skills can be taught and practiced by using fitness testing, and by emphasizing the health-related components of fitness (e.g. cardiorespiratory endurance, muscular strength and endurance, flexibility, and body composition). It should also be stressed that the test results are to be used for self-assessment and not for comparison with others or to assign grades.

Physical education classes offer unique possibilities in schools to learn by active doing. This opportunity is not limited to e.g. learning motor skills, but it can also be used for learning about the effects and benefits of physical activity for functional capacity, well-being, and health. Physical education classes also offer possibilities to learn important social skills, norms and behaviors in realistic situations but on a manageable scale and with correctable consequences. Appropriately supervised team sports offer especially good possibilities to learn social skills, norms, and behaviors.

Physical education only offers the favorable opportunities mentioned above, but it does not bring positive results automatically. The success of school physical education depends mainly on the quality of the teachers as educators. Their most important qualities for the achievement of the primary goals of physical education are not physical and technical but the pedagogic, psychological and social skills. Those qualities enable the teachers to understand and handle the students as individuals with different abilities and motivations. These teachers also see that there is a whole spectrum of opportunities for effective education hidden in even simple forms of physical activity. Thus, in order to fully utilize the potential of physical education as an important part of school curriculum, physical education should always be taught by appropriately trained teachers, who bear the responsibility of long-term, comprehensive education of the students.

5.5. Health education

Health education aims at stimulating students' interests in good health by providing knowledge of the factors that influence health and of the ways and means in which these factors can be influenced at personal, family, group, and community level. The reliable information and examples of successes and failures that are mediated by health education can influence the attitudes, willingness and abilities of the students and their families, and help them to make health-enhancing choices in their everyday life.

Physical activity is one of the many factors that influence health, and health education can give a balanced view of its role for individuals and societies in relation to the other factors. Health education should also bring up the principles of health promotion, and how they can be used to improve the conditions for regular physical activity of all citizens.

Health education should have a self-standing status in schools and it should be taught in a planned and sequential way through the school years. Elements of health education should be incorporated in many other subjects, too. However, using only the integrated approach in health education teaching would not give sufficient visibility and strength for health education, nor the necessary expertise and responsibility for its teaching.

Health and the personal, societal, and environmental factors that affect it are heavily influenced by the values, beliefs, attitudes and even myths of individuals and communities, and these often have deep cultural and religious roots and economic implications. Ethically sound and effective health education has to take these issues into account and appreciate them. This is one reason why it is important to identify groups beyond classroom, that influence the background factors that are decisive for the results of health education. These groups, especially parents, should be stimulated to get involved in discussions and debates concerning the relevant issues in health education.

Health education related to physical activity should stimulate and encourage students to adopt Active Living as one essential part of their way of life. Health education should provide knowledge of the biological, mental, and social benefits of physical activity and of the characteristics of the activities that bring the benefits. Also the health risks associated with physical activity as well as the ways in which to prevent them and to give first aid should be covered.

An important part of the curriculum is to help the students use behavioral skills for the adoption and maintenance of active lifestyle. These skills include self-assessment of activity and fitness level, evaluation of their own readiness and abilities for certain activities, setting of goals for activity, making decisions regarding activity, identifying and managing barriers of participation, techniques for self-regulation and reinforcement, and communication and advocacy skills.

It is obvious that health education and physical education have much in common. Both subjects are commonly taught by the same teachers. This practice offers many advantages and can be recommended when possible and practical.

5.6. Health Services

Health care personnel both in the schools and in the communities at large is in key position to promote active living in schools. Their role is one of the most influential ones in advocating the importance of physical activity and physical education in schools. They are in the position to use their knowledge and expert authority to influence the knowledge and attitudes of all important parties in the community and schools, the decision makers, planners, administrators, teachers, staff, parents and students. Health care personnel has a special role in working for improved opportunities for physical activity of people who have barriers and limitations in participation due to disabilities or social or economic reasons. The credibility and strength of the advice and recommendations of the health personnel is greatly increased, if they show themselves up as active role models.

Health care personnel also has responsibilities and possibilities in organizing services which support realization of appropriate physical activities. School or community health services should periodically assess the physical activity patterns and the key parameters of health-related fitness of the students. On the basis of these assessments, the students, teachers and parents can be given advice and encouragement concerning the participation in physical activities that meet the needs, possibilities, and individual interests of the young people. A special responsibility of the health care personnel is to refer to appropriate school or community services and programs the students, who have chronic diseases and conditions or risk factors, or physical and cognitive disabilities.

5.7. Health promotion for the school staff

A school health program should not be limited promoting health of the children enrolled in school, but it should be extended to include the whole staff for several reasons. The teachers, administrators and supporting staff have to know, at best based on their own practical experiences, the concepts, principles, strategies and methods of the implementation of health promotion and its various measures. Only a very small part of even teachers responsible for health education in schools have got training in health promotion. The members of the school personnel are important role models and potential advocators of health promotion in the school, and also in the community at large. The school staff is doing work that requires commitment, multiple responsibilities and continuous learning and renewal. The protection and improvement of their health should also be taken care of.

Physical activity offers several advantages as a health promoting measure for the school staff. All its effects, biological, mental as well as social, are necessary for, and welcomed by the staff. The activity itself can be realized in enjoyable, inexpensive, safe, social, and usually socially acceptable ways. It can often be incorporated into daily life as utility or recreational, even sporting activities that bring relaxation and change to the mentally demanding, sedentary work. Personal experiences of the teachers of physical activity are likely to increase their understanding of its value and its acceptance as one important subject in the school curriculum.

5.8. Nutrition

Adequate nutrition and physical activity are both cornerstones of good health and both of them have to be included in comprehensive school health program.

Nutrition and physical activity are also linked together in several ways. The strongest link is between quantities; if the energy intake from food and the energy expended in physical activity are not in balance in the course of weeks and months, there is a change in the amount of stored fat, and consequently in body mass. Undereating in relation to the amount of physical activity can be found mainly among competitive, intensively training female athletes who have a clear advantage of leanness, such as gymnasts, ballet dancers, figure skaters and endurance runners especially in affluent societies. A much more common problem is, however, overeating in relation to the amount of physical activity, leading to overweight and obesity.

The problem of overweight among young people is serious for several reasons. It causes or aggravates many physical, mental and social health problems, or is their risk factor. These problems, such as adult onset diabetes, high blood pressure and degenerative joint diseases, are so common partly because overweight is so common. The primary cause of overweight is more commonly sedentary lifestyle, i.e. small amount of physical activity and "normal" or excessive amount of food, than overeating concomitant with physically active lifestyle. This is true in both affluent and developing countries.

The trend in many countries shows that overweight among young people is increasing. Some reasons for this development are the increased size and increased fat and sugar content of restaurant, especially fast food, meals and decreased physical activity of daily life. Once overweight has developed in youth, it has a strong tendency to continue into adulthood.

The negative health consequences of overweight and especially obesity are likely to be more serious in the sedentary than in the active obese people. Thus, physically active lifestyle is important both in the prevention of overweight itself and in decreasing its harmful effects. Schools can and have to play an important role in obesity prevention by using the possibilities of school nutrition, health education, and physical activity. If schools succeed in fostering balanced eating and exercise habits resulting in the maintenance of healthy weight and metabolism and adequate fitness among the students, the schools make a great service because those results are likely to influence health deeply and last for a long time.

If healthy weight is maintained in the absence of physical activity, there may be a risk that the relatively small amount of food does not contain sufficiently mineral, vitamins, and trace elements. On the other hand, if the amount of physical activity is large, that risk does not exist due to the greater total amount of food. Further, the increased metabolism due to physical activity tends to have favorable effects on some risk factors of cardiovascular diseases, e.g. on blood cholesterol and triglycerides, already in young people.

It is logical to think that healthy eating or healthy activity habits are reflected in the other living habits, too. This does not occur automatically and no to a large extent. However, one healthy living habit gives opportunities to use it as a vehicle to influence other habits, too, by using the possibilities of school nutrition, health education, and physical education.

5.9. Extracurricular programs

School physical education can offer only part of the recommended one hour daily physical activity for children and adolescents. Extracurricular activities, i.e. those related to schools as outside activities, give great possibilities to complement the formal physical education and at the same time maintain and increase cooperation between schools, parents, communities, and voluntary organizations.

Schools and communities can often provide the facilities, and the sport and other organizations can take care of the supervision and guidance. This cooperation can also increase in the community the understanding of the value of physical activity, and its acceptance as an important part of the young people's life.

Participation of several responsible parties in the organization of the extracurricular activities can also increase the credibility and visibility of, and commitment to physical activity in both schools and in the community. The reflections may be even larger, because organization of activities for young people is a concrete, motivating task that gives opportunities for many for participation in joint tasks on an equal basis. This experience may create sense of coherence, achievement, confidence, and independence especially in small communities, and encourage the citizens to undertake further tasks as community activities.

Extracurricular physical activities are generally oriented towards sports and competition. This is natural, because these qualities attract those students, who are the most motivated for participation. The same applies to the organizers of the extracurricular activities. In the course of the activities the selection and self-selection of the most talented and best motivated students tends to continue.

The disadvantage of the selection process is that there is not enough facilities, supervision and other services nor motivation for participation for the less talented and less competition oriented students, who anyway could be interested of regular practice of exercise and sports at less or non-competitive level. This risk can be avoided only by planning and resourcing programs that are targeted for broader participation.

Physical activity in its various forms has great potential to influence positively the psychosocial development and behaviors of youth by offering various natural and socially acceptable outlets for self-expression, emotions and even rebellious features associated with maturation to personal independence. Therefore it is important that the schools as well as the communities seek actively individuals and groups which could benefit of physical activities that meet their needs, abilities, and interests. These programs should be given high priority among supported community activities.

6. Training teachers and other school personnel to foster Active Living

Active Living is a way of life, in which individuals choose to make physical activity a preferred and integral part of daily life. In school physical education is the main part of Active Living, but there are also other opportunities for activity. Those opportunities should also be actively created and offered for the students. Correspondingly, teaching of Active Living is mainly the responsibility of the teacher who is primarily responsible for teaching physical education, but fostering Active living is the responsibility of other teachers and staff member as well.

Successful teaching of physical education requires many qualifications. An ideal solution is to have specially trained physical education teachers responsible for this subject. In reality this is possible only to a limited degree. Therefore, it is very desirable that other teachers also get trained in the essential aspects of physical education and also in health education and health promotion. This applies to a more limited extent also to other members of the school staff. It also and definitely applies to those, who organize and supervise the extracurricular physical activities.

Every person who is responsible for fostering Active Living should know and understand the general value and main benefits of physical activity for physical, mental and social health and well-being as well as for growth and maturation on the same domains. They should also know and understand the quantitative and qualitative requirements that the various activities set on the participants, and they should be able to assess the matching of the requirements of the activity and the abilities of the participant. They should know the risks involved in various activities and conditions and how to avoid them. Especially the teachers should know the principles, concepts and strategies of health promotion, and the main methods that can be used in the instruction of physical and health education. The specialized teachers should get training also in the skills and techniques that can be used in the advocacy for health and Active Living.

In all education and training of the teachers and other staff members it is important to emphasize that the adoption and maintenance of Active Living is based on numerous and continuously repeating personal choices. These are likely to be made in favor of Active Living, if the active alternatives are considered and experienced as enjoyable, useful or otherwise satisfying. Thus, it is in very high degree, especially among the young people, the emotions and feelings that count. They are based on earlier expectations and experiences. There is no place for many negative experiences due to any reason, especially among the less talented and less interested children and adolescents, if Active Living is wanted to be their preferred choice. These aspects emphasize the desirability of the psychological and social skills and empathy of the teachers and guardians who are responsible for teaching and supervising physical education and Active Living for young people.

7. Evaluation

Fostering Active Living in schools is a highly accountable task for many reasons. The expressed goals are high, the expected results are considerable, a substantial amount of resources is used, and every student goes through the curriculum only once.

It is important to know, e.g. in what extent the goals are attained how satisfactory are the results from the school's, students', and parents' point of views, how sufficient are the resources, and how effectively are they used.

7.1. Evaluation as a planning tool

The results of evaluation can be used to improve various aspects of physical activity promotion, e.g. policies, facilities, environments, instruction programs, personnel training, extracurricular activities, health and other services and integration of physical and health education to other parts of the school curriculum. The results of objective evaluation are one of the best means to request for additional support from, e.g. the school or community or improved collaboration with parents or voluntary organizations. An important aspect of the evaluation is that the purpose is not to find victims but to obtain reliable information to be used for the continuous planning - implementation - evaluation - planning cycle.

7.2. Types of evaluation

Efforts to foster Active Living can be evaluated in a number of ways. A thorough evaluation of both what was done and how it was done, i.e. process evaluation and what were the results, i.e. impact evaluation is a task that requires a substantial amount of resources and mastery of various methods. However, an evaluation can also be performed in simple ways and with small resources. It is better, and it is actually essential, that some evaluation rather than none at all is done on the condition that the obtained, even limited results are pertinent and reliable.

7.3. What to evaluate

It is obvious that the activities of fostering Active Living in schools are much easier and less costly to evaluate than the various effects of the accomplished measures. Both types of evaluations are needed, however, in order to maintain and increase the credibility and acceptance of physical and health education as well as the promotion of Active Living in schools.

A suitable international division of labor could be that the affluent countries take the responsibility for developing methods and conducting thorough and large scale evaluations of both types, and countries with limited resources conduct process evaluations at various levels.

The main aspects to be evaluated are the qualitative and quantitative aspects of physical education instruction, physical activity programs and facilities. All evaluations must naturally be made with reference to the set goals and available

opportunities and resources. The exact content of the evaluation depends on local circumstances. The facilities are usually the easiest to evaluate. In some countries models and standards have been developed for evaluation of, e.g. the quantity and quality of physical education instruction, lesson content, fidelity of curriculum implementation and opportunities for other physical activities. Also the competence of the teachers and other professionals in health and physical education, and the training programs for these people can be evaluated using standardized methods and criteria. The same applies to the evaluation of students' attainment of knowledge and achievement of motor and behavioral skills related to physical activity as well as to the adoption of healthy behaviors. If the developed methods and accepted standards can be applied in other national and local circumstances, the evaluations can be done, at least on a small scale, with even limited resources.

7.4. Reporting progress and achievements

Any evaluation is useful and complete only when its results are reported and interpreted to those who need and can use them. The value of the evaluations is greatly increased if they are reported using repeatedly the same objective criteria as possible in order to attain continuity and comparability in the interpretation.

The evaluation reports contain interesting and easily understandable material for many parties in the schools, communities and families. This potential should be fully used to create discussion, debate, proposals, etc., and in this way to contribute to the development of, and increased support for physical education, Active Living, and more broadly for Health Promotion in schools.

School Based Health and Nutrition Programmes:

Findings from a survey of donor and agency support

Carmel Dolan

JUNE 1998

Partnership for Child Development

The Partnership for Child Development (PCD) was established in 1992 to help co-ordinate global efforts to assess the developmental burden of ill health and poor nutrition at school age. It brings together a consortium of countries, donor organisations and centres of academic excellence to design and test strategies to improve the health and education of school-age children.

The Partnership has international agency support from UNDP, WHO, UNICEF, The World Bank and British DFID, and is sustained through support from participating governments, the Rockefeller, Edna McConnell Clark and James S McDonnell Foundations and the Wellcome Trust.

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Contents

List of Abbreviations used in text

United Nations Organisations, Funds and Agencies
UNICEF – United Nations Children's Fund

WHO – World Health Organisation

FAO – Food and Agriculture Organisation

WFP – World Food Programme

UNESCO – United Nations Educational, Scientific and Cultural Organisation

UNDP – United Nations Development Programme

UNFPA – United Nations Population Fund

UNAIDS – United Nations Programme on HIV/AIDS

IAEA – International Atomic Energy Agency

Multilateral Finance Agencies
IADB – Inter-American Development Bank

Bilateral Agencies
CIDA – Canadian International Development Agency

DANIDA – Danish International Development Assistance

DFID – Department for International Development, UK

GTZ – Deutsche Gesellschaft fur Technische Zusammenarbeit

NORAD – Norwegian Agency for Development Co-operation

SIDA – Swedish International Development Agency

USAID – United States Agency for International Development

Non-governmental organisations (NGOs), research groups and institutions
AHRTAG – Appropriate Health Resources and Technologies Action Group

CARE – Co-operative for Assistance and Relief Everywhere

CAFOD – Catholic Fund for Overseas Development

CFNI – Caribbean Food and Nutrition Institute

CRS – Catholic Relief Services

DBL - Danish Bilharziasis Laboratory

PCD – Partnership for Child Development

PLAN – PLAN International

SCF (USA) – Save the Children, USA

SCF (UK) – Save the Children, UK

WVC – World Vision Canada

Key Observations

- There is increasing donor interest in the health and nutrition of the school-aged child, adolescents and youth generally. This is most apparent in the UN system but also in some of the Bilateral Organisations and increasingly among those NGOs surveyed.
- NGOs in the UK are reporting an increase in requests from governments for support to the formal and informal education sector and within this the health and nutrition needs of school-aged children.
- There is a move towards inter-agency school health planning, monitoring and evaluation, particularly in the UN. This reflects a move by the UN system and bilaterals towards a sector-wide approach to funding, and away from a project approach. This is also seen as an essential development among other donors e.g. SCF (US).
- Those donors contacted who stated that they are not supporting school-based health and nutrition programmes at present, indicated that they are currently considering the issue.
- In the view of donors, the PCD acts as a catalyst to promote donor commitment in the area of school health, particularly among US based Organisations and agencies. The level of awareness of school-health issues among UK based NGOs is not as well developed.
- Strong interest has been expressed in the school health web-site and mail list currently being developed by PCD with the World Bank. This could provide the necessary vehicle for greater collaboration among donors/agencies and governments to share school health related experiences, research, programming etc.

Caveats

- The inter-sectoral, crosscutting nature of school health and nutrition programmes, along with the lack of available information at HQ level (many regional offices are autonomous) combines to make information gathering in this area quite difficult. If a detailed and more accurate picture of donor support for school health programmes were required, it would be necessary to make a more detailed regional analysis and to visit the HQ of all the major donors.
- The results of the telephone survey of donors presented below should be viewed as an incomplete but reasonable indication of current donor support in this area.

Introduction

This paper was commissioned by the Scientific Coordinating Centre of the Partnership for Child Development (PCD), based in the University of Oxford, England. The main objective of this work was the preparation of a synopsis of donor support for school-based health and nutrition initiatives. The information was collected over a three week period using telephone, fax, email and the web site. These media provide a useful introduction to the subject but fall short of providing a comprehensive overview.

The paper is divided into four sections: Multilateral Organisations, Bilateral Organisations, NGOs and Academic Institutions. As many Organisations as possible were contacted in the time frame available and it is likely that some Organisations have been overlooked.

The quality of the information received from the different Organisations is inevitably a function of the interest of particular individuals and their willingness to give up valuable time to share and research relevant details. To this effect, thanks should be given to all those who contributed to this paper.

Section I: United Nations Organisations, Funds and Agencies

UNITED NATIONS CHILDREN'S FUND (UNICEF)

UNICEF's medium-term strategy for 1996-2001 has identified women and young people as two main priority groups. Their policy is to help meet the basic rights and expand opportunities of children aged 0 to 18 within the framework of the 1989 UN Convention of the Rights of the Child, the 1990 World Summit for Children and the 1990 World Conference "Education for All" (EFA). In addition, UNICEF's mandate is to support WHO and UNESCO policies and develop common strategies that address school health and the joint UN Programme on AIDS, which improves coverage and quality of school-based life skills/AIDS programmes. They also work within the Framework for Girls Education (1996) and take guidance from the Notebook on Programming for Young People's Health and Development (1997).

UNICEF has been involved with school health programmes for many years and collaborates with a number of agencies including the World Bank, WHO, UNESCO and UNFPA. Recently UNICEF has worked in some depth with several countries (Cameroon, Eastern Caribbean, Ghana, Sri Lanka, Thailand and Zimbabwe) on school health programme policy.

Currently UNICEF supports a range of school health programmes in the following areas:

- **Water, Sanitation and Hygiene** programmes for schools in many countries (e.g. Uganda, Vietnam, and West Africa). These include health education courses in primary schools that focus on hygiene and the environment, provision of facilities for safe water, latrines, handwashing and garbage disposal.
- **Life skills/AIDS** programmes in schools including curriculum training (e.g. Zimbabwe, Thailand, Caribbean, Uganda, and Sri Lanka).
- **Child-to-Child** and extra-curricular activities for the whole community, with NGOs, for example: World Scout Federation, Red Cross and Red Cross Crescent Societies.
- **Health and Nutrition** services including the provision of micronutrients, anthelminthics and malaria tablets as part of UNICEF's overall strategy.
- **Situation Analysis** including adolescents' needs and responses. This was developed as an inter-agency (UNDP, UNESCO, UNFPA, WHO) activity, with PCD, and has been evaluated (by WHO) in Ghana, Zimbabwe, Botswana, Uganda and Kenya.

UNICEF is also currently developing ideas for a package of school based interventions that have the scope for sustainable national adaptation. Currently this package has four components as follows:

- **School Policies**: the focus will be country specific but should include protecting children against physical/sexual abuse, protecting the rights of pregnant schoolgirls, protecting the rights of children who are disabled or are living with HIV/AIDS, and avoiding tobacco and substance abuse.
- **Skills-based health education/Life Skills Training**: ensuring school children get the skills as well as the information they need (for everything from preventing HIV/AIDS to contributing to civil society), in a way that fosters an interactive relationship between teachers and school children.
- **Water , Sanitation and Hygiene Promotion**: which should be linked to environmental issues and the hygiene component of health education. Schools could possibly act as a central point for community managed water programmes.

- **Specific medical/nutrition interventions**: there are a number of interventions that can be safely and simply implemented by teachers including the regular treatment of helminth infections, micronutrient supplementation (iron, vitamin A and iodine) and possibly, in selected areas, malaria treatment and tetracycline for the treatment of trachoma.

Four programme principles have been identified to support these four interventions:

- **Strengthening partnerships/linkages**: between schools and communities/ parents, between education and the health sector including water and environmental health and between teachers and health workers.
- **Capacity building**: supporting the work teachers are already doing rather than overwhelming them; this includes the provision of training and the production of materials.
- **Sustainability**: seeking long term programmes, although not necessarily independent of external support.
- **Children's participation**: programmes which respond to needs recognised by the beneficiaries, and involving them actively in implementation.

Many UNICEF country programmes are already supporting elements of the package outlined above. For example in Punjab Province, Pakistan, UNICEF supports the Government Education Department in an integrated water, sanitation and hygiene education project in primary schools (IWSHEP). The IWSHEP aims to increase access to water and sanitation facilities (through the provision of hand pumps and construction of latrines) in primary schools for girls; to promote hygiene practices and improved health among school-aged children and to strengthen the capacity of the Education Department by improving in-service teacher training which includes a hygiene-education component. Additional support is targeted at NGO elementary schools to promote personal hygiene awareness and environmental sanitation among primary school children. School children and teachers provide an effective channel for education and appropriate training materials have been developed. About 8000 teachers were trained under the project in 1994.

In Zimbabwe, UNICEF supports a LST/AIDS programme that is now under the Ministry of Education. In 1992 UNICEF gave US$350,000 for the hire of local staff and programme start-up after which a fundraising campaign with local donors led to the raising of US$4 million of supplementary funding for 2 years. The programme supports weekly (compulsory) lessons on life skills and HIV/AIDS in all schools for children from grade 4 (9-10 years of age). Teacher and student manuals are provided which are appropriate for the grade level, which address relationships, growing-up, life skills and health. Self-esteem and assertion are positively encouraged and concrete ways of responding to negative peer pressure are role-played at school. Children undertake community-based projects that explore drug use, coping with HIV/AIDS and responsibilities of husbands and wives.

Whilst many UNICEF country programmes are supporting school health initiatives, these have not yet been adequately tried and tested in order to be formalised within the organisation. It is anticipated that a select number of countries will be identified to pilot the package outlined above and explore the various programming implications before UNICEF formerly adopts the approach as a broad-based strategy. A body of people with expertise in key areas such as LST, water and sanitation (including hygiene promotion), helminth infection control, interactive health education (including HIV/AIDS) along with representatives of donors and key organisations could be brought together to co-ordinate and catalyse the process.

In addition to school based programmes, UNICEF are also considering the more difficult area of reaching children in crises, as well as street children and working children, who are often not attending schools and whose health and nutrition are often most compromised. Work is also underway to examine options for improving the nutritional status of adolescents.

WORLD HEALTH ORGANISATION (WHO)

In 1996, WHO launched the Global School Health Initiative (GSHI) which aims to increase the number of schools that can be called "health promoting" schools (HPS). A HPS is defined as a school that "constantly strengthens its capacity as a healthy setting for living, learning and working". Within WHO this initiative is coordinated by a multi-sectoral working group that incorporates expertise in mental health and LST, health and nutrition, physical environments etc. Some 22 WHO divisions are relevant to school health strategy, and 8 of these are represented in a coordinating group. WHO also collaborates with other UN organisations and with the World Bank. WHO is a cosponsor of PCD.

Four broad strategies have been identified to help schools become health promoting:

- Building capacity to advocate for improved school health programmes
- Mobilising resources for developing Health Promoting Schools
- Strengthening national capacities
- Research to improve school health programmes

This initiative emphasises the need to harness existing resources that exist at country, community and school level whilst also assisting governments to advocate for increased funds for HPS. The focus therefore is on influencing government policy through advocacy and the longer term sustainability of the initiative.

To date, a broad range of advocacy orientated activities have been implemented under the auspices of WHO. This includes the development of guidelines and action plans by task force members, training and workshop based activities and the production of key documents that provide an important entry point for the development of health promoting schools. Ten documents, earmarked for production, address important technical issues such as: the reduction of helminth infections: the prevention of violence: the dangers of tobacco use and the improvement of nutritional status. These documents are intended for use by governments and those concerned with advocating the allocation of greater resources for school health.

Although all seven WHO regional offices are actively involved in supporting this initiative, they are at various stages of development and employ different entry points to HPS depending on the regional location. The WHO European Region joined forces with the European Commission and the Council of Europe to create the European Network of HPS in 1992. Starting with four pilot countries in Central and Eastern Europe they have expanded to cover 37 countries by 1997.

The Western Pacific Region network is also reportedly well developed whilst in South East Asia the initiative is just starting up. In Africa, the initiative is receiving a great deal of interest. In South Africa for example, the HPS network is credited with bringing together the ministries of health and education to plan joint action.

In Fujian, China, for example, WHO have been supporting a project for de-worming since 1996 as an entry point to the development of HPS. A pilot study was undertaken to demonstrate the benefits of de-worming and health education.

In addition, the HPS project has become a trigger for activities that improved the physical environment through mobilising local government and community funds. These improvements included tree planting, extending the school buildings, increased numbers of toilets and taps for handwashing and other general environmental improvements.

WHO has also supported research on school based health services through the Task Force for Healthy School Children, within TDR/WHO. This Task Force, within which PCD was represented, undertook enabling research on school based health service delivery, and field tested the UNICEF-led inter-agency Situation Analysis in Africa.

The Division of Control of Tropical Disease (CTD) has conducted school based deworming activities in Zanzibar, Seychelles, Oman and Mauritius and has worked with World Bank projects

in West Africa (Guinea, Mauritania, Mali) to design school based health service delivery of anthelminthics. The Division is currently establishing a formal collaboration with the World Bank to support school based deworming projects.

Other sector work on school health is also underway. For example, a general survey of the role of the school environment on child health has been completed. An interagency evaluation of life skills training in schools is being planned.

Regional offices are also actively pursuing their own programmes in this area. For example, the Pan American Health Organisation has a well established network of health promoting schools in the Americas. Schools are also the basis of health delivery for the 'PEPIN' disease control initiative that is active in Nicaragua, El Salvador, Guatemala and Honduras, and is currently expanding to 12 other countries. In October 1997, the World Bank and PAHO launched a joint initiative to promote school health and nutrition programmes in the Americas.

FOOD AND AGRICULTURAL ORGANISATION (FAO)

FAO's approach towards school aged children's health is guided by the resolutions agreed at the International Conference on Nutrition in December 1992 and further reconfirmed at the World Food Summit in 1996.

FAO's current focus is on a school nutrition programme that involves the development of nutrition education materials for children aged between six and fourteen years. The design of these materials is based upon the findings of a survey of forty countries which revealed a great deal of need and interest at primary schools for nutrition related materials and for teacher training in the use of these materials. FAO are collaborating with the Netherlands Nutrition Centre and plan to pilot test the nutrition education materials in South Africa toward the end of 1998. Following this, they will adapt materials to country specific situations, and to the level of detail and involvement countries are ready to absorb. For example, some countries may wish to incorporate nutrition education into the education curriculum whilst others will want to use the materials in a less structured way.

Whilst FAO and WHO currently have no formal link with respect to HPS, FAO are supportive of the approach and are developing a dialogue with WHO to avoid duplication and to maximise resources. They are to a large extent following the principles of the WHO European HPS model in their current work on nutrition education and anticipate that the programme will run over a period of five to ten years. The operating budget for this work is approximately US$50,000 for 1998 (excluding the salary of one full time person).

WORLD FOOD PROGRAMME (WFP)

WFP is concerned with two main areas in relation to school health: school feeding programmes and a micronutrient and health programme.

WFP has a long-standing role in support of School Feeding Programmes (SFP) and supports around 60 programmes today. SFPs are increasingly targeted at poor countries and poor population groups within these countries: by the end of 1997 90% of WFP resources are to be directed at low-income food deficit countries. SFPs are justified on the basis that they contribute to improvements in school enrolment and attendance rates, improvements in children's capacity to concentrate and assimilate information by alleviating short-term hunger and because they reduce the prevalence of some micronutrient deficiencies through the provision of fortified foods (Vitamin A, iron and iodine).

Increasingly, school-based de-worming programmes (which follow the WHO technical guidelines) are being integrated into SFPs. Training of ministerial government staff, teachers and health staff at the peripheral level enables them to take responsibility for drug distribution.

WFP, in collaboration with WHO, has recently completed the production of a "Health and Nutrition Manual for School Feeding Programmes" and is in the process of completing a manual

for the use of school feeding programmes in rehabilitation and recovery. These guidelines are based on case studies of the health and education sectors in Mozambique and Angola.

WFP is also coordinating the Women's Health and Nutrition Facility (WHNF), a programme funded by CIDA. WHNF started in 1996 and is targeted at 15 low-income countries reaching over 900,000 women and 2.2 million children, including the school-aged child. Fortified foods, and specific micronutrients (depending on country needs) along with de-worming tablets are targeted to the most vulnerable in the population and at the most vulnerable stages in their life. For example, vitamin A is targeted at women during pregnancy. The programme, costing Canadian $ 30 million will be implemented over a 3-4 year period depending on the particular circumstances of the countries involved. Where possible, WFP aims to integrate the programme into their existing regular programmes for example Maternal and Child Health (MCH) and SFP and to work closely with other organisations (e.g. UNICEF) in the target countries.

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANISATION (UNESCO)

UNESCO was one of the first of the UN organisations to undertake sector work on school health and nutrition. During the late 1980's UNESCO hosted a series of technical meetings on this topic.

UNESCO has a number of roles in relation to school health. The global Programme of Education for the Prevention of AIDS has a focus on the integration of HIV/AIDS education into school-curricula. Putting in place large-scale national programmes that draw on the experiences from other projects and programmes forms the main aim of the programme. Information on activities, materials and documents already developed by innovative NGO projects are disseminated by UNESCO's resource centres. UNESCO also support seminars/training workshops for ministerial staff and teachers on HIV/AIDS, and is a co-sponsor of UNAIDS.

UNESCO also provides technical support for school health and nutrition programmes. In 1995 a study of six rural districts in Kenya was done in collaboration with the Kenyan Ministries of Education and Health, to examine the factors surrounding child health, nutrition and educational participation. The findings demonstrated high levels of morbidity (malaria, intestinal parasites) and poor nutritional status (17.8% suffer from severe undernutrition, 34.3% from mild-moderate growth retardation) among Kenyan school children; as well as delayed school entry and grade retardation and a poor school environment (e.g. lack of water and sanitation). The findings have informed UNESCO's current focus on realistic and feasible actions that can be implemented by the national, district, school and community levels to improve the health and nutrition of school children; for example, the involvement of teachers in the collection and use of available information at the school level. This includes the use of proxy indicators for child health such as the sanitary facilities, school water supplies and the nutritional status of pupils.

UNESCO provides technical support for WFP School Feeding Programmes. This includes assistance with the appraisal of new programmes, management reviews, the evaluation of existing SFPs and the development of manuals in relation to SFPs.

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

The mission of UNDP is to promote sustainable development. UNDP has a history of promotion of school based health and nutrition approaches. In 1992 it played a leadership role in creating the Partnership for Child Development to undertake operations research into the role of school health and nutrition in child development, and remains a cosponsor. UNDP is also a cosponsor of the Micronutrient Initiative.

UNDP has supported pilot school health and nutrition programmes in Colombia, Ghana, Tanzania, India, Indonesia and Vietnam, and contributed to programmes in some 14 countries. An innovative programme to facilitate the creation of local NGOs in school health and nutrition is being piloted in Africa.

UNDP is currently commissioning sector work on development, including an analysis of the role of school-based health and nutrition in child development. This work is being undertaken collaboratively with WHO, and with technical input from PCD.

UNITED NATIONS POPULATION FUND (UNFPA)

UNFPA, along with most of the UN organisations, is increasing the number and scope of health programmes for youth and adolescents. In recognition of the need to strengthen the impetus and direction of actions for adolescent health, WHO, UNFPA and UNICEF jointly convened a Study Group on Programming for Adolescent Health in 1995. This resulted in a number of guidelines for policy direction at the country, regional and global level.

Currently, UNFPA support adolescent reproductive health programmes (adolescent defined as persons aged 10-19 years) in approximately 100 countries. These include educational programmes (In-school education programmes can cover population education, family life education, sexuality education, "life-planning" and parent education); information and communication programmes (in-school production of Information, Education and Communication - IEC - materials) and health services programmes.

UNFPA also supports HIV/AIDS prevention activities for youth and adolescents in approximately 95 countries within the global strategy of the Joint United Nations Programme on HIV/AIDS (UNAIDS) which became operational in 1996. The main focus of UNFPA's activities is at the country level where the AIDS prevention activities are integrated into ongoing programmes and projects in reproductive health. Collaboration with NGOs in undertaking HIV/AIDS prevention activities is an integral part of most country programmes.

UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

This programme was launched in 1996 and seeks to coordinate global - especially UN - strategy on HIV/AIDS prevention, research and advocacy. Co-sponsors include WHO, UNFPA, UNDP, UNESCO, UNICEF and the World Bank. There has been a specific focus on school-based activities, and one of the inter-agency working groups deals only with this topic. The major aim is to promote life skills and IEC programmes through schools.

UNAIDS also acts as an information resource and can provide access to evaluated materials for use in schools.

INTERNATIONAL ATOMIC ENERGY AGENCY (IAEA)

The IAEA has a mandate to enlarge the contribution of atomic energy to health (and peace and prosperity) throughout the world. Specifically, IAEA supports a Human Health Programme, which includes a nutrition and health-related environmental studies sub-programme. Projects supported under this sub-programme include "applied human nutrition assessment and research using nuclear and isotopic techniques" which aims to demonstrate the practical use of nuclear and isotopic techniques as tools for improving nutrition monitoring and for identifying effective food and nutrition strategies in developing countries. During 1997, the IAEA supported co-ordinated research in 33 developing countries and technical co-operation in 9 countries.

In Peru, the IAEA has been working with the Government on a Model Project which provides food supplements through a daily breakfast to over 500,000 school children over a four year period in six regions of the country. Nuclear techniques are being used to evaluate the programme impact on nutritional status of the school children. The IAEA is also considering supporting similar school based programmes in Latin America and Asia as part of their growing interest in monitoring and evaluating nutrition programmes.

Section II: Multilateral Finance Agencies

THE WORLD BANK

The World Bank is now giving greater emphasis to social sector approaches which are child-centered, which target poverty and which are responsive to client country needs. School based health and nutrition programmes contribute to this new approach, and are endorsed in the Health, Nutrition and Population Sector Strategy and are in the current draft of the Education Sector Strategy (scheduled for completion in late 1998). Africa Region has a School Health and Nutrition Affinity Group and an articulated strategy. Latin America and the Caribbean Region also has a strategy paper, and has launched a joint initiative with the Pan American Health Organisation to undertake operations and sector work in the Region.

The World Bank is seeking to coordinate information on school health and nutrition approaches through an International School Health Initiative based in the Human Development Network. This seeks to enhance the quality of school health and nutrition programmes by:

- Providing access to expert advice, particularly in and from client countries.
- Providing a clearing house for examples of good practice.
- Developing practical toolkits for implementation, based on actual experience.
- Making quality information available through the Internet, the World Bank intranet and the World Bank Advisory Services.
- Building partnerships with governments and international agencies, institutions and NGOs.
- Assisting task teams to prepare school health components for World Bank projects.

The World Bank has established collaborations in order to promote quality technical input into programme design. The Bank has a formal partnership with PAHO in Latin American Countries (LAC), and is in dialogue with WHO on technical support for Africa. Within the UN system, partnerships are being developed with UNICEF, UNAIDS and WFP, amongst others. Partnerships are also being created with bilaterals. For example, USAID are co-sponsors of the International School Health Initiative, and DFID, UK, are co-sponsors of sector work on the out of school child. The Bank is also developing partnerships with NGOs, for example Save the Children Federation, USA, and is a co-sponsor of the Partnership for Child Development and the Micronutrient Initiative.

The rationale for World Bank interest in school health and nutrition programmes includes the following issues:

- There are more school-age children, and more in school, than ever before.
- School children are neglected by most health systems.
- Freedom from disease promotes intellectual as well as physical development.
- Healthy children get maximum benefit from their only opportunity for education.
- The benefits are greatest for the most disadvantaged - the girl child, the malnourished and the poor.
- The combination of an accessible population and an extensive trained workforce of teachers keep financial costs to a minimum.
- Builds on the investment in early child development, and builds the basics for appropriate social behaviour in adolescence.

Experiences of good practice suggest that, in terms of World Bank Human Development strategy, school-based health and nutrition programmes should be simple and locally relevant, and should not overload already overstretched teachers or the curriculum. The following items might usefully contribute to such programmes:

- Life Skills Training and IEC - as part of a strategy to promote healthy lifestyles, and avoid violence, substance abuse, HIV/AIDS and teenage pregnancy.
- Health Services - as part of the Primary Health Care system, and providing screening for sight and hearing, simple health interventions (deworming, first aid) and referral.
- School Snacks - which are fortified with micronutrients and provided early in the school day.
- Exemplary School Environment - which supports health education messages about hygiene and sanitation.
- Equitable School Health Policies - that ensure the rights of school children.
- Strategies Beyond the School - that use the school as a community centre to provide services to out of school children.

A Knowledge Management Site has been established on the intranet to assist World Bank task teams to prepare school health and nutrition components for client governments. As part of the International School Health Initiative this site is being transferred to the external internet, where it will be supported by a mail list for exchange of information amongst co-sponsors and subscribers.

The activities described above are intended to build and promote partnerships with technical agencies and to ensure the quality of technical advice to client governments. Bank operations in school health and nutrition involve the inclusion of this component within government projects or sector-wide approaches supported by Bank credit. Examples of operations include:

- SHN as part of **Education** projects that seeks to enhance participation in education. The overall project will enhance access by traditional means (build schools, train teachers, provide textbooks) but will also promote participation and learning through better health and nutrition, not least because EFA aims to reach the poorest children. Projects of this type (Guinea, Dominican Republic, El Salvador) range from US$ 34 to 57 million, of which some 4% to 9% is allocated to school heath and nutrition.
- SHN as part of **Nutrition and Health** projects that seeks to improve growth and nutritional status. The US$ 34 million Community Nutrition Project in Madagascar allocates 17% to school-based snacks, micronutrient supplements and deworming.
- SHN as an identified use for **Community funds**. These represent an increasingly important lending instrument since they place the decision-making within the community. A central government agency is provided with finance which is released to local communities on the basis of specific requests made from a menu of options which typically might include school construction and bore-hole provision, and which increasingly now include support for school health and nutrition programming. Funds for SHN have been activated in Panama, the Philippines and Tanzania, but have yet to be evaluated.
- SHN as a component of **Sector Wide Approaches** (SWAP). A SWAP involves a partnership of donors which works with the government to support activities in an integrated fashion across a whole sector, rather than as separate projects. This new approach has obvious benefits but has proved slow to implement. SHN has been identified in SWAP assistance strategies (for example by Malawi, Ethiopia and Kenya) and is being developed jointly by USAID and the World Bank as a component of the Zambia SWAP.

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- SHN as a **Learning and Innovation Loan** (LIL). These new lending instruments are intended to allow governments to explore new approaches and strategies by providing modest (<US$ 5 million) support through a fast track system. A LIL is being appraised with Colombia to support youth development in the community and schools.

Many of these operations are implemented with UN agencies (for example, UNICEF, UNDP, WFP, WHO) and INGOs (for example, Save the Children, CARE) at the country level. The World Bank has also supported the development of local inter-sectoral capacity to implement SHN programmes (for example, in Malawi) by grants from the International Development Fund.

INTER-AMERICAN DEVELOPMENT BANK (IADB)

IADB has an established record in supporting school-based health and nutrition projects.

- In El Salvador the "Basic Education Modernisation" project aims to promote greater equity, quality and efficiency in the provision of education services. The components include activities to develop a school health and nutrition programme targeted to the El Salvador's poorest 135 municipalities. The total resources allocated are US $1.5 million.
- In Dominican Republic the project "Basic Education Improvement Programme, Stage 11" aims to increase the equity, efficiency and sustainability of pre-school and basic education for Dominican children. An integral part of the project entails the support provided by the Secretariat of Education, Arts and Culture (SEEBAC) to design deliver and co-ordinate expanded school nutrition programmes. Resources for this component are US$3.5 million.
- In Mexico, the "Integrated Compensatory Education Programme" has a number of aims which include increasing access to education among poor children, providing child-rearing education to illiterate/uneducated parents, literacy training for adults and education in remote areas without schools. Specifically, parents are trained to recognise the imperative of good nutrition in fostering healthy growth and development. They are also taught how to improve nutrition and developmental activities.
- In Jamaica, the "Primary Education Improvement Programme II" supports research into the link between cognition and nutrition to enable the Ministry of Education to plan the timing and distribution of its nutri-bun programme.

Section III: Bilateral Organisations

CANADIAN INTERNATIONAL DEVELOPMENT AGENCY (CIDA)

CIDA is a lead donor in the area of nutrition programming. Since 1992, CIDA has contributed over $87 million to nutrition projects of which $78 million have been focused on micronutrients. An additional $120 million has been contributed to integrated projects which combine nutrition with health, basic education and income generation activities. CIDA is a founding member of the Micronutrient Initiative (MI) which has a grant of approximately $53 million and is supported by IDRC, UNDP, UNICEF, USAID and the World Bank. Examples of CIDA programmes that affect the school-aged child include:

- Funding to WFP for school feeding/health programmes and through the Women's Health Facility (see section on WFP for more details).
- The MI South Asia Programme which aims to eliminate iodine and vitamin A deficiency and reduce iron deficiency in women (includes school children) in Bangladesh, India, Nepal and Pakistan by the year 2000.
- The Ecuador Iodine Deficiency Disorder (IDD) Programme which has implemented a school-based IDD monitoring system where school children bring samples of salt to school to test for iodine in class using low-cost rapid tests.
- A School Feeding Programme in Haiti implemented by a French-Canadian NGO costing $1.6 million which started in 1998.
- CIDA has supported UNICEF in its African Programme for Girl Child Education which is now in its second phase. This involves HIV/Life skills curriculum development in Zambia and Zimbabwe and hygiene and bilharzia education through curriculum development in Egypt.

DANISH INTERNATIONAL DEVELOPMENT ASSISTANCE (DANIDA)

DANIDA do not have a defined strategy for support towards school based health programmes although they are supporting other agencies through their bilateral programme. For example funding to UNICEF in Uganda for school based health education activities.

Members of the education and health sector in DANIDA have discussed the need for school-based health and nutrition programming on a number of occasions but constraints on time and finances have prevented them from taking this further.

Although DANIDA's water and sanitation strategy, "Water, Sanitation and Hygiene (WASH)" does not refer to schoolchildren directly, DANIDA supports the provision of water supplies to primary schools within their rural water supplies programmes in developing countries. The health education component of their water strategy, which incorporates messages about hygiene behaviour and water-related diseases also, targets primary schools.

A typical example of the DANIDA approach is in Burkina Faso where they are working with 110 urban and rural primary schools in the south-east of the country (population covered approximately 400,000) to improve water supplies, construct latrines and provide teaching materials about hygiene education to the teachers and students. In this programme, each school must have an active parent-teachers association (PTA) to purchase low-cost hand pumps, open bank accounts for maintenance costs and for the purchase of ventilated improved pit latrines. The health education activities involve teacher training in the use of hygiene education materials that are prepared by a local NGO and includes the use of videos that show local defecation practices as part of the

training. DANIDA are intending to expand to a new project in the north west of the country to cover 83 schools over two provinces. They support in similar programmes in Ghana and Benin.

See also "Child to Child" in Kenya.

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT, U.K. (DFID)

DFID do not have a current policy which refers specifically to the school aged child although they do support a range of projects and programmes which directly benefit this group. Examples of these are outlined below:

Support to SCF in South America for an HIV/AIDS programme which works with adolescents within schools and a programme that supports professionals (school teachers, health workers) in detecting and providing follow-up to individual cases of child abuse.

In Bolivia, a reproductive health project for adolescents which includes curriculum development, development of teacher training materials and teacher training systems targeted at 13 year olds. Also in Bolivia, DFID support a project that aims to improve the living conditions of school children through health education as an integral part of the school curriculum. An example of this is a project to increase awareness about Chagas disease using health education in schools as well as radio broadcasts.

In India, DFID have been supporting a large programme in Andhra Pradesh aimed at improving the health of school children by reorganising and strengthening existing school health services. The programme, costing more than UKPDS 4 million over a five-year period has recently been terminated for diverse reasons. Also in India DFID provides funding for the School Health Action and training Programme (SeHAT) Programme and its expansion into Delhi centre (see Child to Child and AHRTAG).

In Iraq, the rehabilitation of school facilities, water and sanitation systems and the procurement and distribution of educational materials in order to prevent the spread of communicable diseases in the schools.

In Kenya, HIV/AIDS prevention for the 7 – 14 year age group and a project that supports low-cost rainwater catchment tanks for 800 schools in 8 districts with an estimated coverage of 300,000 children.

In Mozambique, DFID supports SCF to promote the integration of disabled school children into mainstream school.

In Peru, support is given to the work of the United Nations Drug Control Programme (UNCDP) on drug abuse prevention through primary education curriculum development and teacher training

DFID also support many countries HIV/AIDS Control Programmes that target school-aged children.

DEUTSCHE GESELLSCHAFT FUR TECHNISCHE ZUSAMMENARBEIT (GTZ)

GTZ, through a Multi-Sectoral Planning Group (MPG) have recently developed a Youth in Development Cooperation concept paper (1997) which outlines their thinking on youth (defined as 12 to 18 years) as a distinct target group for development co-operation. The paper points to the growing realisation among the donor community that the needs of children and youth have been inadequately addressed and highlights the potential for increased programming in this area.

GTZ conducted an evaluation of Deutsche Gesellschaft fur Technishe Zusammenarbeit (GTZ TC) projects in the child and youth sectors which provided important input and 'lessons learnt' for the concept paper. The evaluation revealed that they currently implement youth-specific projects as well as cross-sectoral approaches which include life-skills-oriented education, youth health and nutrition, and rural youth in agriculture and community development. A relatively large number of

projects dealing with youth are in Africa. GTZ projects include various approaches to LST (for youth in and out of school), health education and HIV/AIDS education.

NORWEGIAN AGENCY FOR DEVELOPMENT CO-OPERATION (NORAD)

NORAD does not have a particular policy focus for school-aged children but does support the education sector in basic education. NORAD are, however, currently supporting a School Nutrition Programme (SNP) in Sindh, Pakistan which is implemented with co-operation from the Government of Sindh and Aga Khan University along with NGOs.

The SNP is a pilot programme that supports school feeding in schools in four rural districts. Initiated in 1994 the programme reaches around 12,000 beneficiaries and supports the following objectives:

- Increase enrolment, retention and regular attendance of children in school
- Improve the nutritional status of primary school children and their siblings
- Improve student achievement
- Increase parental and community awareness of the importance of child nutrition and education
- Explore possibilities for community involvement at the school level in improving education and nutrition
- Explore the possibilities for implementing SNP through NGOs.

The SNP supports participatory training for PTAs and NGOs to enable them to take increasing responsibility for the programme and thus ensure its long-term sustainability. PTAs are responsible for dealing with the funds, food purchasing and in some areas, food preparation. The formation and commitment of the PTAs is viewed as a particular strength of the programme.

The SNP is being expanded into additional districts and is being considered as an approach for replication in Nepal.

The impact of the SNP has recently been evaluated (report not yet available) which suggests that whilst the nutritional status of children has improved along with the school enrolment and retention rates, there has also been a decline in educational achievement. The latter may be due to the programme demands on parents and children time.

SWEDISH INTERNATIONAL DEVELOPMENT AGENCY (SIDA)

SIDA has no special policy with respect to the health and nutrition of the school aged child but supports basic education and education reform.

Within their education reform programme, SIDA supports, and intend to increase their support for, curriculum development work relating to HIV/AIDS education such as the production of materials, teacher training and the use of popular theatre media etc to reduce risk behaviour. They consider school-based programmes to be most effective if integrated with other curriculum content i.e. health education, social science and biology.

They are working closely with governments as well as international organisations (UNAIDS and UNICEF) and NGOs. They also support UNESCO's resource centre for HIV/AIDS education and UNESCO's regional training programme for HIV/AIDS education.

SIDA and NORAD are co-funding an African Medical Research Foundation (AMREF) project "Regional Adolescent Sexual and Reproductive Health (ASHR) Project" with components in Kenya, Tanzania, Uganda and Ethiopia. The project aims to "achieve an improved and maintained health status of adolescents in the region through healthy sexual relations and behaviour, reduced exposure to STD/HIV, unwanted pregnancy and increased access to effective services". Youth

both in and out of school are targeted as well as service providers, teachers, parents and community elders.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

USAID's Africa Bureau (Office of Sustainable Development/Education) has formulated a school health position paper that emphasises the same program elements and rationale as that of the World Bank (see page 14). USAID's position paper particularly emphasises that school health activities should support education systems reform, and it emphasises community mobilisation for support of pupil nutrition and community cost-sharing for school-based health interventions. These emphases aim to maximise community impact of health interventions and education, and program sustainability. USAID's Africa Bureau is also a co-sponsor of the International School Health Initiative based at the World Bank.

USAID support large school-based health programs that deliver health interventions such as deworming and micronutrient supplementation across Africa. Many of these programs are in various stages of evaluation. USAID also support smaller school health activities such as latrine construction, community based nutrition grants, school gardens and borehole drilling within USAID and UNICEF sponsored programmes in Africa.

Examples of these programmes in Africa include:

- In Benin, as part of its education reform activities, USAID helped establish a local NGO to work with parents who were asking for sanitation facilities on school grounds for their children. Lack of gender-segregated sanitation was cited as a major barrier to girls attending school. The NGO also delivers health and sanitation education to schools and communities. The NGO is participating in dialogue with the Ministries of Health and Education on formulation of a national school health policy, and the NGO hopes to begin delivery of deworming and micronutrient services in its target schools within a year or two.
- In Ethiopia, USAID's Basic Education System Overhaul program worked with USAID's local child survival program to integrate key community health messages into the new elementary school curriculum. The two USAID programs also have coordinated their community mobilisation activities so that school and health topics are integrated at every opportunity.
- In Uganda, community mobilisation activities of the USAID-sponsored primary education reform incorporated messages to support student health and nutrition. One result of community education efforts has been that children in many parts of Uganda now take food for a mid-day meal to school. Prior to the mobilisation most children in Uganda did not eat during the school day. This intervention has made a substantial contribution to the improved quality of children's classroom experience.
- In Zambia, the Basic Education Sector Investment Program includes a school health component. USAID/Zambia will sponsor several aspects of education systems reform within the sector investment program, including the school health component. The USAID school health intervention will pilot deworming and micronutrients delivery to improve student nutrition and reduce iron deficient anaemia. It also intends to document the benefits for improvement of cognitive capacity and learning outcomes.
- USAID also sponsors Life Skills Training in several African vocational training programs, including Zambia and South Africa. These programs emphasise reproductive health and HIV education.
- USAID/Africa Bureau also supports The Early Childhood and Readiness for Schooling Working Group of the Association for the Development of Education in

Africa (ADEA) (based in Paris). This working group will have a focus on, among other issues, school health interventions.

The Latin America section of USAID is also developing a policy document that will address education and health along the lines of the Africa section document. USAID Latin America is also currently involved in three related areas:

- The development of a plan of action to be signed by the Ministers of Education from 25 countries to work in health and education. This is seen as significant development and provides a mandate for a substantial area of involvement for USAID with the respective countries.
- In Jamaica, USAID supports a pilot project which aims to provide a holistic approach to the problems facing around 100 schools which are located in poor areas of the country. Approximately 15% of the resources for the pilot will be earmarked for health and nutrition activities such as micronutrient supplementation and de-worming. In addition, the programme will tackle the specific problems faced by boys in Jamaica who face disadvantage in educational terms, reflected in very poor results in basic education compared to girls from the same background and even the same families.
- USAID support the World Bank and IADB's education reform in Bolivia through the provision of food aid for school feeding programmes. The aim is to assist with the expansion of quality of education and encourage and retain school children at school.

Section IV: Non-Governmental Organisations (NGOs), research groups and institutions.

APPROPRIATE HEALTH RESOURCES AND TECHNOLOGIES ACTION GROUP (AHRTAG)

AHRTAG is supporting the Indian Government to implement one large programme in India that focuses on primary schools in Delhi and Bombay called the School Health Action and Training Project (SeHAT). This forms part of a major programme in India the "Education for All by 2000 AD" which aims to tackle low enrolment, retention and achievement levels among school children and receives funding from UNICEF.

Initially AHRTAG and the School Health Services in Delhi ran a pilot programme in selected low-income schools for four years, developing methods and materials for incorporating health topics into the curriculum. These include communicable diseases, sanitation, nutrition and personal cleanliness as well as other health-related behaviour including tobacco, safety and pollution. Government policy informs the programme approach: a re-orientation of teaching methodology away from traditional didactic techniques and towards child-centred, activity based teaching that fosters informed choice and a teacher–led, curriculum oriented approach to health education in schools.

Evaluation of the pilot found that there had been a marked increase in awareness of health issues, up-take of programme issues such as self-care, improvements in oral hygiene and a marked involvement by teachers and parents in the programme. SeHAT is well monitored and most recently evaluated in 1997 (report not yet available).

Currently the programme covers 450 primary schools and aims to expand to cover additional 700 schools in the next phase. DFID and UNICEF through Education For All (EFA) have provided funding. Lottery funding is being applied for to support the next phase.

CARE

CARE supports a range of school health and nutrition projects through its education and health programmes. Examples of these are provided below:

- In Thailand, the Children's Health and Environment magazine Project produces and distributes a cartoon-format children's magazine that teaches primary school children about health and environmental issues. Each edition is distributed to 31,000 schools countrywide and is read by over 1 million students. The project also provides a teacher's guide and seeks to inform and motivate students so that they can positively influence environmental practices and community health.
- In Kenya, CARE supports health education in schools using Child to Child approaches and school based water and sanitation clubs.
- In Laos, CARE supports a school nutrition project which involves community based activities for all the primary schools in 22 villages (planting fruit trees and establishing vegetable gardens, fisheries and poultry farming).
- In Zambia, they support peri-urban schools for children who are HIV/AIDS orphans.

CATHOLIC FUND FOR OVERSEAS DEVELOPMENT (CAFOD)

CAFOD's current guidelines are not to support formal education. Recently, however, they are reconsidering their policy on this as Asian and African governments are increasingly requesting

assistance in the education sector (including health and nutrition). This has prompted an analysis of the issues in CAFOD who are currently developing a database of existing education-based programmes.

CAFOD support a range of small programmes in Africa and Asia (usually through partners) that affect the school age child but are not school-based. Examples include support for orphans of AIDS victims through the provision of school fees and education materials; youth programmes which include health components, for example HIV/AIDS education and life skills training.

CARIBBEAN FOOD & NUTRITION INSTITUTE (CFNI)

CFNI have supported two studies relating to school aged children: Nutrition Education and the Consumption of Fruits and Vegetables in School Children and After School Physical Activity Programme and Academic Performance and Fitness Levels of Jamaican Adolescents.

The purpose of the first study was to determine the effect of a school-based nutrition education programme designed for the English-speaking Caribbean region, "Project Lifestyle: Eating Right", on consumption of fruits and vegetables and nutrition knowledge of secondary school students in Jamaica. Two 9th grade classes were assigned to the treatment group and two to the control group. A food frequency questionnaire and a nutrition knowledge test were administered to all students before and after the intervention. The results indicate that the experimental group significantly increased their intake of fruits and vegetables and showed a significant increase in nutrition knowledge compared to the control group.

The purpose of the second study was to determine the effects of an after-school fitness-oriented exercise programme on the academic performance and fitness level of students in an urban secondary school. Three 9th grade classes were assigned to the experimental group and three to the control group. Over a one-year period, students underwent a battery of physical fitness tests and academic tests before and after the intervention. The results indicate that the experimental group did not exhibit a significant improvement in either fitness or academic performance. Physical strength, however, proved to be an important predictor of academic performance in two out of the three academic tests. Results also indicated that students as a whole spent much of their non-school time watching television, chatting with friends and other sedentary activities.

CATHOLIC RELIEF SERVICES (CRS)

CRS currently implement or support education activities in ten countries in Africa, Asia, Latin America and Eastern Europe. The four biggest of these are in Ghana, Burkina Faso, India and Haiti. These are funded primarily by USAID and incorporate health, hygiene and nutrition (HHN) school based activities. In Vietnam, CRS also support Child to Child (CtC) school based activities.

CRS collaborate with a number of donors; the World Bank provide Vitamin A and anthelminthics for Burkina Faso; UNICEF supply Vitamin A in Haiti and the International Red Cross provide first aid kits and some training in Haiti.

In Haiti, CRS support an expanded school-feeding programme (PROSEF) which is a five-year programme (1996-2000) which reaches 150,000 children in 450 primary schools and covers the Southern Peninsula of the country. School canteens provide 1,000 calories per day per child through the provision of a mid-morning meal. This aims to increase attention span, through the alleviation of short-term hunger, and to help increase school retention rates. The HHN element of the programme includes quarterly distribution of vitamin A; a six monthly anthelminthics; and extra-curricula health education activities. First aid kits are also supplied and teaching staff are trained in their use. As far as possible the programme works through parent teacher associations. The programme receives PL40 Title II food aid from USAID and approximately US$50,000 per annum.

Other NGOs are implementing school-based programmes using the same model as the CRS programme through a tripartite agreement with USAID. In effect the programme covers all 2000 primary schools in Haiti. UNICEF is also supporting smaller and more health focussed school based programmes in Haiti, and WFP are supporting a school feeding programme.

CHILD-TO-CHILD (CTC)

CtC support child centred approaches to health education through the production of materials, project planning, implementation and evaluation and through information management and dissemination. More recently, the focus has included work with children in crises (refugees, street children, the war affected and those in extreme poverty) and improving health promotion in schools.

The school based approach is undertaken in-line with the WHO Global Initiative and emphasises what poorer schools can realistically do to improve the health of school children within the framework of existing resources and without the exploitation of children or the over-burdening of the teachers.

CtC has run short courses called Planning Health Promotion in Schools and have published a book, Health Promotion in Our Schools, which is a practical guide for those who wish to develop 'Health Action' schools.

In Pakistan, a five year pilot project entitled Health Action Schools Pilot Project has been initiated (from April 1997) to develop prototypes for 'Health Action' schools and is funded by the Aga Khan Foundation and SCF UK. The project, which is located in contrasting socio-economic areas (urban, rural and mixed urban/rural) supports the development of training and support networks for schools endeavouring to become 'Health Action' schools and has an operational research component to identify changes in health awareness, health behaviour and education performance among the school children.

In Kenya, a CtC project is currently being implemented through which it is hoped that major policy changes will occur, especially the inclusion of health education as a separate curriculum subject in primary education. The programme, based on a three-year plan supports the dissemination of CtC; training for those working for 'Health Action' schools, production of materials, and teacher training in CtC. Funding is provided by DANIDA.

CHRISTIAN AID (CA)

CA projects fall into three main categories in relation to school-age children and health:

- Educating children on health issues through the existing school system. An example of this support is the 'Molo Songololo' project in South Africa which works with school-age children on children's rights and the promotion of equity among all races to promote a more equal society. Molo publish a magazine that is read by more than 50,000 children and teachers. Also in South Africa, CA supports the African and Educational Puppetry Production (AREPP) which focuses on HIV/AIDS awareness, children's empowerment which tackles issues around child abuse. These productions are performed throughout SA in urban and rural schools.

  In Jamaica, CA support an AIDS awareness project, which support school-based workshops and work with youth groups. In Kenya, CA support the Kenya Tourism Concern project which works in schools to sensitise children on the issues relating to tourism and child prostitution.

- Establishing alternative education establishments where health education forms part of the curriculum. CA works in situations where the school system is inadequate (e.g. because of political unrest, government cuts etc.) and therefore supports community efforts to provide education and LST to children who would otherwise not receive any

education. An example of this is the S-Corner project in Jamaica that involved the establishment of a college in a very poor area of Kingston experiencing gang violence and a high dropout rate from schooling. The educational programme includes health education and LST.

- Community-based work which addresses both children's education and health as part of an overall community development strategy. CA support a range of community based projects that assist children who are forced to work in the day to obtain night-time schooling (e.g. in India and Tibet) and therefore help them break away from the destructive poverty cycle which often leads to child-labour.

DANISH BILHARZIASIS LABORATORY (DBL)

DBL is an independent research institution affiliated to the Ministry of Foreign Affairs/ DANIDA, Denmark, and the University of Copenhagen. The core funding is from DANIDA, but a substantial part of the research is externally funded. DBL has the double aim of strengthening research capacity and carrying out applied research, through extensive course activities and collaborative research projects.

DBL main activities take place in a number of sub-Saharan African countries with the main emphasis on Uganda, Kenya, Tanzania, Zimbabwe and Ghana. The focus is on control of water-related, vector-borne diseases (e.g. malaria, schistosomiasis, filariasis, Guinea worm), but DBL is also involved in broader, interdisciplinary public health initiatives, comprising studies of deworming strategies, nutrition, health education, educational psychology and anthropology.

In terms of school health, DBL is deeply involved in school based research projects in Kenya (Kenya-Danish Health Research Project - KEDAHR) and Tanzania (The Pangani Project). The various projects are primarily research projects which aim at improving and developing school health programmes rather than providing services as such. Furthermore, DBL is, or has been, involved in school health projects in Malawi, Northern Tanzania, Eastern Uganda and the Coastal Province of Kenya.

PARTNERSHIP FOR CHILD DEVELOPMENT (PCD)

The Partnership for Child Development is an international initiative to improve the health and education of school-aged children by means of school-based services and research. The Partnership has programmes and activities in Ghana, Tanzania, Indonesia, Viet Nam, India and Colombia and contributes to the development of school health programmes in some 14 countries. Support for the work of the Partnership comes from the United Nations Development Programme, the Rockefeller Foundation, the Edna McConnell Clark Foundation, the James S. McDonnell Foundation, the World Bank, UNICEF, the World Health Organisation, the British Department for International Development and the Wellcome Trust.

PLAN INTERNATIONAL (PLAN)

PLAN has five main inter-related "Domain and Programme Principles"; Growing up Healthy, Learning, Habitat, Livelihood and Building Relations. Ninety per-cent of PLAN funding is from individual child sponsorship which supports an annual budget of around US$300 million. Programmes are being implemented in around forty low income countries.

Within the five principle areas, PLAN supports the following school health programmes:

- Broad based CtC and Child-to-Adult projects targeted at large numbers of school children and their teachers.
- The production of health materials for distribution at schools (for example on the prevention and treatment of malaria, hygiene behaviour), awareness campaigns for

teachers, students, health workers and villagers on STD's and HIV/AIDS transmission.

- LST strategies for children in formal and non-formal education.

SAVE THE CHILDREN FEDERATION, USA (SCF USA)

SCF USA has made the policy decision to establish school health and nutrition as a programming priority. It supports a range of school based health programmes which have in more recent years incorporated micronutrient supplementation and helminth infection control as well as child-centred curriculum development.

SCF USA has mobilised private resources to enhance agency capacity and initiate (Malawi) and plan (Mozambique and Mali) pilot programs to serve as models for school-based health and nutrition activities which can be shared with other countries, donors and interested parties to learn from, share ideas etc. They have successfully used this "living university" approach to expand their nutrition programmes from small pilots to countrywide to-scale programmes. This approach should provide them with a more systematised and structured programme that should be more open to evaluation. In addition, at their headquarters, SCF USA have inter-sectoralised school health allowing health and education staff to collaborate jointly on these programmes, an approach which needs to be mirrored at county level to maximise available resources. Workshops are planned to disseminate state-of-the-art thinking and materials and to develop plans for more focused school health initiatives in other SCF-assisted countries. SCF actively seeks to mobilise additional private and public sector resources to support this global initiative.

SCF USA has school based health programmes in the following countries: Bangladesh, Bolivia, El Salvador, Egypt, Ethiopia, Haiti, Malawi, Mali, Nepal, Nicaragua, Philippines, Sudan, Thailand, Vietnam and West Bank/Gaza.

The programmes cover a wide range of health and education promoting activities for both primary and secondary school age children including curriculum development in health, hygiene and nutrition education, de-worming and improvements to water supplies and sanitation and school lunches and micronutrient supplementation. Not all programmes include all these activities for example, in Ethiopia the focus is mainly on school rehabilitation and urban school latrines whereas in Bangladesh and Malawi the programmes are more extensive.

SAVE THE CHILDREN FUND, UK (SCF, UK)

SCF UK's health sector policy document (draft 7, January 1988), whilst not dealing specifically with the school-aged child, states that "the health services of most countries have focused on very young children whilst the health needs, roles and resources of adolescents have not received adequate attention".

A recent audit of SCF UK's health programmes, shows a number of school-age child related activities. In Nepal, SCF is supporting government schools with health education (using the CtC approach) and with first aid training for teachers. In India, SCF UK is supporting the provision of health care for school children <14 years with hearing difficulties. In Latin America (Honduras) support is given for health education targeting street children and in Peru, health education (inc. HIV/AIDS) at youth centres. In Jamaica support is provided for health education in a marginalised youth programme and in Brazil, SCF UK is funding an AIDS awareness pilot group to get health/AIDS/sex education into school systems.

WATER AID

Water Aid is supporting a joint venture with two small NGOs (SCOPE and CARD) in a School Health and Hygiene Education Programme. A book of guidelines for health educators has been produced which focuses on educating school children on a range of key hygiene messages. Water

Aid programmes in Tanzania, Southern India and Nepal support school based health education although this is a relatively new area for the organisation. In Uganda, Water Aid is exploring methods of working with school age children to promote hygiene but in those who do not attend school.

WORLD VISION CANADA (WVC)

WVC has a Micronutrient and Health (MICAH) Programme currently being implemented in five African countries: Ethiopia, Ghana, Malawi, Senegal and Tanzania. The budget for this is $25 million for phase 1 (1995-99) which is Canadian International Development Agency (CIDA) funded. Whilst school-aged children are not the primary target of MICAH, they are targeted through the programme activities which include health/nutrition education, Vitamin A and iron supplementation, food based activities such as school gardens and water and sanitation improvements at the school level.

The MICAH Programme works closely with the Ministry of Health on a national level, UNICEF and a range of NGO's particularly in Malawi and Ethiopia with whom programme costs are shared. Currently no data are available on community or government contributions. In Ethiopia and Ghana the programme is countrywide, and in the other three countries reaches 200,000 to 500,000 people. There are plans to extend the MICAH Programme to phase 2 and to expand to Asia.

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- **School Health & Nutrition: A Situation Analysis - A Participatory Approach to Building Programmes that Promote Health, Nutrition and Learning in Schools. 1999.**
- **School Based Health and Nutrition Programmes: Findings from a survey of donor and agency support. Carmel Dolan, 1998.**
- **School Feeding Programmes: Improving effectiveness and increasing the benefit to education. A guide for programme managers. The Partnership for Child Development, Joy Del Rosso, consultant, 1999.**
- **WHO information Series on School Health (3 documents currently available)**

School Health & Nutrition: A Situation Analysis - **A Participatory Approach to Building Programmes that Promote Health, Nutrition and Learning in Schools**

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About this document

This document has been developed by The Partnership for Child Development in collaboration with other agencies, including UNICEF, The Edna McConnell Clark Foundation, WHO, USAID, PAHO and The World Bank. It has been field tested in five countries in Africa. The goal of the situation analysis described in this document is to guide the design and evaluation of school-based health and nutrition programmes. A situation analysis can be detailed and comprehensive, but the most appropriate initial approach is usually a low-cost, rapid survey that supplies the preliminary answers necessary for intelligent efforts to develop or strengthen school nutrition and health programmes. The approach outlined in this document is not exhaustive; there are likely to be particular sources and types of information that are relevant to a given country or situation.

A situation analysis following the approach outlined here gathers information sufficient for a report that:

- Identifies the priority health and nutrition problems of school age children;
- Quantifies school participation (enrolment, absenteeism, repetition, and drop-out rates) and

identifies the major causes of absence from school;
- Identifies practicable, sustainable interventions that are likely to most improve children's health, nutrition, school attendance and educational achievement;
- Identifies major gaps in, and problems with, existing school nutrition and health services, and suggests remedies;
- Informs efforts to monitor and evaluate school nutrition and health services;
- Identifies issues requiring further investigation.

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School Based Health and Nutrition Programmes: Findings from a survey of donor and agency support. Carmel Dolan, 1998.

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About this document

- There is increasing donor interest in the health and nutrition of the school-aged child, adolescents and youth generally. This is most apparent in the UN system but also in some of the Bilateral Organisations and increasingly among those NGOs surveyed.
- NGOs in the UK are reporting an increase in requests from governments for support to the formal and informal education sector and within this the health and nutrition needs of school-aged children.
- There is a move towards inter-agency school health planning, monitoring and evaluation, particularly in the UN. This reflects a move by the UN system and bilaterals towards a sector-wide approach to funding, and away from a project approach. This is also seen as an essential development among other donors e.g. SCF (US).
- Those donors contacted who stated that they are not supporting school-based health and nutrition programmes at present, indicated that they are currently considering the issue.
- In the view of donors, the PCD acts as a catalyst to promote donor commitment in the area of school health, particularly among US based Organisations and agencies. The level of awareness of school-health issues among UK based NGOs is not as well developed.
- Strong interest has been expressed in the school health web-site and mail list currently being developed by PCD with the World Bank. This could provide the necessary vehicle for greater collaboration among donors/agencies and governments to share school health related

experiences, research, programming etc.

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School Feeding Programmes: Improving effectiveness and increasing the benefit to education. A guide for programme managers. The Partnership for Child Development, Joy Del Rosso, consultant, 1999.

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About this document

This guide is designed to assist those engaged in the process of creating new School Feeding Programmes (SFPs) or seeking to improve the effectiveness of on-going ones. It is based on a review of the SFP research and program literature from the last decade. The guidelines include:

- **A brief rationale for addressing nutrition and health in schoolchildren**. This section provides the context for this guide by briefly summarizing the role that health and nutrition of school children can play in learning.
- **A summary of the potential benefits of SFPs for education**. This section reviews the research literature that provides evidence that SFPs can improve educational quality and efficiency. References to the key literature documenting the benefits of SFPs to education are provided. Annex 1 contains an annotated bibliography of most of the literature related to SFPs from the last decade.
- **Seven recommendations for building effective SFPs as an integral part of a package of nutrition and health interventions for school-age children**. This section is the core of the guide, discussing the steps to take to implement the seven recommendations, which aim to enhance the impact of SFPs on education. Program examples, both successes and failures, are presented to assist the reader in understanding the potential advantages and caveats in implementation. Specific data are provided on the costs and rations of actual programs to provide a point of reference for other programs.

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WHO Information Series on School Health

Preventing HIV/AIDS/STDs and Related Discrimination: An Important Responsibility of health-Promoting Schools

This document exhibits that HIV prevention programmes are effective in reducing the risk of HIV infection among young people. It explains why schools must accept the responsibility to educate their community members and work with them to determine the most appropriate and effective ways to prevent HIV infection among young people.

Tobacco Use Prevention: An Important Entry point for the Development of a Health-Promoting School

This paper demonstrates that tobacco use prevention programmes have a positive impact on the health of children and adolescents and that comprehensive tobacco use prevention programmes in schools work and effectively reduce tobacco consumption.

Violence Prevention: An Important Element of a health-promoting School

This document explains how violence affects the well being and learning potential of millions of children around the world. It provides interventions that can reduce violence through schools.

If you have any problems opening these documents, please contact: celia.maier@ceid.ox.ac.uk

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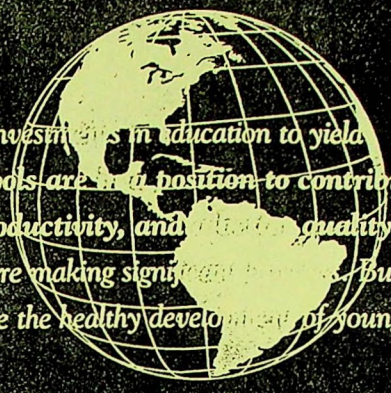
The World Health Organization's

Global School Health Initiative

Geneva 1996

The New Challenge



We expect schools to be places of learning. We expect investments in education to yield benefits to individuals, communities, and nations. Schools are in a position to contribute to social and economic development, increased productivity, and improved quality of life for all. In many parts of the world, some schools are making significant contributions. But even more could be achieved if all schools could promote the healthy development of young people as actively as they promote learning.

For health promotion to be treated as an equal priority, policymakers, community leaders, teachers, parents, and students will need to be convinced of the ways in which health contributes to the overall goals and purposes of the school. They need information about how health promotion through schools can increase the return on investments in education. To learn effectively, and benefit from the investments in education, children must be healthy, able to concentrate, and attend school regularly. People in countries around the world also need to know what steps they can take to create health promoting schools.

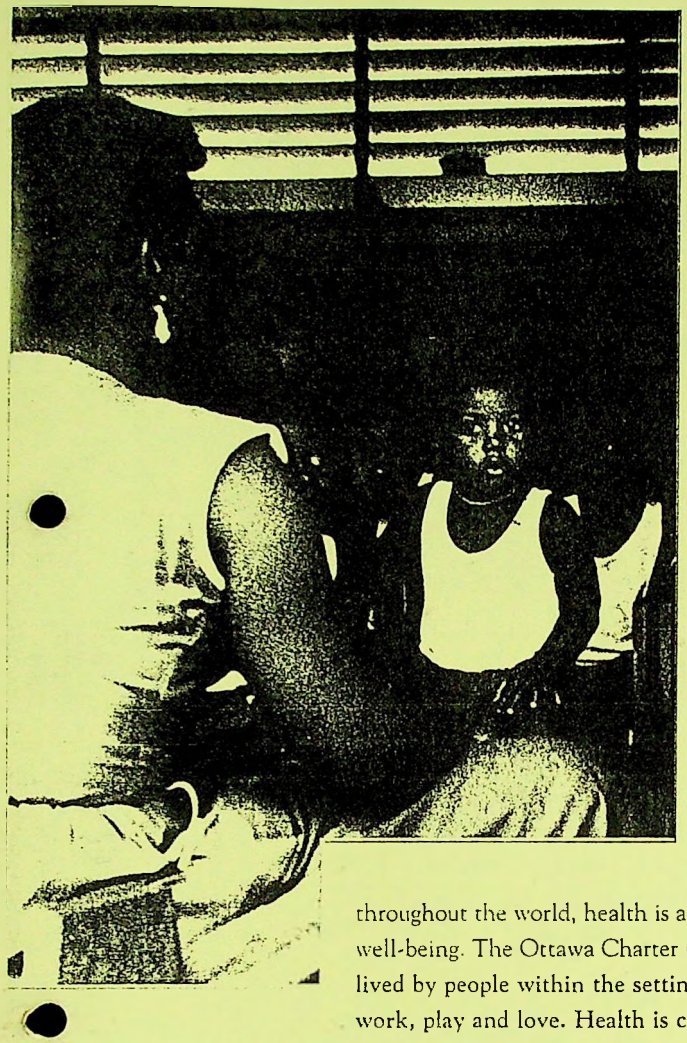
More children than ever are attending school. In the developing world, more than 70% of children complete at least four years of school. There are now one billion young people between the ages of 10 and 19. The vast majority, 84%, live in developing countries. *In only six years*, there will be *2 billion teenagers* on the planet—more than there have ever been in history. They will live mostly in Africa, Asia, and Latin America, but they will be every country's most precious resource. If we nurture their development, their potential to create a better world is great.

When the world focused on child survival, we all learned how to help children survive beyond birth. Now it is time to focus on developing children's and adolescents' minds and bodies.

Today, we know that *promoting health through schools* is one of the most efficient and effective ways to improve our children's lives. We, as educators, parents, policymakers, and concerned community members, know that by creating "health promoting schools," we can advance *both* education and health. It is the next step toward making our dream a reality. This document describes why this step is practical, why we should take it, and how we can do it together.

This document provides a summary of that information. It includes recommendations to help individuals at all levels foster the development of health promoting schools. The recommendations are based on the findings of the WHO Expert Committee on Comprehensive School Health Promotion and Education, which met in Geneva, Switzerland, in September 1995.

Every school can promote health and contribute to a strong and sustainable future for its community and its nation. Working together, as individual parents, teachers, community leaders, government officials, and representatives of international agencies, we can increase the number of health promoting schools in every country. As we succeed, everyone benefits.



What Is Education? What Is Health?

People sometimes think of education as the accumulation of facts and basic skills. They sometimes think of health as the opposite of illness. But education and health are broader, richer concepts—and they are inseparably linked.

Education is about *learning*. It is about the ability to combine knowledge, attitudes, and skills and use that strength to shape one's life and contribute to the lives of others. Throughout the world, a higher level of education often allows people to have better jobs, lead healthier lives, and contribute to family and community well-being. Indeed, as noted in WHO's Constitution and restated in the Ottawa Charter on Health Promotion (1986), education is a ***prerequisite*** for health.

As defined by WHO and accepted broadly throughout the world, health is a state of complete physical, mental, and social well-being. The Ottawa Charter (1986) recognizes that, "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members."

In almost every community, the school is a setting in which many people live, learn, and work. It is a place where students and staff spend a great portion of their time. It is a place where education and health programmes can have their greatest impact because they can reach students at influential stages in their lives—childhood and adolescence.

Thus, schools are not merely one of the institutions and settings in which health can be created, but are among the most important. Because we know much about the relationship between education and health, we can use that knowledge to help create health promoting schools, *which improve education and learning potential* as they improve health. Here is why.

Good Health Supports Successful Learning

We know that healthy children learn well. If young people are healthy, they can take full advantage of every opportunity to learn.

We also know *a child's ability to attend school is affected by health.* Health and health-related conditions—such as illness among children and their families, the lack of hygienic and sanitary conditions in the school, and fear of violence or abuse en route to school or at school—all of these factors can prevent children from being enrolled in school or reduce their attendance, thus reducing the value of investments in education.

Successful Learning Supports Health

We know that simply by attending school, children's health is improved. Mothers with even one year of schooling tend to take better care of their babies. They are more likely to seek medical care for their children and to have their children immunized.

We know that investments in education yield benefits by improving maternal and child health. In developing countries, as the literacy rate improves, fertility rates tend to decline. Literate women tend to marry later and are more likely to use family planning methods to space their children, protecting their own health and that of their babies.

Schools can make it possible for children and adolescents to gain the knowledge, attitudes, values, skills, and services they need to be healthy and to avoid important health problems. The promotion of healthy lifestyles can contribute to children's and adolescents' health now and in their lives as adults, enabling them to contribute to their communities and nations now and in the future.

Important public health problems common to all countries, such as HIV/AIDS; injuries caused by violence; and the effects of using tobacco, alcohol, and other drugs, are preventable through education and other school-based interventions. Important health problems of developing countries, such as schistosomiasis, other helminth infections, nutritional deficiencies, and vaccine-preventable diseases can be prevented, reduced, or controlled through efficient and cost-effective school-based treatments and education. Schools can also contribute to improved health among children and staff by referring them to services at local health institutions. Thus, through prevention, treatment, and referral, schools influence many of the health problems that *affect learning* as well as health.

Even how a school is organized—its policies, physical and social environment, curricula, teaching and learning styles, examinations, and the ways in which students are engaged in their own education—can promote or discourage health. Thus, investments in both education and health are compromised unless a school is a healthy place in which to live, learn, and work.

Finally, we know that there are too few safe places for children today. Many children live and suffer through physical, social, or cultural conditions that jeopardize their physical safety, emotional health, or security. For much of the day, a school can provide safety and security, if it is a *healthy* place, as well as a place of learning.

Education and Health Are Inseparable

If we nurture the health, hopes, and skills of children and teenagers, their potential to improve the world is unbounded. If they are healthy, they can take the best advantage of every opportunity to learn. If children are educated, they can live fulfilled lives and contribute to building a future for everyone.

The extent to which each nation's schools become health promoting schools will play a significant role in determining whether the next generation is educated and healthy. Education and health support and enhance each other. Neither is possible alone. Together, they serve as the foundation for a better world.

Health Promoting Schools: *Foundation for a Better World*

Every school is different. From country to country, and even within different regions and communities of one country, each school has its own strengths. But by building on those strengths and harnessing the imaginations of students, parents, teachers, and administrators, every school can become a health promoting school. And every health promoting school can respond to the challenge to *improve and support* the education and health of students and the health of staff. By fostering health and learning with all of the measures at its disposal, every health promoting school is a building block in the foundation for a better world.

To do so, a health promoting school must be more than a collection of different programmes and services. It must be an organism, a living thing in which all of the parts work together.

How Does a Health Promoting School Accomplish Its Goals?

A "health promoting" school:

- Fosters health and learning with all the measures at its disposal.
- Engages health and education officials, teachers, students, parents, and community leaders in efforts to promote health.
- Strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counseling, social support, and mental health promotion.
- Implements policies, practices, and other measures that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements.
- Strives to improve the health of school personnel, families, and community members as well as students, and works with community leaders to help them understand how the community contributes to health and education.

What Can We Do to Help Create More Health Promoting Schools?

For all schools to become health promoting schools, a variety of supportive actions are required by organizations at various levels. No organization or sector can meet these requirements alone. We must take these steps together.

In September 1995, WHO convened an Expert Committee Meeting on Comprehensive School Health Education and Promotion to encourage education and health institutions and other agencies and individuals to support health promotion through schools. WHO charged the Committee to make recommendations on policy and action steps that should be taken at the local, national, and international levels to help schools become health promoting schools.

The Committee reviewed research from both developing and developed countries and noted that, without question, promoting health through schools "*could simultaneously reduce common health problems; increase the efficiency of the education system; and thus advance public health, education, social and economic development*" in all nations. The committee agreed that a rich base of knowledge exists on which to act now.

The Committee's recommendations are made with the recognition that:

an investment in education is an investment in health

the health of children significantly affects their ability to learn

schools can be health promoting environments only if they are healthy organizations

On the following pages, the full text of each of the WHO Expert Committee's recommendations is presented in ***red***. Each recommendation is accompanied by information that individuals and organizations can use in advocating for school health programmes.

Investment in schooling must be improved and expanded.

Education is a fundamental human right. Therefore, every Member State must provide education in schools that meets the full range of children's learning and developmental needs, and should extend education to children who are not receiving schooling, including those who have physical or mental impairments.

Article 26 of the Universal Declaration of Human Rights (1948) specifies that, "Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages."

Although much work remains to be done, the nations of the world have made great strides in increasing the number of children who attend at least the lower grades of school. According to UNESCO's *World Education Report 1995*, over a billion young people are involved in formal education (in all grades) today. But nearly 145 million 6- to 11-year-old children remain out of school.

Many obstacles prevent children from attending school: poverty, lack of transportation, or parental attitudes. Perhaps among the most tragic cases are those children whose physical or mental disabilities currently prevent them from attending or benefiting from school. With the success of child survival programmes, many children who might have died from polio and other diseases are living, although still suffering from physical disabilities. With the increasing success of the WHO Global Immunization Programme, polio may well be eradicated in the next century. But other problems persist:

- In 1990, iodine deficiency killed 60,000 infants; the 120,000 children who survived are afflicted with cretinism. Progress is being made, but the problem persists.
- In 1990, 250,000 children died within their first year as a result of Vitamin A deficiency; many of the 250,000 who survived will never see again. Progress is being made, but the problem persists.
- The vast fields of buried landmines in every region of the world are daily creating a new generation of disabled children. Little progress has been made either to remove existing landmines or prevent their further use. (The U.S. Department of State has conservatively estimated that there are at least 85–90 million unexploded landmines distributed across more than 60 countries.)

Each of the disabilities resulting from these problems greatly reduces the likelihood that a child will be sent to school. But Article 23 of the Convention on the Rights of the Child (1989) is very clear:

[A] mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

The full educational participation of girls must be expanded.

Full participation and a dignified, decent life require education. To provide that education, schools must be accessible to, and appropriate for, children with disabilities. Educational programmes should take into account both the specific developmental needs of disabled students and the common developmental needs of all students.

Even when children are able to attend school, the investment made to enroll them will be wasted unless schools have the basic resources to provide a safe environment and a developmentally appropriate and intellectually challenging education. Making it possible for all children to attend school is critical, but not sufficient for investments in education to yield the greatest possible benefits. Once the children arrive, they must be met by teachers who are well-trained, healthy, and supported in their professional tasks. Throughout the world, many schools aspire to meet these needs, but many need help to do so.

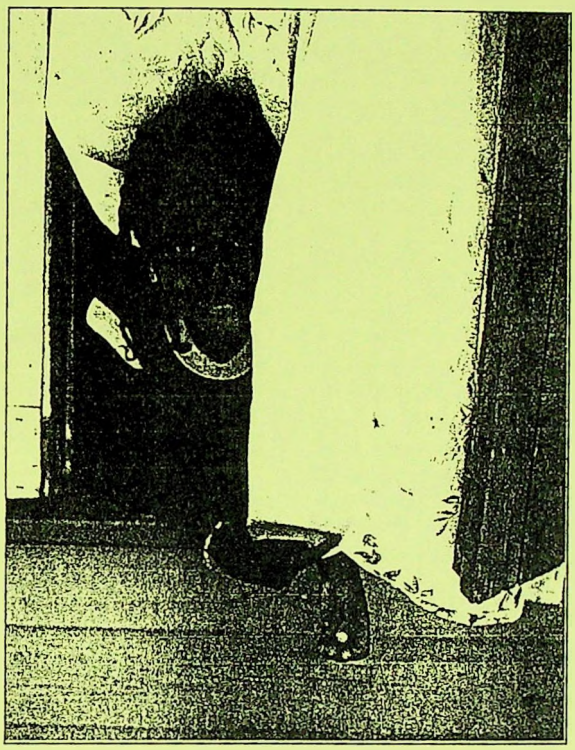
The enrollment and retention of girls in school lag significantly behind those of boys. Improving and expanding educational opportunities for girls is one of the best health and social investments a country can make. Every Member State and community must strive to break down the social, cultural, and economic barriers to the education of girls.

Improving the health and education of girls is a special challenge. Even as the total number of children in school continues to grow, the education of girls lags behind that of boys. The imbalance between boys and girls attending school is dramatic. While *one-sixth of 6- to 11-year-old boys* is not in school, *one quarter of 6- to 11-year-old girls* is being denied an education and the benefits it confers. A basic human right is at stake. As numerous international declarations and conventions affirm, girls and boys have equal rights to health and education.

Girls benefit from education just as boys do—their health and ability to learn improves. But everyone else benefits as well when girls are educated. Educated girls choose to bear children later, seek prenatal care earlier, and give birth to healthier babies.

A child's chance to be healthy improves if both parents, but especially the mother, are educated. The research is unequivocal: the *single most important factor* in determining a child's health is its mother's level of education. For example:

- Many national reports state that the more years of education a female receives, the more likely it is that her children will survive the first five years of life.
- Data from 13 African countries between 1975–85 show that a 10 percent increase in female literacy rates was accompanied by a 10 percent reduction in child deaths.
- In Peru, seven or more years of schooling for girls reduced children's mortality risks by 75 percent.



Education also increases access to better jobs for women, just as it does for men. As countries seek to achieve sustainable development, they can ill-afford to waste any of their precious resources. We must be determined, in the words of the Beijing Declaration (1995), to:

> Promote people-centered sustainable development, including sustained economic growth, through the provision of basic education, life-long education, literacy and training, and primary health care for girls and women.

3 Every school must provide a safe learning environment for students and a safe workplace for staff.

Too often the school environment itself can threaten physical and emotional health.

The school environment must:

- ➢ *provide safe water and sanitary facilities;*
- ➢ *protect from infectious diseases;*
- ➢ *protect from discrimination, harassment, abuse, and violence;*
- ➢ *reject the use of tobacco, alcohol, and illicit drugs.*

Students and staff cannot practice healthy behaviours and protect themselves from disease if a school does not provide clean water and functioning latrines. The absence of such essentials can even further reduce the participation of girls during the days of the month when they are menstruating because they cannot wash or care for themselves in privacy.

Injuries are a major cause of death and harm to children and adolescents. Studies in Europe, North America, and other regions indicate that schools are an important place in which those injuries occur. Falls, sports injuries, and injuries related to fighting are common.

- In the United States, 22 million children are injured each year; 10% to 25% of the injuries occur in or around schools.
- In the United Kingdom, one child in 50 is treated for a school-based injury each year.
- In Tasmania, Australia, one-third of childhood injuries occurred in school.

Discrimination, harassment, and physical or sexual abuse affect access to school and the quality of children's health and education. One reason often given by parents for refusing to send their daughters to school at all is either their knowledge (or fear) that they could be physically or sexually abused by staff or male students.

Finally, schools have the power not only to teach healthy behaviours but to support or undermine them. A school that teaches tobacco use prevention must also prohibit smoking by staff in or near the school grounds. A school that teaches about good nutrition should also provide nutritious food.

4 Every school must enable children and adolescents at all levels to learn critical health and life skills.

Such education includes:

- ➢ *focused, developmentally appropriate, skills-based health education in topics such as infectious diseases, nutrition, preventive health care, and reproductive health;*
- ➢ *comprehensive, integrated, life skills education that can enable children to make healthy choices and adopt healthy behaviour throughout their lives;*
- ➢ *health education that enables young people to protect the well-being of the families for which they will eventually become responsible and the communities in which they reside.*

Research about the healthy development of children and adolescents and the health risks they face has identified the keys to making successful and efficient school health programmes possible. Students who are at risk of engaging in one unhealthy behaviour (such as smoking tobacco, early sexual behaviour, or violence) are often at high risk of engaging in others as well. Similarly, the positive actions that can protect them from harm (such as the ability to communicate with parents, to assess risks realistically, and to resist peer pressure) apply not just to one risk, but to many. This fact makes it possible for health programmes to address underlying life skills that can determine risk or protection.

Life skills education focuses on the combination of psychological and social factors that contribute to healthy behaviour. These are the skills—communication, decision-making, conflict resolution, critical thinking—that permit children to avoid unhealthy behaviours in the present and maintain healthful ones as they grow into adulthood.

Life skills education has been implemented in many schools with positive results both for the health and educational achievement of students. For example, the effect of such education on reducing tobacco and other drug use, on decreasing fighting among adolescents, and on improving students' self-esteem and overall mental health status have all been documented.

Every school must more effectively serve as an entry point for health promotion and a location for health intervention.

Schools should prevent when possible, treat when effective, and refer when necessary the common health problems of children and staff.

They should:

- *provide safe and nutritious food and micronutrients to combat hunger, prevent disease, and foster growth and development;*
- *establish prevention programmes to reduce the use of tobacco, alcohol, and illicit drugs, and behaviour that promotes the spread of HIV infection;*
- *treat when possible helminth, malarial, skin and respiratory infections, as well as other infectious diseases;*
- *identify and treat when possible oral health, vision, and hearing problems;*
- *identify psychological problems and refer those affected for appropriate treatment.*

The World Declaration on Education for All (1990) notes, "Learning does not take place in isolation. Societies must ensure that all learners receive the nutrition, health care, and general physical and emotional support they need in order to participate actively in and benefit from their education." Thus, a school that provides a safe environment for learning, that gives its students the opportunity to learn and practice life skills that will enable them to make healthy decisions, must also serve as a location (or referral point) for prevention and intervention services if it is to be a health promoting school in the fullest sense.

In fact, it is precisely because schools are so well-positioned to carry out this third role that they can provide such an efficient and cost-effective component of a community's healthcare system. Researchers from the World Bank, the Partnership for Child Development, WHO, UNICEF, and other agencies have concluded that delivering health and nutrition interventions in schools (to provide supplementary food and specific nutrients such as iodine or vitamin A; to give drugs to prevent or treat infections; or to screen for hearing, vision, dental, psychological, and other problems) can prove to be a very high-yield investment. Researchers at UNESCO, the UN Development Programme, and other agencies have documented the positive effects that addressing such problems can have on children's ability to learn.

The prevention role of the health promoting school is particularly important in building a sustainable future for our teenagers. For example:

- Nearly one quarter of people with AIDS are in their 20s. Many became infected in their teenage years. In combination with other prevention programmes, the health promoting school can help to change the future. Otherwise, by the year 2000, *26 million people* will have AIDS or be HIV positive. *Two million* of them will die each year.
- Injuries are one of the major causes of death and disability among the young in countries at all stages of development. Through the efforts of health promoting schools we can reverse the rate of injury, which now *continues to grow.*
- In many countries adolescents are the fastest growing group of new smokers. Unless we strengthen our efforts for prevention, and help those teenagers who already smoke to quit, in 30 years *more deaths in the developing world will be caused by tobacco* than by AIDS, tuberculosis, and the complications of childbirth combined.

Policies, legislation, and guidelines must be developed to ensure the identification, allocation, mobilization, and coordination of resources at the local, national, and international levels to support school health.

This support includes:

- ➢ *helping decisionmakers and the public to understand that schools could provide the most cost-effective means to improve the health of children and thus to advance social and economic development;*
- ➢ *fostering active collaboration between the health and education ministries;*
- ➢ *developing school health committees and networks that include representatives of government agencies (such as transport, planning, agriculture, and physical exercise and sport) and nongovernmental organizations who can contribute expertise and resources necessary to improve comprehensive school health programmes;*
- ➢ *identifying, training, and developing qualified staff at the national and local levels;*
- ➢ *establishing clear lines of responsibility and accountability for comprehensive school health programmes.*

Well-organized and coordinated school health programmes, delivered through health promoting schools, can be among the most efficient and *cost-effective* ways to improve both education and health. For example, one recent study looked at the relative value of such school-based health promotion activities in preventing *just three* of the major risks and determined that:

- Money spent on preventing the use of tobacco was worth 19 *times* as much as money spent treating the consequences of that behaviour.
- Money spent on preventing alcohol and drug abuse was worth 6 *times* as much as money spent on treating the consequences of that behaviour.
- Money spent on education to prevent early and unprotected sex was worth 5 *times* as much as money spent on the consequences of that behaviour.

Teachers and school staff must be properly valued and provided with the necessary support to enable them to promote health.

This support includes:

- ➢ *providing the resources to train and enable existing teachers, school staff, and school administrators to address the health and educational needs of students;*
- ➢ *involving universities, teacher-training colleges, and relevant nongovernmental organizations in preparing new teachers, school staff, and school administrators to promote the health of children and adolescents;*
- ➢ *providing opportunities and facilities for teachers, school staff, and school administrators to improve their own health.*

For example, the Teacher Empowerment Project in India brings educators together for seminars in which they share their experiences, learn skills, and create new learning materials and strategies. Beginning in 23 of Madhya Pradesh state's school districts, the project now includes the state's 45 districts and 77,000 schools. As a result, teachers report feeling greater empowerment, participation, and satisfaction. And there have been dramatic improvements in student attendance and learning achievement.

In other studies, health promotion programmes for school staff have decreased teacher absenteeism as well as that of students. And one programme for school staff in the United States demonstrated reductions in such important indicators of good health as weight, heart rate, blood pressure, and cholesterol level.

8

The community and the school must work together to support health and education.

Families, community members, health service agencies, and other institutions have an important role to play in improving the health of young people. At the same time, the school can play an important role in improving the health of the community as a whole. Such roles include:

- *advocacy and support by the community for the development of the school as a healthy organization;*
- *active consultation and collaboration among families, the community, and the school to improve the health of children and adolescents who attend school, as well as those who do not;*
- *active participation by the school and its students in programmes to improve the health and development of the entire community.*

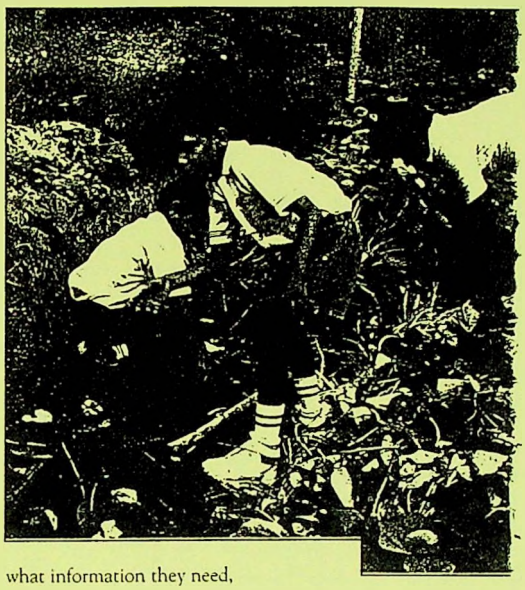
The Ottawa Charter recognizes that, "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. ...This requires full and continuous access to information, learning opportunities for health, as well as funding support." The health promoting school must be a participant in this process and can be one of its beneficiaries as well.

Students and staff *benefit* when the community makes the creation and support of health promoting schools one of its priority strategies for achieving better health. Health promoting schools *participate* when they make their resources available to the community as a whole. For example, in many communities, schools have organized health fairs. Parents, students, teachers, and other community members come together to spend an enjoyable afternoon learning about health and about the availability of preventive services. Often such fairs are used by community health educators and health care providers to screen for important and treatable health conditions, such as high blood pressure or the need for glasses.

WHO's Adolescent Health Programme has developed a number of strategies to build community participation and support:

The Grid Approach—a one-week workshop that enables participants to use a grid to identify health problems, examine existing responses, and identify actions to reduce the gaps between the two.

The Gatekeeper Method—a process used to solicit the opinions, support, and recommendations of "gatekeepers." These practitioners working in the field can be asked about problems, how to handle them, what information they need, how they react to suggested plans or reforms, and who else should be interviewed.



Drama as a Research Tool—a method to engage students and key adults in the community in discussion and decision-making after seeing a student performance on a key topic. By providing a shared experience to stimulate audience reaction, dialogue is stimulated.

The Narrative Research Method—a tool employed for studying behaviour patterns of young people, by young people, through the development and testing in the community of prototypical stories.

School health programmes must be well-designed, monitored, and evaluated to ensure their successful implementation and outcomes.

These actions include:

- ➢ *developing or adopting in each Member State the most appropriate and affordable methods to collect data about children's health, education, and living conditions, by age-group and sex;*
- ➢ *emphasizing, whenever possible, research that draws on the knowledge and skills of local educators, students, families, and community members;*
- ➢ *developing methods for the rapid analysis, dissemination, and utilization of data at the local level, where they can have the greatest impact.*

We now know a great deal about the health and education needs of school-age children. We have learned much, too, about how to meet those needs through health promoting schools. There are still important research questions to be answered (e.g., what are the precise relationships among specific nutritional deficiencies and specific learning problems; what is the lowest, most cost-effective dose of anti-helminthic drugs that will prevent infections; what is the extent to which schools promote health; what is the extent to which students and others receive health promotion information through schools), but we are well-poised to implement *and evaluate* programmes now.

If we carefully document what school health programmes do and evaluate their achievements, we will learn which approaches work best and under what circumstances. As we come to know more about such "promising practices," we can turn our attention to how they can be adapted best for a broad range of communities and cultures.

International support must be further developed to enhance the ability of Member States, local communities, and schools to promote health and education.

Such support includes:

- ➢ *developing a global school health initiative, with concerted action by organizations such as WHO, UNESCO, UNICEF, UNFPA, the World Bank, the World Food Programme, Education International, the International Union for Health Promotion and Education, and others;*
- ➢ *coordinating among international organizations and Member States to share efforts, reduce fragmentation and duplication of effort, and establish a broad vision of comprehensive and integrated school health programmes.*

A wise and experienced government leader once said that, "All politics is local." Similarly, investments in school health programmes will only be fully realized if they make it possible for educators, parents, students, and members of their communities to create local health promoting schools. But, in order for this to happen, the development of health promoting schools must be supported at every level: local; district, state, or provincial; national; regional; and international.

There is a need for partnerships at every level and among levels. There is a need for communications systems that will encourage dissemination of the best knowledge and experience within and across levels. But these systems can only succeed when individuals within them have:

- A passion to promote health through schools.
- Authority and responsibility to develop plans and implement activities.
- Sufficient time and other resources to make their goals and objectives practical.
- A commitment to work in partnership with others to improve education and health.

Finally, these individuals must be charged with working together to develop efficient and flexible mechanisms for planning and implementing programmes. When they do so, when they carefully document their achievements and evaluate the results, we will travel far along the road to success.

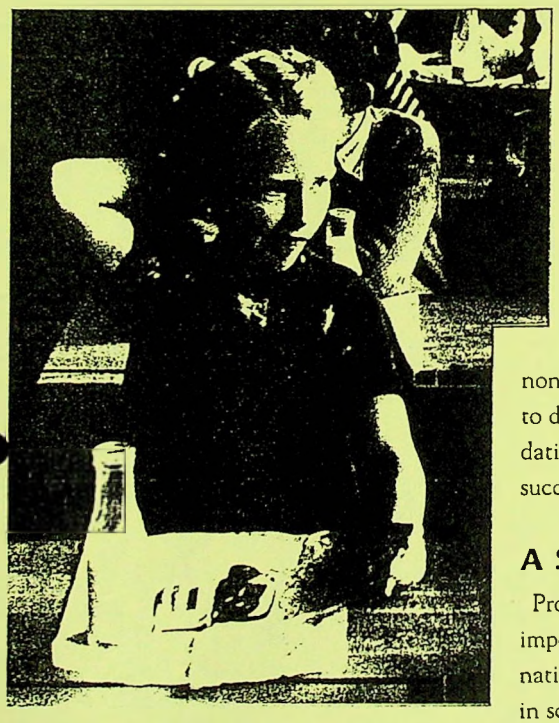
The time has never been better, nor the need more important.

Developing a Global School Health Initiative—
A Call to Action

The WHO Expert Committee on Comprehensive School Health Education and Promotion urges all people to imagine:

***A future** in which schools in every nation have the healthy development of all children as an essential part of their core mission.*

***A world** where schools take on this challenge and implement new and exciting ways to coordinate the educational process, the environmental conditions within and outside the school, and the range of available health services to enhance the educational achievement and health of young people.*



Indeed, the recommendations of the WHO Expert Committee, if implemented, could attain that vision and could make a significant contribution towards achieving the major goals established by the Health for All by the Year 2000 and Education for All movements, as well as The Children's Summit, New York, 1990; The Social Summit, Copenhagen, 1995; and The Fourth World Conference on Women, Beijing, 1995.

Therefore, the Expert Committee calls on all Member States, relevant international organizations, relevant nongovernmental organizations, and schools around the world to develop and implement plans for achieving these recommendations, in order to develop more fully the potential of successive generations.

A Strong Foundation on Which to Build

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 and support for school health was further enhanced when the Director-General of WHO created the Division of Health Promotion, Education and Communication (HPR).

The new Division was charged with strengthening WHO's capacities to promote health through schools. Many divisions within WHO, including its regional offices, provide technical support for a wide range of school-based health promotion, health education, and disease and injury prevention efforts.

The support of many WHO programmes is needed to foster the development of integrated and comprehensive approaches to school health. Thus, the Division established a School Health Team as part of its Health Education and Health Promotion Unit, to serve as the secretariat for an inter-divisional Working Group on School Health. Through the team, the working group, and its regional offices, WHO is committing its full organizational capacity toward the development of a Global School Health Initiative.

The WHO Global School Health 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. It is built on a strong foundation of past actions:

1985	The WHO/UNICEF International Consultation on Health Education for School-age Children
1987	Publication of The Comprehensive School Health Programme. Exploring an Expanded Concept (The Journal of School Health, USA)
1988	WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) develops Action-Oriented School Health Curriculum
1989–95	The US Centers for Disease Control and Prevention supports the Comprehensive School Health Education Network, which trains 350,000 teachers across the country
1990	WHO establishes a Collaborating Center of Health Promotion and Education for School-age Children at the Division of Adolescent and School Health, US Centers for Disease Control and Prevention
1991	Joint WHO/UNESCO/UNICEF meeting on Comprehensive School Health Education (and the publication of Guidelines for Action)
1991	WHO Regional Office for Europe (WHO/EURO) pilots Health Promoting Schools projects in Hungary, Czech Republic, Slovak Republic, and Poland
1992	The European Network of Health Promoting Schools (ENHPS) is founded by WHO/EURO, the Council of Europe, and the Commission of the European Communities
1992	WHO Regional Office for Southeast Asia (WHO/SEARO) develops Guidelines for Implementing and Strengthening Comprehensive School Health Education
1993	The World Bank's World Development Report. Investing in Health confirms the value of school health programmes
1994–95	WHO Regional Office for the Western Pacific (WHO/WPRO) holds school health promotion workshops in Australia, Singapore, Fiji (with more planned for 1996), and establishes two Regional Networks of Health Promoting Schools
1995	WHO Expert Committee on Comprehensive School Health Education and Promotion
1995	WHO/UNESCO/Education International Global Conference on School Health and HIV Prevention in Harare, Zimbabwe
1996	WHO Regional Office for the Americas (WHO/AMRO), WHO/HQ, Bolivia, Costa Rica, and Education Development Center, Inc. develop and pilot a Rapid Assessment and Action Planning Tool for countries to examine their ability to promote health through schools
1996	WHO Regional Office for the Americas (WHO/AMRO) and the WHO Regional Office for Africa (WHO/AFRO) begin development of regional plans for health promoting schools

This is but the beginning. As the Global School Health Initiative advances, WHO will continue to work in partnership with other organizations, governments, and individuals 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.*
- *Provide an impetus for mobilizing and strengthening school health.*
- *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 on Comprehensive School Health Education and Promotion:

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The following Expert Committee documents are available from WHO (HPR/HEP).

Promoting Health Through Schools. Report of the WHO Expert Committee on Comprehensive School Health Education and Promotion, *Geneva, 18–22 September 1995.*

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

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

Research to Improve the Implementation and Effectiveness of School Health Programmes *(WHO/HPR/HEP/96.3)*

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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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- **Johnson and Johnson European Philanthropy Committee**
  Kent, United Kingdom

Organizations wishing to contribute to the work of WHO by supporting the Global School Health Initiative and anyone desiring further information about the Initiative or the WHO Expert Committee on Comprehensive School Health Education and Promotion should contact Dr. Desmond O'Byrne, Chief, Health Education and Health Promotion Unit (HEP), Division of Health Promotion, Education and Communication (HPR), WHO, Geneva, Telephone. (41 22) 791 25 78; FAX. (41 22) 791 07 46.

Recommendations of

The WHO Expert Committee on Comprehensive School Health Education and Promotion

1

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2

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3

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Every school must more effectively serve as an entry point for health promotion and a location for health intervention.

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7

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The community and the school must work together to support health and education.

9

School health programmes must be well-designed, monitored, and evaluated to ensure their successful implementation and outcomes.

10

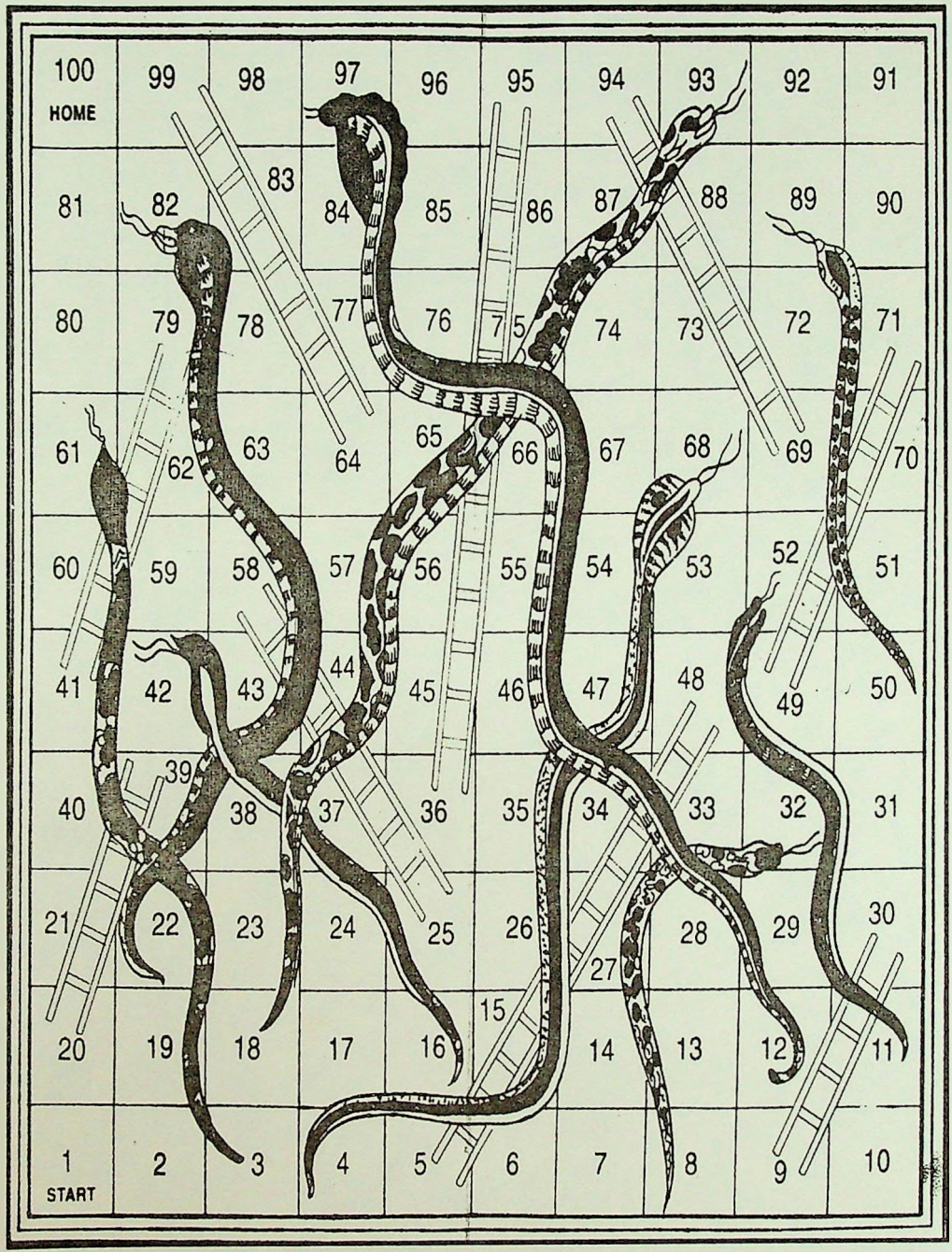
International support must be further developed to enhance the ability of Member States, local communities, and schools to promote health and education.

Geneva, Switzerland, 18–22 September 1995

9th STANDARD
ACTIVITY MATERIALS

Increasing Motivation to Study - Snakes and Ladders

ACTIVITY MATERIAL - 2.1



Increasing Motivation to Study - Snakes and Ladders

ACTIVITY MATERIAL - 2.1a

FACTORS, WHICH AFFECT STUDENTS' PERFORMANCE AT SCHOOL (HAND OUT):

1. Parents sending you to school
2. Parents wanting you to learn
3. Parents believing that you can learn
4. Teachers believing that you can learn
5. Natural intelligence
6. Student friendly school
7. Regular study habits
8. Hard work by you
9. Teacher who teaches well
10. Friends who help you learn
11. Marks oriented school
12. Friends not interested in learning
13. Poor memory
14. Past failure
15. Poor interest in studies
16. Excessive interest in hobbies
17. Poor health
18. School with poor student-teacher ratio
19. Poorly motivated teacher
20. Parents not keen on studies
21. You believe you are stupid
22. Having to work due to poverty
23. Distance from school
24. Being a girl
25. Books not bought by parents
26. Teachers partial to first rankers
27. Friends forcing you to cut class
28. Subjects not interesting
29. Dreams of finishing school
30. Anger when marks are less
31. Studying with friends
32. Learning only by getting byheart
33. Discontinuing school after failure
34. Parents helping you in studies
35. Parents checking on your difficulties at school
36. Parents attending Parent Teachers Meeting on a regular basis
37. Having a specific ability based on interest - 'becoming a lawyer' or 'becoming a teacher'
38. Giving up trying if marks are less
39. Believing that education is not at all important to be successful in life
40. Becoming very anxious when there is an examination

Study Habits - Work While You Work; Play While You Play.

ACTIVITY MATERIAL - 2.2

Situation - 1:

BRILLIANT BOY WHO FAILED IN EXAMS

Krishna is a very bright and intelligent boy. He has always scored high marks in all the exams he has appeared so for in the school. Topping has been a habit for Krishna till about three months ago. He has fared very badly in his first term exams. Krishna has recently taken up pop music as a hobby. His parents presented him a Walkman and all the latest pop music cassettes of his choice because he was doing very well in studies. Over the previous three months, his parents return home late because of their work commitments and not provide enough supervision. Taking advantage of this, Krishna would read as he listened to music. He was more keen on knowing all the songs by heart and hummed along with the singer as he read. He thought he understood all that he read and was confident that he would stand first in the class. Unfortunately, Krishna failed very badly and indeed scored very poor marks in two subjects. His parents were shocked to see his marks card and wondered what went wrong with their son from whom they had high expectations. Krishna has no problem in reading or writing and his communication is excellent. This made parents curious to know the reasons for his failure.

Situation -2:

I FORGET EVERYTHING

Raji is a 14 year old adolescent studying in VIII standard. Raji, is not very much interested in studies. Her parents are educated and working. Education is their first choice for all their children.

Till the VII standard, Raji's mother would sit with Raji two days before the exams and help her to learn the portions in simple ways and write the exams. With this help, Raji was able to pass the exams with 55% in VII standard. Raji's mother insists that she studies every day. Raji also spends time with books every day; but most of the time is spent in copying notes. She tries to study just before the monthly tests. When she goes to the class, the question papers especially Maths and Science, look very complicated. Raji usually comes back home crying and complaining of having forgotten whatever she has read. Parents feel that Raji works hard but has poor memory.

Discussion Questions for the Groups :

1. Are the problems of Krishna and Raji common among young persons today?
2. Why did Krishna fail in his class test?
3. What do you think about Krishna's reading habits?
4. What should Krishna do to overcome his difficulties?
5. What is the role of his parents in helping him overcome the problems?
6. Do you think Raji has poor memory?
7. What is wrong with her study habits?
8. What should she do to improve her memory - especially for Mathematics and Science?
9. What skills are needed by a student to understand his or her study habits?
10. What skills are needed by a student to improve study habits?

Boy Girl Relationship - Romance with Ravi - I Love Ravi Verrrrry Much!!!

ACTIVITY MATERIAL - 2.5

Situation :

Rupa is a 14-year-old girl studying in VIII standard. She has two younger brothers and one elder sister. Her parents are poor, but are very proud of their family. Father runs a small petty shop and mother helps the father in running the shop.

Rupa is an intelligent girl. Recently Rupa was taken by the school authorities to a music competition where she had the opportunity to meet students - boys and girls from other schools. She made a number of friends there. One of them is Ravi, who is studying in X standard in another school 5 kms. away from her school. Ravi helped Rupa in getting drinking water and also shares and eat with her. They have started meeting after school hours. They talk about their friends, T.V. programs etc. They tease each other a lot. Rupa has not spoken about Ravi to her parents or sister. She received a small card from Ravi on her birthday saying that he likes her very very much. Rupa was happy to see such a card from Ravi. Whenever she sits to study, her thoughts drift to Ravi.

Discussion Questions for the Groups :

1. How can we describe the relationship between Rupa and Ravi?
2. Why is romance more common among teenagers and young people?
3. How can we recognize love, romance, infatuation, desire, lust, and sexual feelings in us towards somebody else?
4. How can we recognize friendship, love, romance, and lust towards us by somebody?
5. Can a girl and a boy be friends - when would somebody else think that they are lovers but not friends?
6. What skills does a girl or a boy need to understand the type of relationship he/she has with another person of opposite sex?
7. What do you think of young people dying and committing suicide for the sake of romance/love?

Sleep Hygiene - Goodnight! Sweet Dreams !!

ACTIVITY MATERIAL - 2.4

SLEEP HYGIENE - TIPS

Some Do's Before Sleep:

- ☑ Establishing a regular time to go to bed and to get up in the morning and following it even on weekends and during vacation/holidays. The brain is trained by this to slow down activities and help the person to go to sleep during a specific period - Sleep Routine.
- ☑ Wearing loose and light clothing while going to bed.
- ☑ Choosing a place, which is airy, dark and less noisy.
- ☑ Sleeping in the same place.
- ☑ Practicing relaxation for half an hour before bedtime is useful.
- ☑ Reading something light, meditating and walking leisurely for a short time are all appropriate activities.
- ☑ Exercising before dinner. A low point in energy occurs a few hours after exercise; one sleeps more easily at that time. Exercising closer to bedtime, however, may increase alertness.
- ☑ Having a cup of warm milk is also helpful.
- ☑ Taking a hot water bath 1 - 2 hours before bedtime is good. This alters the body's core temperature rhythm and helps people to fall asleep more easily and more continuously (Taking a bath shortly before bed increases alertness).

Some Don'ts Before Sleep:

- ☒ Avoiding beverages with caffeine, such as coffee, soda after 4 PM.
- ☒ Avoid smoking before sleep or when one does not get sleep.
- ☒ Avoiding large meals before sleep time.
- ☒ Avoiding interesting reading or computer games before going to bed.
- ☒ Avoiding violent or scary television shows or movies or reading mystery and horror books that might disturb sleep.
- ☒ Avoiding fluids just before bedtime so that sleep is not disturbed by the need to urinate.
- ☒ Avoiding sleeping in a noisy place; in an uncomfortable place/posture.
- ☒ Avoiding thinking about problems/stress while trying to sleep.
- ☒ Avoiding taking sleeping tablets without doctor's advice.
- ☒ Not forcing oneself to sleep. Getting out of bed and doing something non-stimulating until one feels sleepy is more helpful.

Anemia - "I am Tired"

ACTIVITY MATERIAL - 2.3

Situation :

'I AM TIRED'

Rekha, Anita and Jayalaxmi are classmates and good friends studying in standard IX of a village high school.

Rekha : Jayalaxmi! Come, let us practice throw ball. The sports competition is about to start and the sports day is two weeks away

Jayalaxmi : No Rekha, I cant play. Please don't force me.

Rekha : Why, Jayalaxmi what happened?

Jayalaxmi : I don't know Rekha; now a days I become very tired and breathless while doing simple work. I told my mother. She says it is just weakness and that it will become OK within some time. She is giving extra milk for that. But I still feel very weak and tired.

Rekha : OK Jayalaxmi take rest. I will check with Anita and play with her.

Rekha : Anita come let us play throw ball.

Anita : Rekha where is our friend Jayalaxmi?

Rekha : Jayalaxmi is not well. I am worried about her.

Anita : What happened to her? I find her to be very dull and not interested in any activities in the class or school. She was never like this before.

Rekha : Do you know Anita; yesterday our Miss scolded her for sleeping in the classroom and for not doing homework assignment. Her mother had come to school and complained to Miss that she does not eat properly and that she gets irritable with everyone in her home for simple reasons. I feel very sad about her. She was not like this before..... Poor girl. She has another problem also. She has been bleeding heavily since she started her periods last year. Now she is not well with this problem of tiredness. I don't know what is going on with her.

Discussion Questions for the Groups :

1. What are Jayalaxmi's problems?
2. What are the causes for lack of interest, increased sleep, decreased appetite, tiredness, lack of energy and appearing dull and irritable behavior?
3. Do you think Jayalaxmi has anemia?
4. What should Jayalaxmi do to solve her problems?
5. Do you think Jayalaxmi requires a doctor's help?
6. Who usually suffers from anemia?
7. What should a student do to avoid anemia?
8. What skills are needed by a student to prevent anemia?
9. Can poor children prevent anemia in themselves?
10. How can they do that?

Study Habits - Work While You Work; Play While You Play.

ACTIVITY MATERIAL - 2.2a

STUDY HABITS QUESTIONNAIRE

Read the following statements and mark at the end of each statement whether it is True (✓) or False (×).

Part - A

I finish my work before I go to play.

I spend a definite time every week in revising each subject.

I recall the important points after I read a lesson.

I spend most of my time on difficult subjects and less time on the easy ones.

I take class notes.

I am careful to learn the important words used in each subject.

I have a regular time and place for studying.

I know how to underline and take notes when I study.

I relate material learnt in one subject with those learnt in others.

I use free time in the school for studying.

My spelling ability is good.

I feel satisfied if I read my lessons.

I look for main ideas while reading a lesson and associate the details with them.

I pronounce the words as I read.

I study with others rather than by myself.

I make use of computer, Internet etc for enriching my understanding about a subject.

I regularly solve old examination papers.

I take mock examinations periodically.

My health is good. I need not worry about it while studying.

I plan out the answer to a question in my mind before I write it in the examination.

I read up the lesson before I go to the class and review what is done in the classroom soon after I get back home.

Part - B

I don't feel like studying at all.

I am a slow reader and therefore, I have difficulty in finishing the assignment in time.

I understand a lesson while reading it but I have trouble remembering what I have read.

I find it hard to concentrate on what I am studying.

If I read faster, I could study more efficiently.

I find it difficult to decide key points that are important in a lesson.

I don't study until evening.

I take longer time to get started with the task of studying.

I daydream instead of studying .

I postpone studying my lessons.

I feel so tired that I cannot study efficiently.

I cannot make out much of what I read.

Many activities like working on a job, household work, play and other such activities interfere with my studying.

I worry a lot about my studies.

I miss important points in the lecture while taking down the notes.

My dislike towards my subject and teachers interferes with my success.

I study the subject that I enjoy regularly and put off studying those which I don't like till the last minute.

I study in the midst of distractions, like radio, TV, people talking, children playing etc.

I become nervous at the time of examination and I cannot answer as well as I should.

I spend too much of my time in reading fiction, going to movies etc which decreases my efficiency in studies.

I have to be in a good mood before starting my studies.

Peer Pressure - Let Us Enjoy

ACTIVITY MATERIAL - 2.6

Situation :

"I AM SORRY, I DID NOT KNOW"

Hemantha is the son of a politician. He is the only son of his parents. He is used to wearing expensive clothes to college, spending a lot of money on his friends. He has his own car and smokes the best cigarettes. Friends always like to go out with him as they get the best of everything. Last year Hemantha and his friends decided to celebrate New Year at Goa.

Hemantha and his friends Jayanth, Roshan, and Raju went to Goa and stayed in a hotel. Hemantha had brought alcohol and other injectable drugs to have 'fun' on New Year's Eve. He offered drugs to Roshan, Raju and Jayanth. Jayanth and Raju refused to take drugs and firmly said no to his offer. Hemanth was very upset with them and picked up a big quarrel with them. Both of them were willing to leave the hotel and Goa but refused to have drugs. Roshan initially refused but later agreed to join Hemantha as he promised him a job in Hemanth's father's business. Both used one syringe to inject the drug over the next two days. They also visited a set-up where commercial sex workers were available. Both had a good time and felt it was the most memorable day in their lives. Roshan felt very happy and felt that the others were fools to have refused such an offer.

After returning home, few months later Roshan started to fall sick repeatedly. His parents took him to the family doctor. They got to know after investigations that Roshan had developed HIV infection. While talking, Roshan found out that the probable time he could have picked up the infection was with the commercial sex worker or from Hemanth with whom he shared the needle. Roshan was unable to bear the shame and also a future with AIDS, jumped to death from his fifth floor flat.

Discussion Questions for the Groups :

1. Is the story of Hemantha and Roshan common?
2. What skills did Hemantha need to convince Roshan to take drugs and indulge in sex?
3. What skills did Roshan lack?
4. What skills did Raju and Jayanth have to say 'NO' to Hemantha?
5. What skills did Roshan need to face the stress of having HIV infection?
6. What are the common activities for which students have pressure to follow others or friends?
7. What techniques/skills does an average student need to avoid such pressures from friends?

Appearance - Pimples - Mera Kubsurathi Ka Rastha - Gori Plus Goro Plus!!!!

ACTIVITY MATERIAL - 2.7

TEENAGE COLUMN IN A FASHION MAGAZINE

Letters to the Magazine Doctor from Teenagers

1. Letter from Niveditha

Dear Doctor, let me introduce myself to you. I am Niveditha, 14 years old studying in VI standard. I am worried about my face. From the past 1 year small pimples have started appearing on my face. My friends told me that I eat more oily foods because of which I have pimples on my face. I have stopped eating oily food items but still have pimples. I also see ads on the T.V. which say eating potato chips can cause pimples. Doctor, tell me what should I do. I also want to make my skin fairer. What should I do for this?

2. Letter from Tara

Dear Doctor, please help me. I have too many pimples on my face. My friends laugh at me saying that I think more about sex because of which I have pimples on my face. I do not think of boys. How is it that I have so many pimples? They are also painful at times.
I feel very shy to go to school. I want to know what causes pimples and how to get rid of this problem.

3. Letter from Alice

Doctor, I have small pimples on my face, neck, shoulders, upper back and chest. I wash my face 4 to 5 times with soap. I have severe itching and feel like scratching my face often. I have applied various creams like Far and Lonely, Goro Plus, Samami Ayurvedic Cream etc. and my friends told me to take internal medicines (Ayurvedic ones) to purify my blood. I tried all these but there is no improvement. In spite of using Never Marks cream the pimples leave black spots on my face and forehead. My mother told me to stop applying anything to my face. She told me to not to prick or squeeze the pimples as it leaves a scar mark on my face and it increases pimples on my face. She also tells me that a fat girl like me will always have acne. Doctor, please suggest what I should do to decrease weight and get rid of the pimple marks? Should I consult a Doctor? What kind of a Doctor should I consult?

4. Letter from Aaron

Dear Doctor, I am a 15 years old student in IX Standard. I want to become a model in future. The only block to this are the pimples on my face. My friends make fun of me saying that pimples are more common among girls and I am girlish - so I get more pimples. I read in a magazine recently that some very expensive treatment electro-curetting can be used to get rid of the pimples. Can you advise me whom to consult for this treatment? Am I getting more pimples because I have more female hormones? Can I use male hormones to decrease the pimples and also to develop muscles?

Discussion Questions for the Groups :

1. Is acne a common problem among the teenagers like Niveditha, Tara, Alice and Aaron?
2. According to you, why do adolescents get acne or pimples?
3. How to take care of acne? Are there any 'Do's and Don'ts?'
4. How effective are the creams, soaps and surgery in curing or preventing acne?
5. Are adolescents with no pimples and looking beautiful or handsome more confident than those with pimples?
6. What can a teenager do if he/she is very self - conscious about his/her pimples?
7. What are the other aspects of appearance which we teenagers are especially worried about ?
8. Other than appearance what qualities can improve our Self - esteem?

High Risk and Adventure - Living Life King Size

ACTIVITY MATERIAL - 2.8

Situation - 1:

Ashoka is a X standard student who hails from a very conservative family. He is a good student and known to be friendly. Ashoka loves cricket and has joined a group of older students to practice cricket during the vacation. These older boys are in the habit of having 'fun' on Saturday evenings by going to one of the boy's hostel terrace and drinking alcohol till late at night. Ashoka also goes with them on these occasions. On the first two occasions Ashoka resists the pressure to drink. He is teased by his friends as a 'goody, goody boy' and 'girl'. Later, he starts drinking alcohol with these boys as he has seen that nothing wrong has happened to these boys and they seem to be having a lot of 'fun' by drinking. They are bolder, comment at girls, sing and dance.

One Saturday night Ashoka was returning home on his bicycle after 'drinking'. He felt he was totally under control. He suddenly saw a lorry coming in the opposite direction. Ashoka thought he was slowing down correctly; but he was not. Hence he fell down with the cycle into the pit by the side of the road and broke his leg. The lorry owner did not have to pay any compensation to Ashoka's parents as he was smelling of alcohol. That blame was on Ashoka.

Discussion Questions for the Groups :

What do you think of this situation?

Why do students drink?

If drinking is 'bad' why does the government permit sale of drinks?

What are the other drugs apart from alcohol, which are used by students of your age?

How do students start these habits?

What skills does a student need to say 'NO' to drinks?

Situation - 2:

Surabi is a X Standard girl. She is very fun loving and is always ready for any activity which is playful and enjoyable. She is always the first in the class to play pranks on other girls and boys. two of her friends in the class planned to run away from home for 3 days to have fun. They planned to go to Bangalore - the city that they have never seen, stay in a lodge have fun, see movies, if possible meet their favorite movie star. After 3 days they would come back and tell the parents that they were kidnapped and managed to get away. They expected Surabi to join them willingly. But Surabi refused to join them saying that their plan was 'very risky'.

Discussion Questions for the Groups :

What do you think of Surabi's decision?

Is there anything wrong in taking 'risks' - small ones like Surabi's friends did?

Life should be lived King Size - It will be boring if young people do not do adventurous and risky things - what is your opinion?

What sorts of risks are all right?

What skills does a student need to decide whether an activity is 'adventurous' or 'high risk'.

High Risk and Adventure - Living Life King Size

ACTIVITY MATERIAL - 2.8a

ADVENTURE QUESTIONNAIRE

'Adventure' or 'Calculated Risk' is when a person does something very different from the routine, but has thought through the whole novel (new) activity and has a clear idea of what he/she would do in case of difficulties and setbacks. Here the goal is to achieve something and feel the high by achievement through the novel method. One's thoughts, feelings and preparation goes into this. For example, a trained cyclist deciding to cycle backwards between two cities for 100 kms. He prepares himself by planning and training to cycle backwards. The cyclist understands the novelty and difficulty of the task but prepares carefully for that.

'Risk Taking Behavior' is when a person does something quickly and impulsively for the momentary high without thinking about the consequences of the act. 'Let me handle it when it happens' is the attitude of the person. There is no thought or preparation. Only feelings of wanting a quick high for self or pleasing somebody else is predominant. For e.g., jumping from a high building to attract the attention of the crowd, driving on the wrong side of the road for long distances and observing the anxiety of the other drivers.

Decide which of the activities are Adventurous (A) and are of High Risk (R)

Driving a bike at high speed in a crowded street without a helmet.

Joining a group to climb the top of Ramnagaram Rock through a new route.

Drinking and driving with friends.

Joining friends and going for horse racing to gamble.

Having sex with a neighbor during vacation as she says it is fun.

Driving a van at high speed without lights along a busy street.

Playing Lottery with pocket money.

Breaking a coconut with bare hands in a karate class after training.

Smoking ganja with friends at the beach during holidays.

Jumping from the first floor of a building.

Taking part in a car race.

Demonstrating that you can cook for 100 people within 60 minutes without anyone's help.

Developing a new method of writing (not Kannada or English).

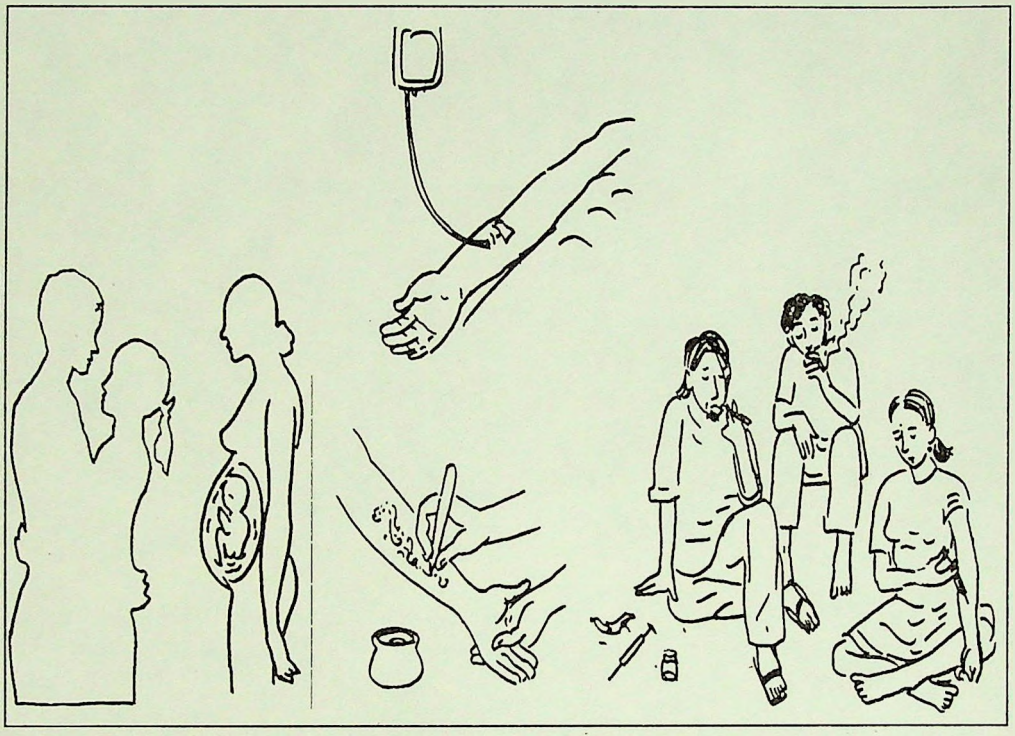
Playing 'KHO KHO' with everybody's eyes blindfolded.

Breaking into a shop along with your friends.

Running away from home and calling parents to say that you have been kidnapped to make them pay a ransom.

Sexually Transmitted Diseases - Save Yourself

ACTIVITY MATERIAL - 2.9



Sexually Transmitted Diseases

Discussion Questions for the Groups :

Set 1:

1. What disease do these pictures illustrate ?
2. What is the full expansion for the words - HIV, AIDS? What is the difference between the two?
3. What are the other diseases, which can be transmitted by having sex with an infected person (STDs)?
4. What are the activities that can spread STDs among men and women?
5. What are the activities, which do not spread STDs, but are still usually feared?
6. What should an infected person do?
7. What are the usual fears about AIDS/HIV, Syphilis and Hepatitis B among students?

Set 2 :

1. What can a student do to avoid these diseases?
2. What are the abilities a student needs to prevent STDs?
3. Is it possible to suggest some activities, which can increase and decrease our sexual urges?
4. Which sets of questions (Set 1 or 2) were difficult to discuss and answer? Why?

HIV/AIDS - Health is in Your Hands!!!!!

ACTIVITY MATERIAL - 2.10

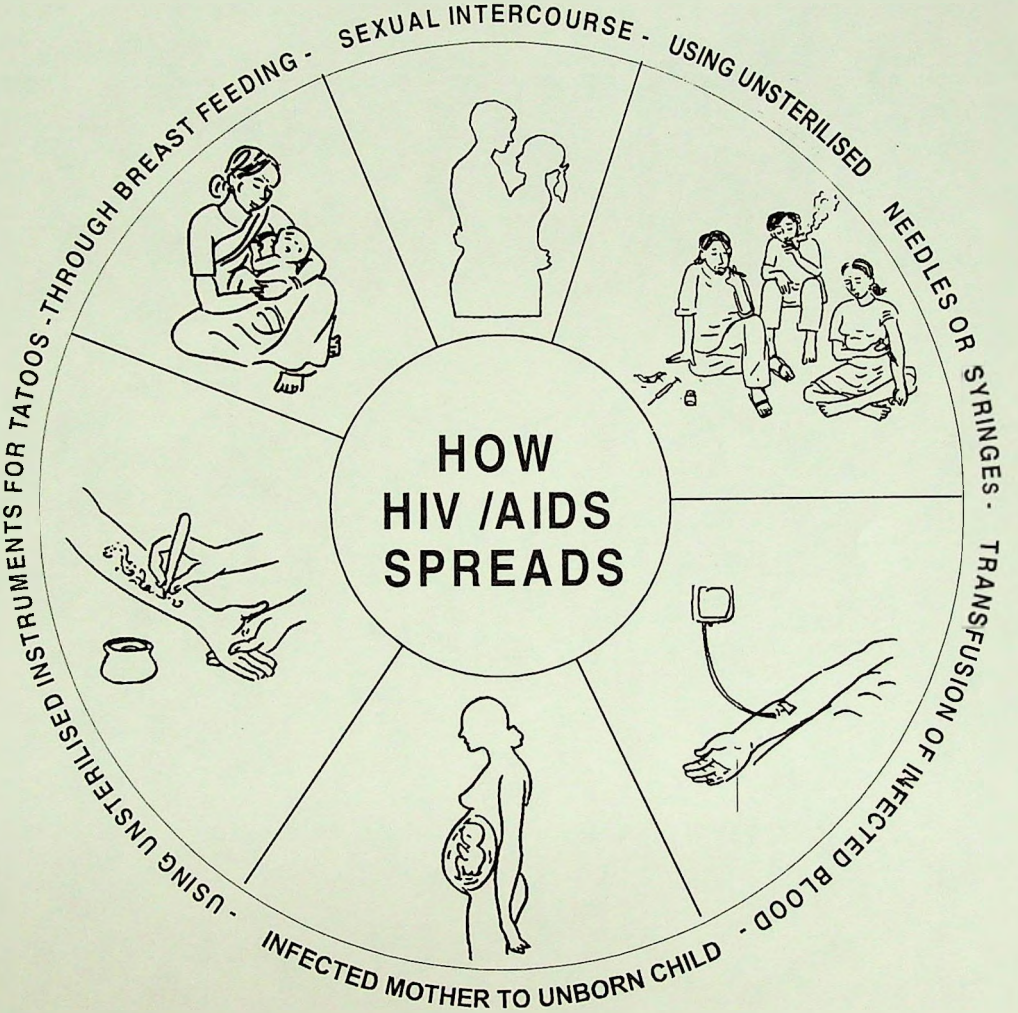
Read the following statements and mark at the end of each statement whether it is True (✓) or False (✗).

Modes of Transmission of HIV/AIDS :

1. You can become infected with HIV by sleeping with others.
2. You can become infected with HIV from sharing toothbrush.
3. People get HIV/AIDS by sexual intercourse with an infected person.
4. A person can get HIV/AIDS using unsterilized needles or syringes used by infected person.
5. A person can get HIV by hugging an HIV infected person.
6. A person can get HIV by shaking hands of infected person.
7. A person can get HIV by kissing, hugging, playing, swimming with infected person.
8. A person can get HIV/AIDS by eating food prepared by infected person.
9. A person can get HIV/AIDS by indulging in sex with a commercial sex worker.
10. A person can get HIV by indulging in sex with multiple partners.
11. An unborn child can develop AIDS if the mother is infected.
12. A person can get infected by sharing toilets with an HIV/AIDS infected person.
13. A person can become infected with HIV if he or she has anal sex with an HIV infected person.
14. A baby can get AIDS by breast-feeding from an HIV infected mother.
15. A person gets HIV by having unprotected sex with multiple partners.
16. Bed bugs, mosquitoes can spread HIV/AIDS.
17. A person can get HIV through blood transfusion from an HIV infected person.
18. Having vaginal sex with an HIV infected person transmits HIV infection.

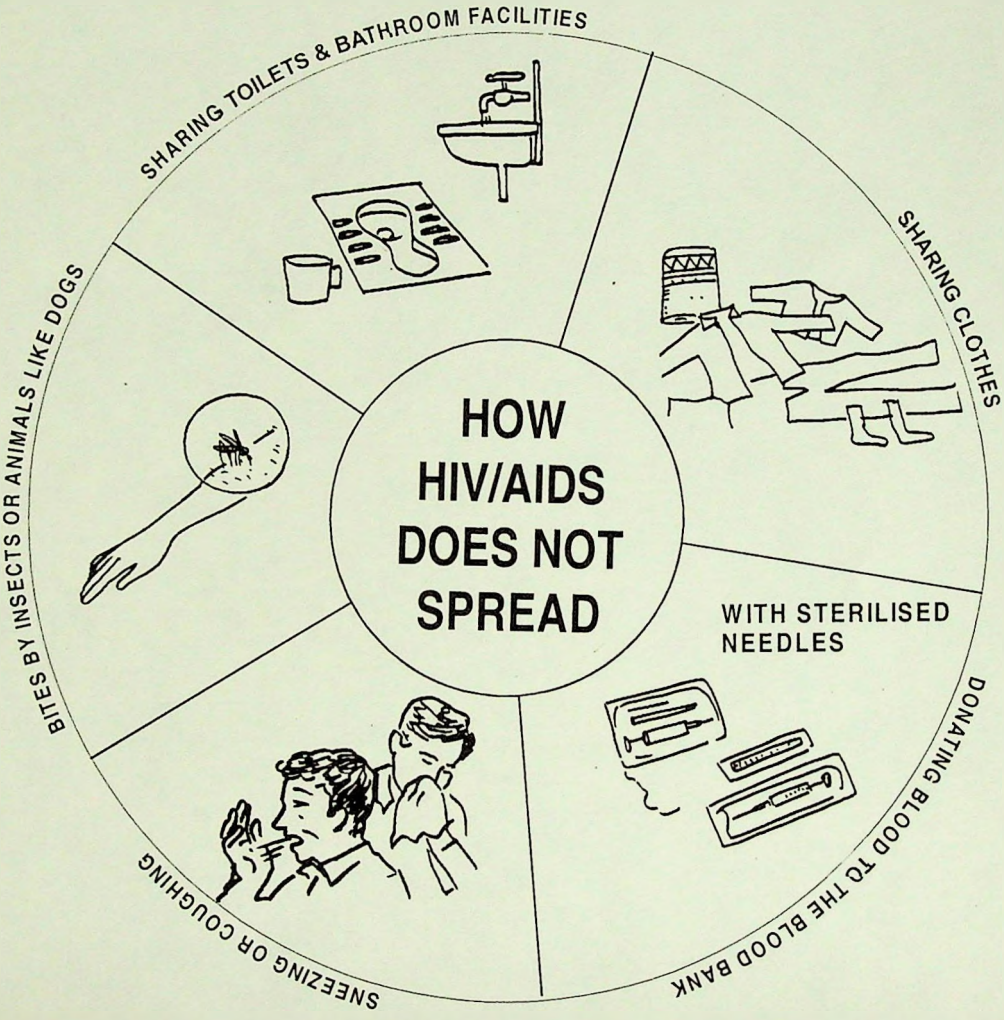
HIV/AIDS - Health is in Your Hands!!!!!

ACTIVITY MATERIAL - 2.10b



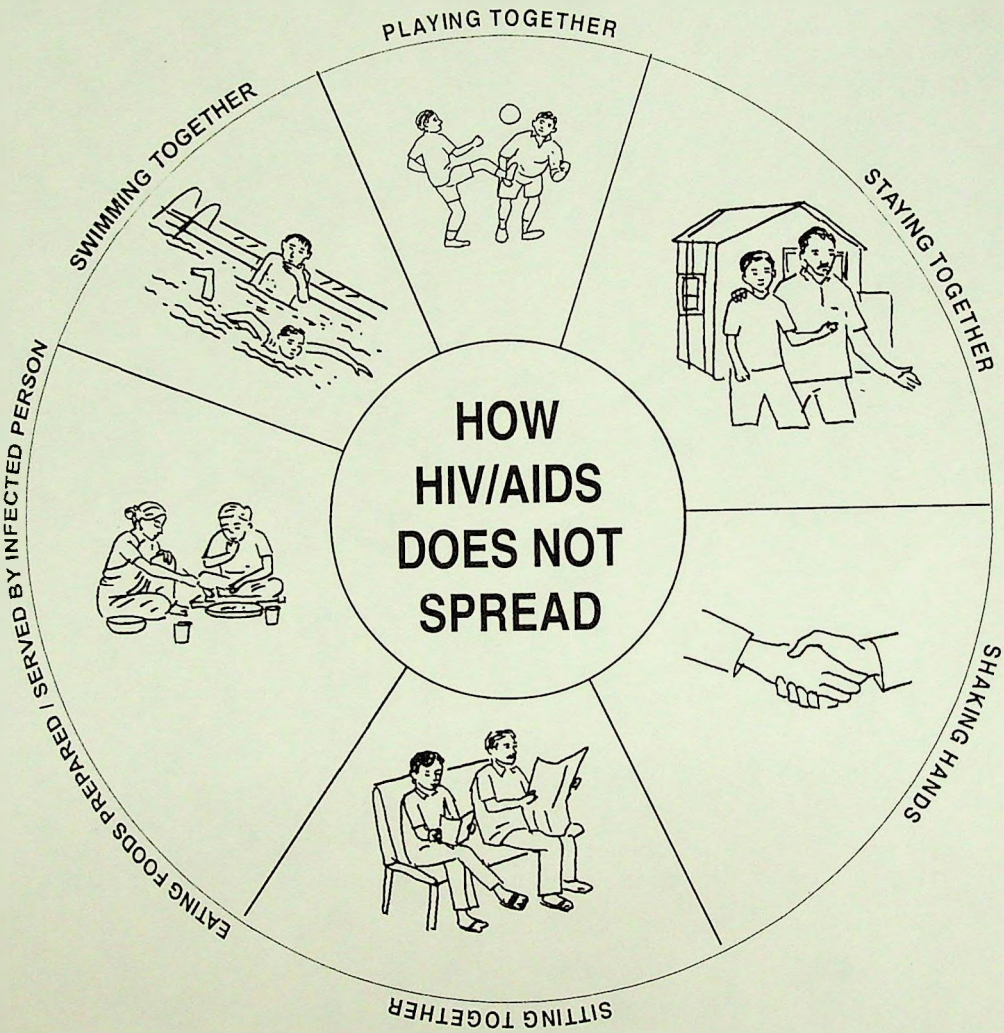
HIV/AIDS - Health is in Your Hands!!!!!

ACTIVITY MATERIAL - 2.10c



HIV/AIDS - Health is in Your Hands!!!!!

ACTIVITY MATERIAL - 2.10c



Sexual Harassment - Road Side Romeos and Bus Teasers

ACTIVITY MATERIAL - 2.11

Situation - 1:

A group of school girls are traveling in crowded bus to school. While traveling a man who is standing next to one of the girls Vani, intentionally leans against her, touching/brushing her shoulder and bottom. Whenever the driver applies the breaks he falls against her. Vani _____.

Situation - 2:

Raghav, is a 15 year old boy. Past 1 month, he is receiving 'calls' in which the person does not speak, but keeps making noises - as if kissing. If somebody else receives the call, the caller disconnects the call. Raghav, initially felt very good about such calls; now he has become tired of them and hates these calls. He _____.

Situation - 3:

Rachitha, has to pass a small shop on her way to school. A group of boys stand there and pass comments - describing her physical features and comparing to that of a movie star. One boy makes the comments and the others roar in laughter. Rachitha _____.

Discussion Questions for the Groups :

1. Are the above types of sexual harassment common?
2. What are the other types of sexual harassment you are aware of?
3. How do girls/boys respond to such harassment?
4. What do you think are the correct ways of responding - reporting to teachers, police, calling Makkala Sahayavani, etc?
5. How much is the harassed girl/boy responsible for the harassment?
6. What skills are needed for a girl/boy to face such harassment?
7. Why do some people involve in such harassing acts?

Sexual Harassment - Road Side Romeos and Bus Teasers

ACTIVITY MATERIAL - 2.11a

Some Useful Methods to Handle Sexual Harassment:

- 'Ignoring' if the incident is by a total stranger in a strange place and the chances of repetition is very low (noticing some one exhibiting genitals in a bus). Here the ignoring must be total - expressing 'shock' or 'surprise' encourages the person.
- 'Not responding' is also effective in some other incidents - anonymous obscene calls.
- Indicating that one is aware of harassment and not appreciative of it. For example, if a man harasses a girl in a moving bus by brushing against her repeatedly, she could handle it initially by moving away from him; later firmly telling him to stand properly without abusing him. If abuser continues to harass, complaining to others or conductor is desirable.
- Predicting and avoiding a harasser - e.g., if a male teacher often touches a girl student whenever she is alone, the girl could foresee this and always take a friend along while meeting the teacher.
- Taking support and being in company are effective for a variety of harassment - for being bullied, ragged, leered, teased or followed by a male or group of boys.
- Informing to a supportive sibling, friend, parent or teacher, if the harassment is repetitive.
- Lodging complaint with the police after discussing with the parents if the harassment continues.
- Screaming for help, taking instruments for confidence (a stick, knife or chilli powder) can be helpful for girls to face harassment.
- Adolescents especially boys to be taught that sexual harassment does not indicate superiority but rather inadequacy.
- Have 'Sexual Harassment Awareness Week' and discussing the above issues in the school.

8th STANDARD
ACTIVITY MATERIALS

LSE-NIMHANS/2002

Continuing School - Stepping Stone to Success!!!!!

ACTIVITY MATERIAL - 1.1

Situation - 1:

Ramappa is a 20 years old youth who works as a helper in a scooter garage. Ramappa used to be an average student in 7th standard about 7 years ago when his earning brother died in an accident. He decided on his own to give up studies and join his brother's work as a garage helper. His parents were against his decision. But Ramappa was very happy with the fact that he was able to earn Rs. 50 per day and help his parents. He was proud that he was only 13 years but earned like a man. He felt that God would bless him as he helped his parents live a better life. He now earns about Rs. 75 per day and is hardly able to meet the basic needs of his life. His family consists of an old, sick mother and two sisters. The sisters have also discontinued studies and work as labourers in a garment factory. They earn Rs.75 each per day, but spend about a third of their income everyday traveling up and down to their places of work and eating lunch. Ramappa meets some of his old school friends and learns that they are continuing their education in commerce, engineering, medicine, arts and so on. He deeply repents his decision of discontinuing school and often spends sleepless nights. He now understands that the present job fetches him money, but it is hardly enough to meet the demands of his family. He has not learnt any specialized skills, which would help him to earn much more. This makes him worry a lot resulting in decreased efficiency at work. Ramappa feels totally lost in his life; neither can he restart schooling to acquire higher skills nor can he do something different to earn more money to meet the demands of his family. Lately, his worries make him resort to using alcohol which is further worsening his financial situation. Ramappa did not give a thought to the consequences that would follow when he decided to stop school. He feels sorry about his situation and wonders why he did not listen to his parents.

Discussion Questions for the Groups :

1. Why did Ramappa discontinue studies?
2. What should he have done when he thought of giving up studies?
3. Did Ramappa prepare himself mentally to face the consequences of discontinuation of education and problems that were likely to come up in future?
4. What should Ramappa do to handle his unhappiness and worry now?
5. What are the other reasons why a student stops attending school without completing X or XII standard?
6. What should any one of you do if similar situations arise in your lives?
7. Is it necessary to study even in the face of difficulties?
8. Why should one continue studies, when completing X or XII standard does not guarantee anyone a very good job nor can the youth then go back to manual or unskilled work?
9. What are the skills/abilities needed and steps to be taken by a student to continue studies even in the face of difficulties?
10. How can others like teachers or parents or friends help in such a situation?

Understanding Motivation - We can Still Do It

ACTIVITY MATERIAL - 1.2

Eating Habits - The Key to My Health

ACTIVITY MATERIAL - 1.4

Situation -1:

Rani is studying in VIII standard. She comes from a very poor family. She frequently develops ulcers at the angles of the mouth and complains of burning tongue. These problems occur frequently following bouts of fever. As she is often sick her mother gives her thin rice kanji. Rarely does she sit and eat the simple meal of ragi ball and saru with greens with her two sisters. Rani is short statured compared to her classmates and sisters. Her hair is brown and she looks pale and fairer than her sisters. Rani's mother likes her more than the other children, as she is always sick, and also fairer than the other daughters. She says - she is really a Phirangi Rani - (foreign queen). Mother feels sorry that she is not able to give Rani milk and chicken soup, which can be easily digested and better for her health. Rani always feels weak, unable to play and concentrate on her studies. Rani's mother thinks that she should be given only simple kanji as she is often sick and it is difficult for her to digest ragi mudde and saru. Rani's class teacher says that Rani falls sick because she is not eating normal food and has no resistance in her body.

Discussion Questions for the Groups :

1. Do you agree with Rani's mother?
2. Why does Rani fall sick so often?
3. Do you think her light colored hair and pale skin are signs of beauty?
4. How can Rani's mother improve her health without spending much money?

Stituation-2:

Varun is an intelligent 14-year-old boy in IX standard. He is the only son of his parents. He is very choosy about his food. He is very fond of meat and chicken. He does not like to eat any vegetables. He eats rice and thili saru every day. However, he eats rice with meat or chicken curry whenever it is prepared. Parents are not worried as he eats meat and chicken, which are healthier than vegetables. Mother tries very hard to make egg curry at least two to three times a week for Varun's sake. Varun also buys snacks (cotton candy, potato chips) from the shop and eats them twice a day.

Discussion Questions for the Groups :

1. What do you think of Varun's eating habits?
2. He seems to be healthy - is there a necessity to eat vegetables at all?
3. How can Varun's parents encourage him to eat vegetables?

Stituation-3:

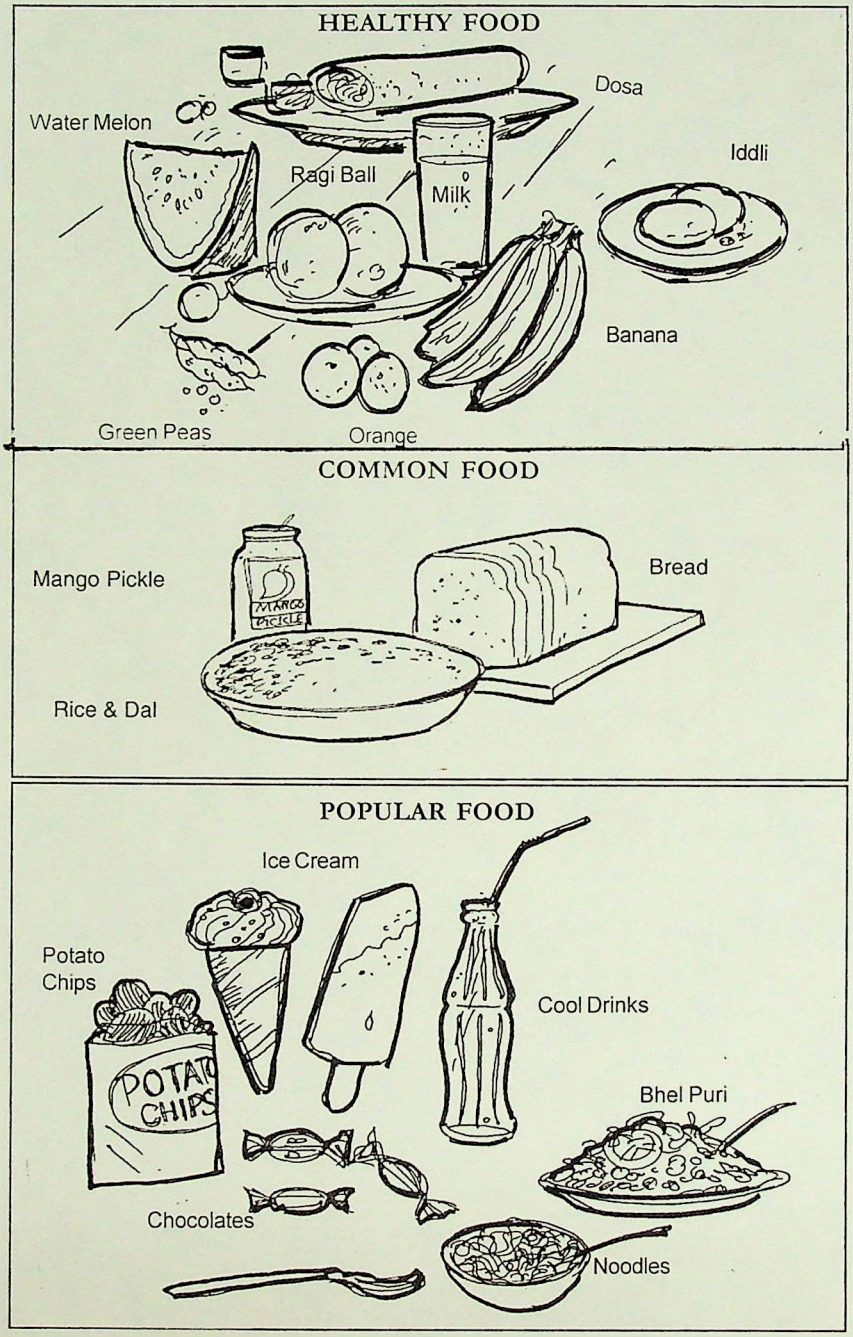
Ayesha is a X standard girl who is worried about her final board exams. Often she has no time in the mornings to have breakfast as she is attending tuitions from 6 a.m. So she leaves home after having a cup of tea. Her mothers packs bread and jam almost every day for lunch as she leaves very early. Ayesha comes home at 6.00 p.m. after school. She is very hungry and eats a large meal at that time. This makes her tired and sleepy. She has difficulty in concentrating on studies after the meal. This makes her unhappy and irritable. She has a lot of tea to keep her awake.

Discussion Questions for the Groups :

1. Is this common among students of your age?
2. Is it healthy? If not why?
3. Why is Ayesha tired and sleepy after the meal?
4. What advice can we give to improve Ayesha's food habits to suit her routine?

Healthy and Unhealthy Food - I Do not want Iddli again for Breakfast

ACTIVITY MATERIAL - 1.5



MOTIVATION - HOW TO IMPROVE MEMORY

ACTIVITY MATERIAL - 1.3

Memory Tips:

- *Repeating the learnt material again and again.* This is unfortunately possible only for short pieces of information. Children learn mainly by this method because what they learn is simple. Very large amount of information cannot be repeated easily many times. Other methods are :
- Repeating the concepts has the same effect and this can be achieved in multiple ways.
- Totally understanding what is read - as it is connected to earlier known information.
- Summarizing.
- Explaining in one's own words.
- Discussing with friends.
- Focused group study i.e. a group of students discuss a particular topic.
- Explaining to a friend who has not read the lesson.
- Having a question answer session on it among friends.
- Having mock exams with model questions.
- *Reading the same topic/information in different ways and by different authors* - Bible information by various authors - Luke, Mathew. Different sources give you the same information with different views, which helps the student to understand and repeat thoroughly in his/her mind.
- *Connecting it to earlier known information* - Student remembers that India got independence in 1947. Gandhi died soon after that. So the year of death of Gandhi should be after 1947 - probably 1948.
- *Connecting it to mental images i.e. pictures or numbers* - Remembering that Yellow River flows in China - imagining yellow race men and women with small eyes taking bath in a river in which yellow color lemons are flowing.
- *Making connections between multiple new information by an unique technique to which you are used to* - e.g., the first letters of the color of the rainbow are grouped as VIBGYOR for the order. This is called MNEMONICS.
- *Using methods where the initial registration is good* - by reading in a quiet place with no distractions and focused attention.
- Training the brain to register, review and recall any information by making reading and writing a regular habit and not only before exams. This reading can be books, other than subject books, in which one is interested.
- Training the brain to be prepared to register whenever you sit for studying - sit in the same place, specific time and after a small ritual of decreasing noise, distracting things and a prayer of self suggestion.
- *Reading the information with interest* - positive framework and keen interest make any type of learning easier as the connections are made better and faster. Example, the cricket scores and match dates are remembered better by a student who is a cricket fan, than the geography of South America.
- *Avoiding aspects, which can interfere with registration and recall for* e.g., mental tension. It is a common experience that we sometimes forget names, addresses and telephone numbers very familiar to us in situations when we are anxious. Emotional state significantly impedes recall and one will presume that his or her memory is poor. This leads to lack of self-confidence and poor self-esteem, which further increases the tension and decreases registration and recall.
- *READ, REVIEW* and *RECALL* are the three important steps.

Myths and Facts about Food - Porlicks Jyada Shakthi Detha Hai

ACTIVITY MATERIAL - 1.6

Situation - 1:

Ramu is a 14-year-old boy living in a dry and hot place near Bellary. He is a poor boy whose father is dead and mother is a labourer. Ramu has two other younger brothers. During the summer, Ramu and his brothers ate a lot of mangoes while playing in garden. All three of them developed many boils, which were painful.

Their mother and grandmother explained that the boils were due to 'heat', got by eating too many mangoes and prevented the brothers from eating anymore, although they liked them a lot. They were forced to apply castor oil everyday to their scalp to cool their bodies.

Since the boils did not heal, their mother took them to the doctor. He gave all the three brothers injections and advised the mother to clean the boils by washing with soap and water regularly and to apply some medicinal powder.

The boils healed in four days. Ramu who was studying in class IX, wanted to know why the method of cooling of body with castor-oil on the head did not help the boils heal. He also wanted to know whether the injection given was to cool the body. He asked the doctor his doubts.

Discussion Questions for the Groups :

1. What do you think was the answer of the doctor?
2. Are these 'cold/heat' food items?

Situation - 2:

Ragini is a 12-year-old girl who lives in Tiptur. Recently she attained puberty and since then she has heavy bleeding every month. Ragini feels very weak and tired. Father and mother took her to a doctor who advised healthy food and iron tablets. Her father bought a bottle of a popular health drink and biscuits for her and felt that these would help her.

Discussion Questions for the Groups :

1. Do you think that the health drink and biscuits would have helped Ragini to get adequate nutrition?
2. What should she do to take care of problems such as weakness and tiredness?

Situation - 3:

Krithika is a 14-year-old girl in IX standard. She is the only daughter of her parents. She is very choosy about her food. She does not like vegetables and fruits. Bananas (yelaki bale) is the only fruit she likes. Her mother does not allow her to eat yelaki bale as she gets cold and running nose whenever she eats it, since childhood. She eats rice and rasam every day. She enjoys meat preparations, as well. Krithika is often constipated and feels very uncomfortable in her stomach due to this. There is a lot of tension in the house in the morning if Krithika does not have a good bowel movement. Krithika's uncle who is a nurse visited her during holidays. He clearly told her and her parents that the constipation was due to improper food habits and she needs to eat all vegetables and fruits including bananas - yelaki bale.

Discussion Questions for the Groups :

1. Do you think Krithika has good food habits?
2. Is her uncle correct?

Being Clean - Do not Hold Your Nose!!!!!!!

ACTIVITY MATERIAL - 1.7

Cleanliness Statements:

The sheet has various activities which we do everyday/week/year. Discuss among your group members and mark by the side of each statement whether it C or S or F.

a. Activities one does to keep himself/herself clean/healthy in a day/every two days/each week / each month/each year (H)

b. Activities one does for social reasons - to be presentable or cultural (S)

c. Activities one does for improving one's appearance or for being fashionable (F)

1. Brushing teeth in the morning
2. Brushing teeth in the night
3. Bathing in the morning
4. Bathing in the night
5. Cleaning the ears and nose
6. Scrubbing the tongue
7. Gargling after eating food
8. Brushing the teeth after eating food
9. Removing footwear before entering the house
10. Washing the feet before entering the house
11. Wearing footwear while going out
12. Wearing footwear while going out to pass motion in the fields
13. Washing hands with soap before food
14. Washing hands with soap after eating
15. Shaving and trimming the beard and moustache
16. Cutting hair
17. Removing lice from hair - by medicine
18. Washing private parts after passing urine
19. Washing the bottom after passing motion
20. Washing hands with shikakai/soap after passing motion
21. Using a silk handkerchief
22. Using a small cloth as a hanky to cover your mouth while coughing
23. Wearing a tie
24. Wearing shoes
25. Wearing chappals
26. Washing undergarments every day
27. Washing clothes when they look dirty
28. Wearing socks
29. Washing socks when it is dirty
30. Washing handkerchief and towel everyday

31. Drying undergarments and towels in the sun
32. Drying clothes in the shade
33. Drying clothes in the sun
34. Wearing cotton salwar kameez
35. Wearing nylon salwar kameez
36. Wearing cotton pant/shirt
37. Wearing terry cot pant and shirt
38. Shaving underarms
39. Shaping eyebrows
40. Washing underarms
41. Wearing a wristwatch
42. Wearing bangles and chains
43. Applying powder to the armpits
44. Applying powder to the face
45. Cutting nails every week
46. Washing hair with shampoo/soap everyday, once a week or twice a week
47. Wearing bindi
48. Washing hair with shikakai
49. Applying oil to the hair
50. Applying nail polish
51. Applying mehendi to the hair
52. Wearing washed clothes every day
53. Changing bra/banian, underwear every day
54. Applying cream to the face
55. Wearing ironed clothes
56. Wearing kajal
57. Wearing flowers on the hair
58. Eating with a spoon
59. Applying oil to the hair
60. Combing the hair
61. Applying lipstick
62. Spraying scent on the body
63. Wearing undergarments
64. Wearing chandan or vibhuthi on the forehead
65. Plaiting or tying the hair
66. Wearing a hat or holding an umbrella or a wearing a cloth around your head while going out in the sun
67. Washing bed sheets and pillow covers every week
68. Wearing cooling glasses while going out in the sun
69. Wearing well fitting clothes
70. Wearing nylon bra/banian and underwear

Prevention of Infectious Diseases - Wash, Wash, Wash!!!!!!

ACTIVITY MATERIAL - 1.8

Red Card Infectious Diseases	Yellow Card Signs and Symptoms	Green Card Prevention Card
Diarrhoea	Watery stools with blood	Avoid eating contaminated food
Chicken pox	Fever, rashes on trunk which later spread to face and limbs	Isolate infected person Take vaccine
Conjunctivitis	Swelling of eye lids/discharge from eyes and/ red eyes	Do not share personal care items that come in contact with the eyes such as face cloths, towels, pillowcases, makeup or eye drops. Wash eyes regularly. Wash hands frequently and keep away from eyes
Influenza	Cough, running nose and fever	Develop habit of covering mouth while sneezing and coughing. Don't share handkerchiefs, towels of infected person
Typhoid	Fever, body aches and pain, low pulse rate, vomiting, diarrhea and abdominal pain	Develop the habit of washing hands with soap after passing stool. Take vaccine during an endemic breakout and avoid contaminated food.
Measles	Fever, pink colour rashes and Itching	Isolate infected person Immunization
Cholera	Passing stools which is white in colour frequently (rice water stools) and vomiting	Drink boiled water Always cover the food and other eatables. Do not eat articles/ food exposed to flies. Wash hands after passing motions
Hepatitis - A	Yellow urine, yellow eyes, fever, lack of appetite	Wash hands after going to the toilet and immediately prior to handling food
Tuberculosis	Cough, sputum with blood, fever, loss of weight and appetite	Consult doctor immediately Isolate the patient Give BCG to children for immunity
Malaria	Fever with chills, body aches and pain	Prevent mosquito bites Prevent mosquito from breeding Sleep under mosquito net
Lice Crabs	Severe itching in pubic area, seen moving on the body or pubic area	Regular bath with soap and water - keeping the pubic area clean

Peer Pressure - Friend or Foe?

ACTIVITY MATERIAL - 1.9

Situation - 1:

Pramod is a very shy but a bright student. He is hard working, obedient and religious. He has very few friends and most often he is the subject of jokes in his class as he is considered a 'goody goody boy'. He is teased and ragged all the time, which makes him feel isolated and rejected. Pramod spoke about this with his parents and they told him that he should be brave and courageous but did not tell him what he should do about it.The feeling of isolation at school bothers Pramod a lot. He tries a lot to be friendly with his classmates. No matter how hard he tries he is pushed aside and teased. One day when he approaches his classmates they challenge him to prove his becoming a 'Man' by giving a love letter to one of his class girls. They promise to make him a part of their group if he does so. Pramod initially refuses. The boys repeatedly challenge and lure him. After days of bargaining, Pramod takes a decision to do what the boys have instructed. He writes a love letter to one of the class girls, shows it to the classmates, and in their presence walks up to the girl and gives it to her.

The girl is shocked at Pramod's behavior and brings it to the notice of her parents and the Principal. Principal takes a decision to suspend Pramod for 10 days after a preliminary enquiry, for bad behavior, Pramod asks the classmates' help to talk with the Principal and prevent suspension. But the classmates refuse to help him. Pramod realizes that despite their promise to become his friends, they are not extending a helping hand though he gave into their pressure. He regrets that he had not thought through the whole act well, but focused only on becoming a part of the gang.

Situation - 2:

Sarayu is a very bold and intelligent girl of 16 years in X standard. She comes from a poor family. Her parents work as manual labourers and send the children to school. Sarayu is aware of the difficulty of the family and behaves in a responsible way. She is in the Class Squad - two and very popular among the squad members. One day four girls who are best friends of Sarayu plan to cut class and go to a movie and later to a hotel to celebrate before leaving school. Sarayu expresses inability to participate due to lack of money. The girls plead with her repeatedly to somehow join them as this would be their last outing together in school life. Sarayu knows the poverty at home but is lured by the argument of the friends. The friends do not have money to spare. So Sarayu steals money from the God's Hundi, which she plans to put back, whenever she gets money. She is also convinced that nobody will notice the loss of money from the Hundi because no one checks it. She goes to the movie and later to the hotel. When she comes out of the hotel, she sees her father unloading rice bags from a lorry for the hotel. Her father also sees her coming out of the hotel with her friends. When father demands an explanation for Sarayu's behavior she argues and shouts at him that she has a 'right to have good time like other girls'. Also adds that there is nothing wrong with her behavior of using the money from the Hundi which was anyhow not being used by anyone.

Discussion Questions for the Groups :

1. Are the situations of Pramod and Sarayu common among adolescents?
2. How do they handle such situations?
3. What skills are needed by an adolescent to handle such situations?
4. What was Pramod's difficulty in saying 'NO'?
5. What was Sarayu's difficulty in saying 'NO?'
6. Sarayu's arguments with her parents - Is it Assertion? Discuss.
7. What are instances where assertive skills are needed a lot - with whom?
8. With whom is it difficult to be assertive - parents or friends?

Bullying - The Esteemed Chair

ACTIVITY MATERIAL - 1.10

BULLYING "HANDLING TECHNIQUES":

- When being bullied do not show that you are afraid, upset or angry - this needs anticipation and practice by the child/adolescent who is bullied. Bullies usually do not like to trouble others who are not troubled by it.
- Do not fight with the bullies, as they are usually big and well built.
- It is not worth hiding your possessions or money if a bully is looking for it. Preventing physical injury is more important than losing your possessions.
- Making a funny comment or joke when one encounters the bully is very helpful. Such behavior puts bullies off.
- Be in the company of your friends so that you get support even if bullied.
- Disclose bullying to a close friend, a sensitive teacher, parent or other significant adults. It is not telling tales about others.
- If you feel very upset by the bullying write a diary of your feelings. This may help you to handle it without much fear and anger.

Dealing with Anger - I Feel like HITTING Him, Idiot!!!!!!!

ACTIVITY MATERIAL - 1.11

DO'S AND DON'Ts OF HANDLING ANGER :

Do's :

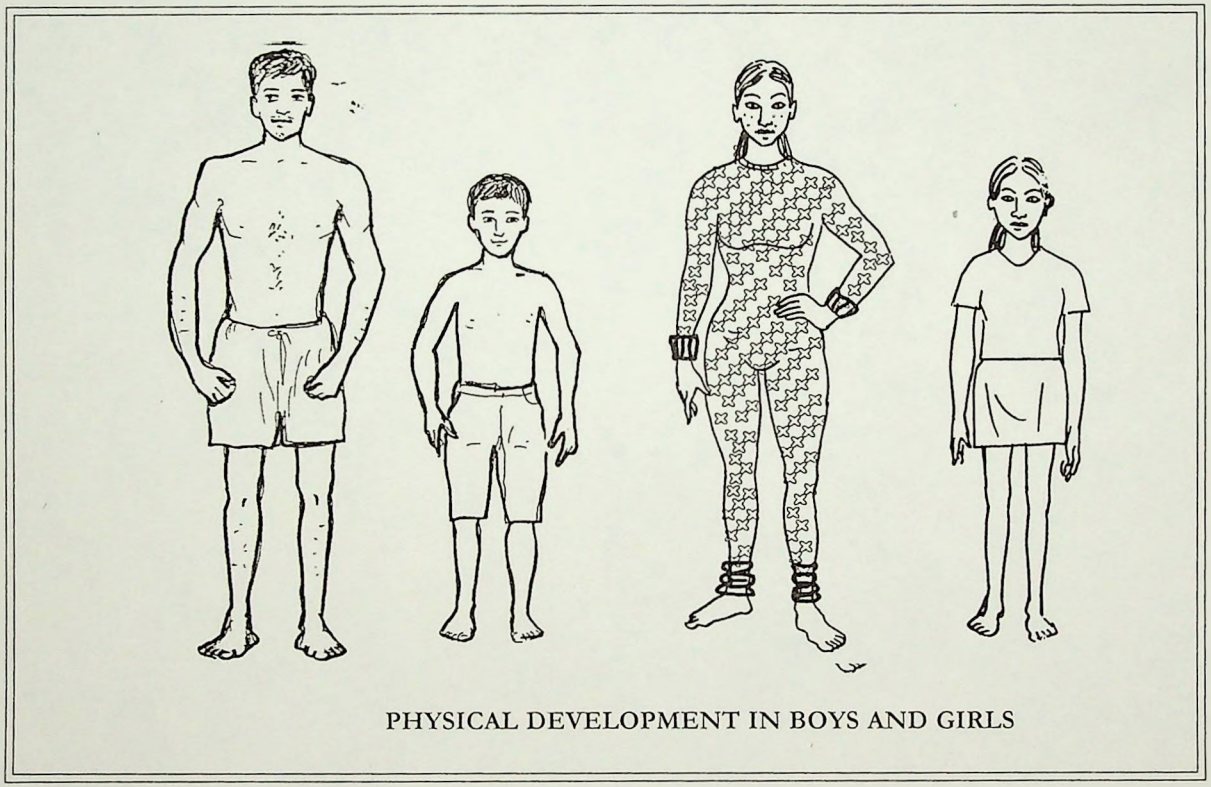
- ☑ Say Stop. Close your eyes count 1 to 10 forward and backward.
- ☑ Take deep breath and tell yourself 'Relax', 'Calm Down'.
- ☑ Walk away from the person or issue which is making you angry until you calm down.
- ☑ Talk to yourself: Say what is wrong. Use your words to say what you do not like rather than what you think the other person is doing to make you angry. Example, say "I do not like being charged excess meter without valid reason" rather than, saying for e.g. "This auto driver is cheating me by charging excess".
- ☑ When you are angry with a person, give a clear indication that you are upset and you do not want to deal with the issue as you are angry - indicate a specific time later when you would be more under control - for e.g., "I do not like the fact that you told about me to Suresh. I would want to talk with you about it tomorrow evening".
- ☑ While discussing about the issue of anger avoid using words like "never or always" and use the "I" word in distress mode. Instead of saying, "You hurt me" say, "I feel so hurt". This is one way of taking responsibilities for one's own emotions (here anger) and allowing space for dialogue and possible ways of solving problem or situation that is causing anger.
- ☑ Write down your feelings when you are angry with others. Read and reread it till you are able to think about the problem in a calmer manner.
- ☑ Express anger more assertively than aggressively (assertion has been dealt with in the earlier two classes). That means know your rights and also respect others' rights.
- ☑ Practice of relaxation also helps in controlling anger.

Don'ts:

- ☒ Do not conclude that "getting angry" is wrong.
- ☒ Don't suppress anger or pretend it is not there.
- ☒ Don't smash things, punch walls, beat, scream etc.
- ☒ Don't drink alcohol to "wash away" problems.
- ☒ Do not blame yourself and injure self.

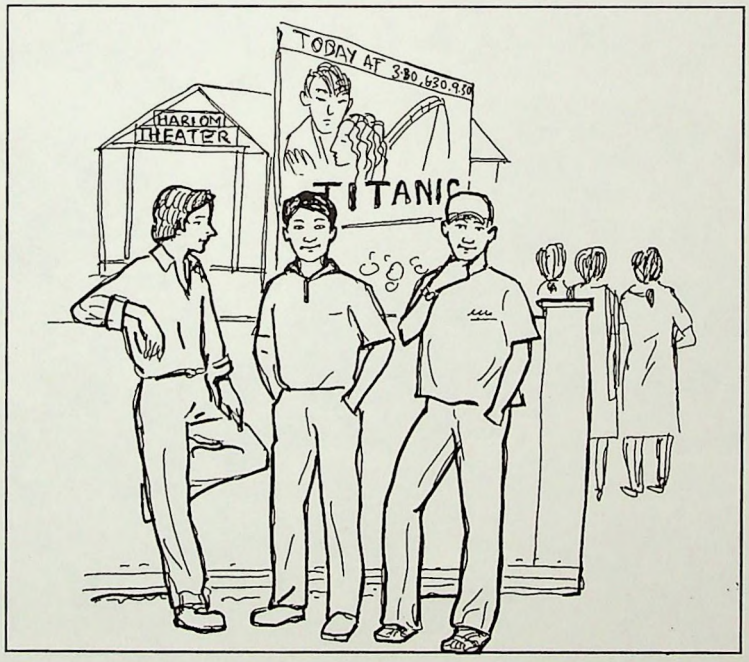
Understanding Body and Mind - I am a Growing Boy/I am a Growing Girl!!

ACTIVITY MATERIAL - 1.12



PHYSICAL DEVELOPMENT IN BOYS AND GIRLS

PSYCHOSOCIAL DEVELOPMENT - 2



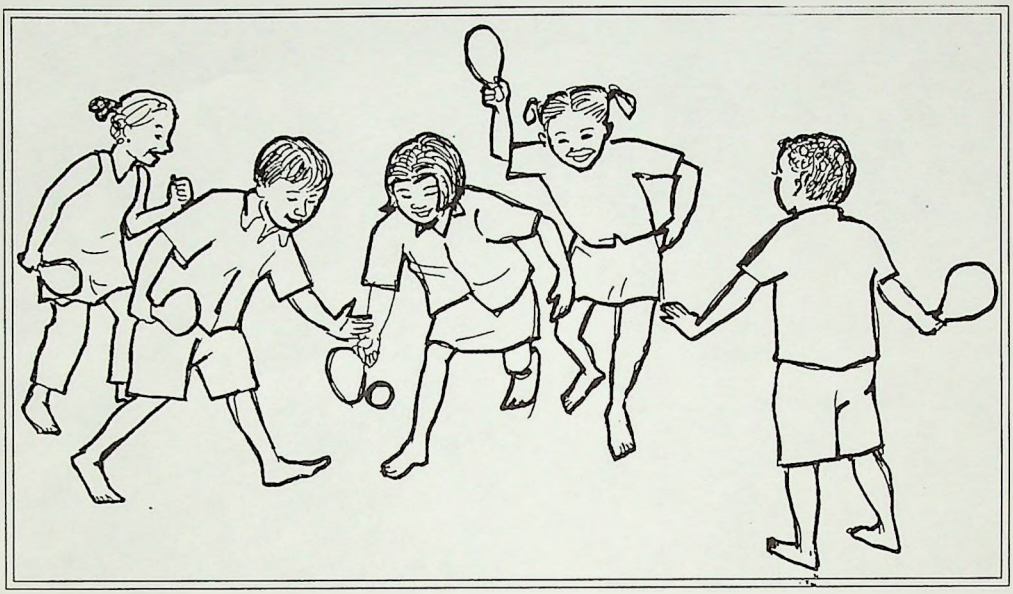
PSYCHOSOCIAL DEVELOPMENT - 2a

Understanding Body and Mind - I am a Growing Boy/I am a Growing Girl!!

ACTIVITY MATERIAL - 1.12a

Understanding Body and Mind - I am a Growing Boy/I am a Growing Girl!!

ACTIVITY MATERIAL - LI2a

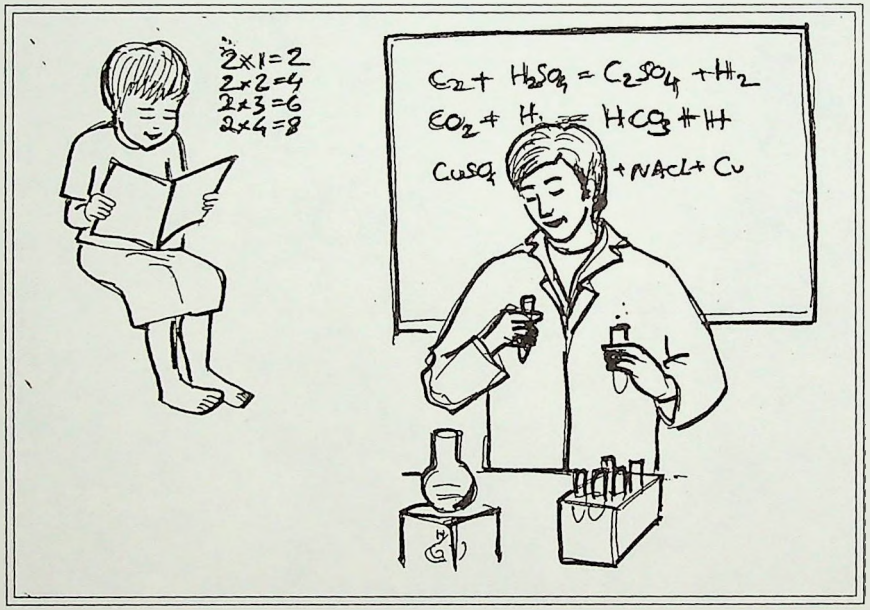


PSYCHOSOCIAL DEVELOPMENT - 3

PSYCHOSOCIAL DEVELOPMENT - 3a

Understanding Body and Mind - I am a Growing Boy/I am a Growing Girl!!

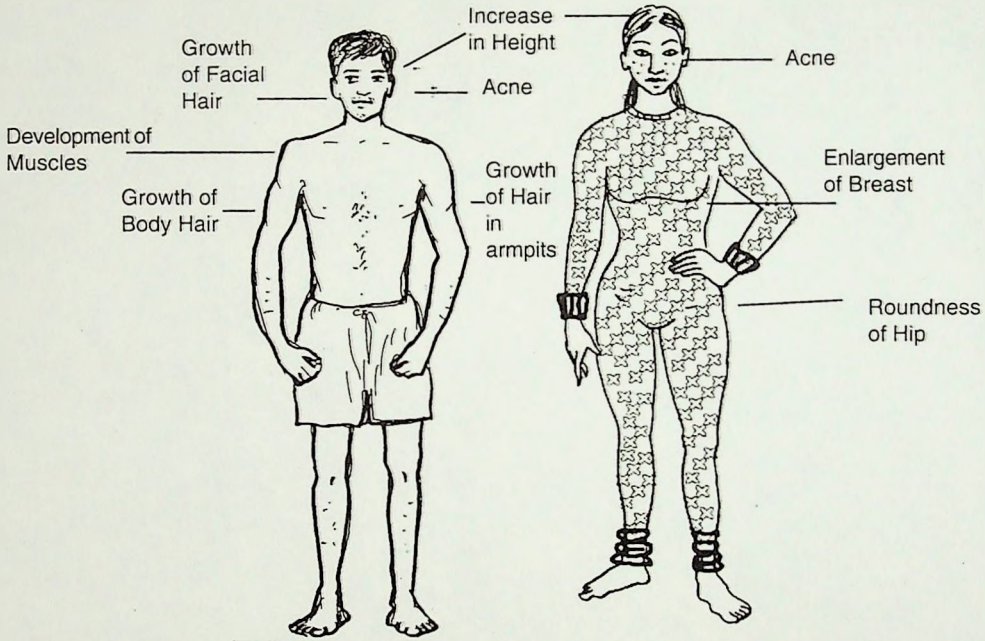
ACTIVITY MATERIAL - 1.12a



INTELLECTUAL DEVELOPMENT - 4

Understanding Body and Mind - Body Mapping

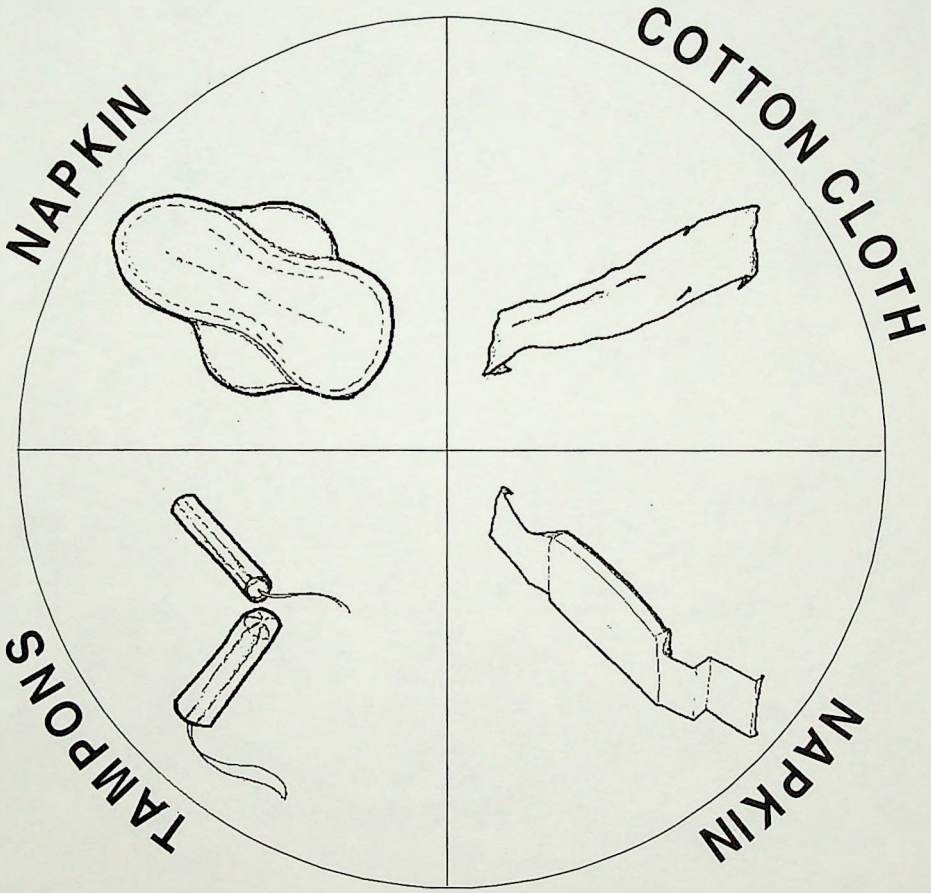
ACTIVITY MATERIAL - 1.13



SECONDARY SEXUAL CHARACTERISTICS IN BOY/GIRL

Menstruation - I Wonder Why ?? !!!!!!

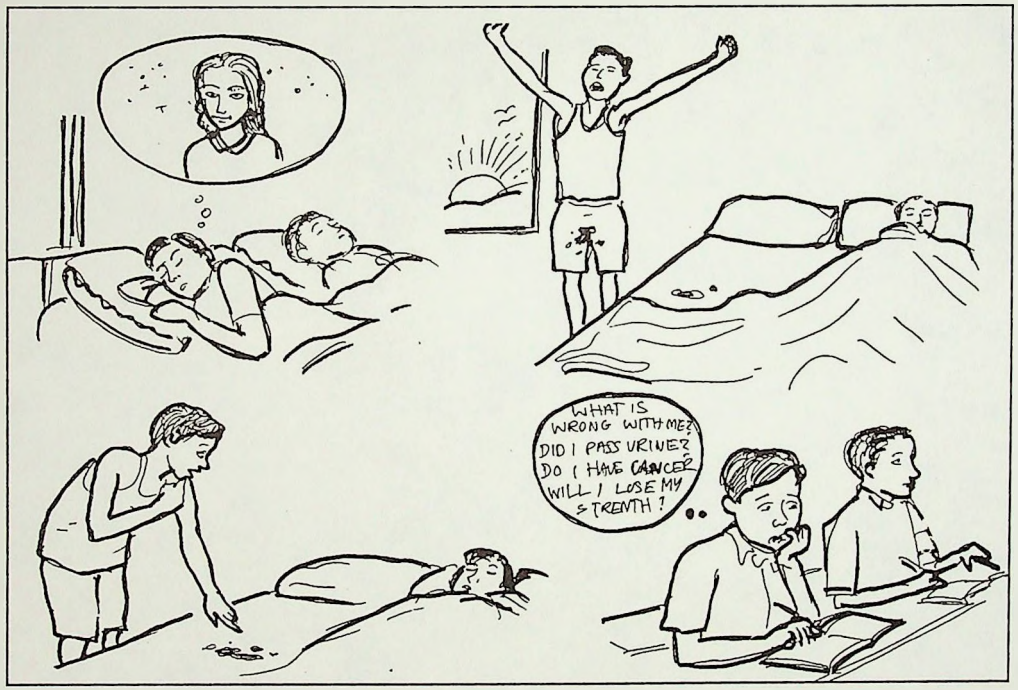
ACTIVITY MATERIAL - 1.14



AIDS FOR MENSTRUAL HYGIENE

Wet Dreams & Masturbation - I Wonder Why??????

ACTIVITY MATERIAL - 1.15



Wet Dreams & Masturbation - I Wonder Why??????

ACTIVITY MATERIAL - 1.15a

Some Myths about Wet Dreams and Masturbation:

- MYTH: Loss of semen during wet dreams leads to weakness of body.
  FACT: Wet dreams/masturbation is normal among adolescent boys. It does not make one tired.
- MYTH: Wet dreams are more among the boys who are over-sexed and always pre-occupied with sexual fantasies.
  FACT: Wet dreams are common soon after puberty in a boy - this is normal. Sexual urges and fantasies are common in all healthy boys. Many learn to channelize and divert their attention to other pleasurable activities like games, studies and hobbies.
- MYTH: Masturbation is more among young boys than married people.
  FACT: Masturbation is common among the young, married and even elderly people. Acting on sexual urges is less among the married and elderly due to other stress and hormonal changes.
- MYTH: Only the young, unmarried and the immature individuals practice masturbation.
  FACT: Even married people can practice masturbation. There is no research evidence to show that only immature people practice masturbation.
- MYTH: Practicing masturbation is a sin.
  FACT: Masturbation is an outcome of a physiological need. The guilt feelings associated with such an act and the attitudes of the society make the person to think that it is a sin.
- MYTH: Only boys practice masturbation. Girls do not practice masturbation.
  FACT: Masturbation is practiced by both sexes. It is more common among the men. Women are taught culturally to suppress sexual needs. This does not mean they have no sexual needs. A woman masturbates by stimulating the clitoris.
- MYTH: Masturbation leads to weakness, impotency and insanity.
  FACT: There is no connection between masturbation and weakness, impotency and insanity. It does not lead to insanity.
- MYTH: Masturbation leads to homosexuality among boys in later years.
  FACT: Masturbation does not lead to homosexuality among adolescents in later years. There is no research evidence to show that practicing masturbation causes homosexuality in later years.
- MYTH: Masturbation causes dark circle around the eyes.
  FACT: Masturbation is normal among adolescent boys and girls. It does not cause dark circles around the eyes.
- MYTH: People who masturbate are not sexually normal.
  FACT: They are normal as it is a physiological need in every adult.
- MYTH: Frequent masturbation leads to shrinkage of penis.
  FACT: No, Masturbation does not lead to shrinkage of penis. After ejaculation the penis normally shrinks to its usual size.
- MYTH: Masturbation causes mental illness.
  FACT: Mental illness is not caused by masturbation. But misconceptions about masturbation can result in anxiety and memory problems due to impaired attention and concentration.

Wet Dreams & Masturbation - I Wonder Why??????

ACTIVITY MATERIAL - 1.15b

Genital Hygiene in Boys:

- Washing genitals daily with warm water.
- Gently removing foreskin back and washing the tip of the penis. Secretions accumulate under the foreskin and could cause infection if not cleaned regularly.
- Changing underwear regularly.
- Using cotton undergarments only - synthetic undergarments do not absorb moisture and also increase the temperature.
- Washing undergarments everyday and drying them in sun.

10th STANDARD
ACTIVITY MATERIALS

Making Life Choice - When I Grow Up I want to become A BIG____

ACTIVITY MATERIAL - 3.1

The Life Choice Career Sheet:

Today you are a student. According to you, what job, will you be in, 10 years from now?

1. Does it need further studies?
2. Does it need training?
3. According to you how many years of further studies does it need?
4. According to you how many years of training does it need?
5. Is it a skilled job or unskilled job?
6. Would you like a salaried job?
7. Would you like a self - employed job?
8. Would like a private firm job?
9. Would you prefer a government job?
10. In what way are you preparing yourself for this job?
11. Is the job - decision, made by you or by your parents?
12. Will your parents support your decision?
13. How much guidance do you expect from parents for this decision? - full/ little/ a lot
14. How much guidance do you expect from your teachers for this decision? - full/ little/a lot
15. How much finance do you need to get this dream of yours realized?
16. Do you think about your job/career?
17. Have you discussed this with your friends?
18. Have you discussed this with your parents?

You have decided on this career because

1. You always wanted it - Yes/No
2. You think you have the abilities required for this job - Yes/No
3. Your parents decided this for you - Yes/No
4. Many of your friends choose it - Yes/No

5. This job is the most popular today - Yes/No
6. Pays most money - Yes/No
7. Gives stability and security - Yes/No
8. Good dowry market - Yes/No
9. Quick money - Yes/No
10. Gives employment to others - Yes/No
11. Socially meaningful - Yes/No
12. Allows you as a woman to be married, have children & work - Yes/No
13. Easy to get - Yes/No
14. Extra income possible - Yes/No

Is there a possibility that you will be unemployed ten years from now? Why?

Family:

1. Do you expect to get married?
2. When do you think you will get married - number of years from now?
3. Will be it an 'arranged marriage' or 'love marriage'?
4. If arranged will you say 'no' if you do not like the person?
5. Do you think your parents will listen to your opinion?
6. Most important quality your life partner should have?
7. Truly speaking will you give/take dowry?
8. Would you like to work after marriage/would you like your wife to work?
9. Have you discussed about marriage with friends?
10. Have you discussed about marriage with siblings - brothers, sisters?
11. Do you love somebody now?
12. Do you plan to marry him/her?
13. Do you plan to have children?

Preparing for Examination - I will do my BEST!!!!!!!!!!!!

ACTIVITY MATERIAL - 3.2

HOW TO PREPARE FOR EXAMINATION: Guidelines

Preparation throughout the Year

- Adequate and early preparation is very important to reduce examination tension.
- Preparation starts from the day the student enters the class for that year.
- Attending classes regularly and listening with interest.
- Taking down proper notes in the class.
- Reading textbooks and comparing it to the class - notes, to a get clear picture and understanding of the lesson covered by the teacher.
- Any reading is to be understood by its concept than just memorizing it.
- Writing and summarizing by the student in a way, which is easy for him/her to remember what is read (using mnemonics as an aid to cover all points).
- Discussing the lesson with friends out of the class.
- Clarifying doubts with teachers or other classmates.
- Getting the help of teachers, parents or a tutor if the student has difficulty in understanding certain topics or chapters.
- Finding a method to connect it to other known information.
- Reviewing notes regularly.
- Giving more time and importance to subjects found difficult by the student - e.g. Mathematics, English.
- Avoiding choosing portions in each subject and reading only that based on earlier question papers.

One Month Before the Exams

- Preparing a study plan.
- Combining favorite and not so favorite subjects in the study plan of a day.
- Trying and completing two Model Question Exams (each subject) in this time.
- Having fixed time of sleep and relaxation (including T.V. time).
- Meditating and doing autosuggestion every day - to be calm in the examination situation.
- Discussing with one's parent or sibling or friend regarding progress in the exam preparation from time to time.

Some DON'Ts Few Days Before the Exams

- ☒ Collecting new notes and materials from friends and reading them till the last minute without time for revision.
- ☒ Trying to learn new things on one's own at the last moment.
- ☒ Sitting for long hours continuously to read. Not taking breaks for bath, food, relaxation and sleep. It makes one feel more tired, reduces concentration and makes studying boring and anxiety producing.
- ☒ Keeping awake whole night and reading for few days before the exams.
- ☒ Excessive use of Coffee or Tea or Cigarettes to keep awake the whole night.
- ☒ Giving up studying totally as the student feels that his/her mind is 'BLANK' and seems to have forgotten everything that was read; hence giving up.

- ☒ Spending time to trace the 'question papers' or teachers who are probably involved in paper correction.
- ☒ Copying large amount of materials on bits of paper thinking that it might help during exams.

Some Do's on the Day of the Examination

- ☑ Having a good night's sleep the previous night.
- ☑ Having a light but adequate breakfast.
- ☑ Leaving for the examination hall well in advance.
- ☑ Checking whether one has taken all the necessary things - pens, pencils, geometry box, hall-ticket - a checklist of all items is essential.
- ☑ Going to the toilet before entering the examination hall.
- ☑ Taking deep breaths, making suggestion or a prayer to do well.

Steps to be Followed when the Student Gets the Question Paper in Hand

- ▶ Reading the instructions carefully. If there are any doubts clarify with the instructor, teacher or invigilator.
- ▶ Budgeting the time and planning the answers. Allocating time for each question. Many times students write one answer for too long a time and ends up with too little time for the other questions.
- ▶ Choosing the best known questions if choices are available.
- ▶ If not sure of an answer, not spending long time thinking and recalling answers. Going to the next known question. Handling the less known questions towards the end.
- ▶ Writing legibly - if a mistake is made do not overwrite but cross it out.
- ▶ Highlighting important points - underline, write in capital etc.
- ▶ Answering to the point and not writing unnecessary information to make the answer appear long.
- ▶ Giving equal importance to things like formulas (maths, science), drawing figures (science), marking on the map (geography), graphs (maths and physics).
- ▶ Trying to finish ten minutes earlier. This helps the student to go through the paper and correct mistakes/underline important points etc.
- ▶ Most of the students have a habit of discussing answers with friends after the examination. This makes the student anxious and worried. The anxiety may interfere with the reading for the next examination. Once an exam is over it is better to concentrate on the next one. Review and discussion could be done after the last examination.

How to Handle the Anxiety:

The Guidelines

- ▶ Following "How to Prepare for Exams" suggestions during preparation before and on the day of exams.
- ▶ Following some specific relaxation techniques many times a day - meditation, breathing exercises, prayers and autosuggestion. This method must be comfortable and useful to the student. So it is necessary that the student starts using it, months before the exams and see whether it is effective for him/her.
- ▶ Solving old examination papers within specified time - 3 hours, i.e. doing mock exams on one's own.
- ▶ Recognizing whether one is mildly anxious or highly anxious that interferes with concentration and learning. If one is highly anxious, sharing it with someone whom the student trusts in and taking help is desirable.
- ▶ Avoiding negative thoughts, for example 'I have not prepared well', 'I may fail in this exams' or 'I have not covered all the portions'.
- ▶ Practice group relaxation exercises in the school for 10 minutes everyday at least 3 months before exams.

Coping with Stress and Suicidal Behavior - Flying the Kite of Hope

ACTIVITY MATERIAL - 3.3

DIRECTOIN : You have to connect all the nine dots by four lines without lifting the pen/ pencil from the paper or retracing a line already drawn.

PROBLEM:

Coping with Stress and Suicidal Behavior - Flying the Kite of Hope

ACTIVITY MATERIAL - 3.3a

Situation - 1:

Krupakar and Vasumathi are good friends studying in X class. They spend time together reading, talking, exchanging class notes etc. They never consider themselves to be 'lovers'. One of Krupakar friends' who is jealous of Vasumathi's friendship with Krupakar, writes on the school walls and black boards that they are 'lovers'. Both of them feel very upset and ashamed by this. Vasumathi goes home during the class and without telling her mother anything hangs herself with her dupatta in her room. Knowing about her suicide, Krupakar drinks Tik-20 the next day but is saved by his brother.

Situation - 2:

Shareen is the only daughter of her parents. Her parents constantly fight with each other on money matters and father's drinking. Shareen often threatens to run away from house if they continue fighting. Her parents never take her threats seriously. One day Shareen jumps out of her flat from the second floor when parents are fighting and hitting each other.

Discussion Questions for the Groups :

1. Are the problems of Vasumathi, Krupakar and Shareen common among adolescents?
2. In the face of failure; Romeo and Juliet committed suicide. What do you think about it?
3. What are the common methods usually used by adolescents like them to solve any problems today?
4. Is there an effective way of solving even the most difficult of problems in our lives ?
5. Is 'suicide' 'an option' at any time for any 'problem'?
6. Solving any problem is not easy. How do you go about solving it?

Sexual Intercourse - What is this Sex Stuff?????!!!!!

ACTIVITY MATERIAL - 3.4

Situation - 1:

Geetha is a 15 years old adolescent student in X class. She feels very nice whenever she sees a romantic song on the T.V. Recently she has started tuitions in her house for mathematics with her cousin Sudhir - a college boy. Geetha does not object, whenever Sudhir touches her while giving notebooks or pencils. He has started brushing against her while teaching her. Geetha feels very light and nice - she knows that Sudhir also likes these small touches. One day when they are alone Sudhir boldly hugs and kisses Geetha and suggests 'sex' indirectly by pressing his body against hers tightly.

Situation - 2:

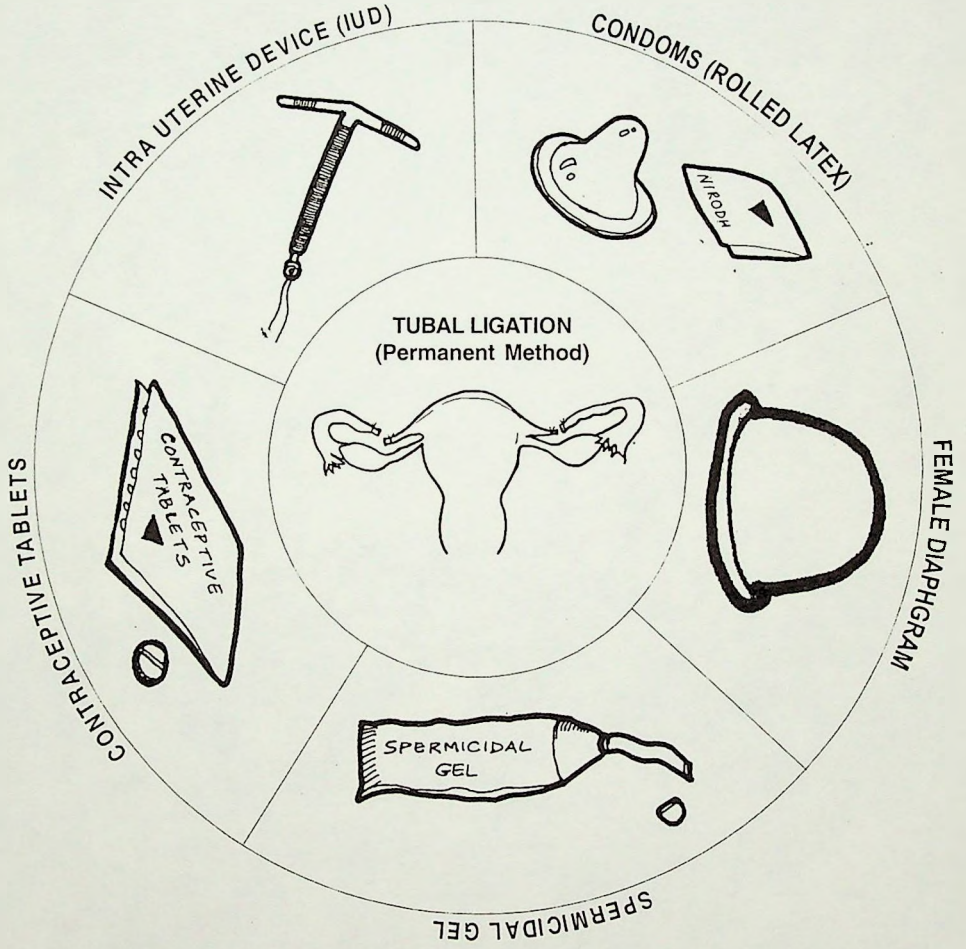
Swapna is a 19 years old girl who is married 2 months back to Roy, who is 28 years old. Swapna has had a strict upbringing where topics like 'love'; 'sex' 'childbirth' were never discussed. Swapna is very afraid to be alone with her husband Roy, as he always tries to touch and talk of having sex with her. Swapna feels uncomfortable and tries to avoid being alone with him.

Discussion Questions for the Groups :

1. What are the abilities a boy like Sudhir or girls like Geetha/Swapna need in order to understand their sexual feelings?
2. What skill does an adolescent boy (like Sudhir) or girl like Geetha or Swapna need in order to decide about when to have sex?
3. What do you understand about sex/sexual act?
4. What is the opinion of your group after discussion about sex?
5. How or from whom do we get information on sex?
6. Do men and women have similar or different sexual needs - why?
7. How is sex seen differently in our country when compared to Western countries?
8. Why is there a Marriage Law in most of the countries which says that marriage is permitted only after the age of 18 years? How does it influence sexual behavior in adolescents?
9. What are common doubts/anxieties regarding sex at your age?

Contraception - I have the CHOICE!!!!!!

ACTIVITY MATERIAL - 3.5



CONTRACEPTIVE METHODS

Myths and Misconceptions - Pretty and Handsome

ACTIVITY MATERIAL - 3.6

STATEMENTS:

PINK CARDS (Myths) AND GREEN CARDS (Facts)

- **MYTH** : Frequent masturbation leads to impotency.

  FACT : Masturbation does not lead to impotency especially in boys. Young people who indulge in that excessively lose interest in other important activities like studies and games. Hence, it is advisable for boys to keep it under control. Anything, even eating in excess is not advisable.

- **MYTH** : Frequent masturbation diminishes size of penis.

  FACT : No, Masturbation does not lead to shrinkage of penis or breasts. After ejaculation the penis normally shrinks to its usual size.

- **MYTH** : Women do not have sexual urges.

  FACT : Women also have sexual urges. Culturally, women have been told that it is wrong to show their sexual desire. Hiding sexual desire is connected to being 'chaste' and also 'good'. These are attitudes. Proper expression of sexual desires by a woman with a stable partner like spouse is satisfying to both.

- **MYTH** : If you are god-fearing you should not have thoughts of sex or sexual urges.

  FACT : Somebody can be god-fearing and yet be sexually active. Proper expressions of sexual desire - within a marriage, with a single partner, with love and trust both by men and women are necessary and healthy.

- **MYTH** : Touching private parts, kissing, holding, hugging lead to pregnancy.

  FACT : Pregnancy is a result of sexual intercourse between a man and a woman. Touching private parts, kissing, holding, hugging do not lead to conception.

- **MYTH** : A well-built person is sexually stronger.

  FACT : Physical strength in a person with good health is not connected to sexual power. If somebody is generally unhealthy and weak, then he/she can be sexually weak due to fatigue.

- **MYTH** : One should not have sexual intercourse during menstruation.

  FACT : One can have sex during menstruation. If both partners are willing and comfortable they can have sex during menses. Infection of genitals if not clean, is a possibility.

- **MYTH** : Taking contraceptive pills causes breast cancer among women.

  FACT : Research does not totally confirm that taking contraceptive pills causes cancer. One needs to keep in touch with the doctor.

- **MYTH** : Loops like Copper - T for women leads to pain in the abdomen and causes severe bleeding. It interferes with sexual act.

  FACT : If a correct size loop is introduced the discomfort and bleeding stops after a few days. It does not interfere with sexual intercourse.

- **MYTH** : Loop inserted improperly may enter the chest/abdomen and cause death.

  FACT : The copper - T (IUD) stays in the womb until a doctor, or nurse removes it. It never enters the chest or stomach and cause death. If it gets dislodged, it usually comes out through the vagina.

- **MYTH** : Sterilization in men and women is irreversible.

  FACT : Sterilization is reversible to a certain extent in both men and women. A minor surgery can be done for re-canalization. The couple can have a child after the re-canalization. Success rate is higher for men than women. It can fail in men also.

- **MYTH** : After sterilization men become impotent and lose interest in sex.

  FACT : Man cannot become impotent after sterilization. What is cut is only the vas deferens (tubes which carry spermatic fluid). Sexual act is controlled by desire, attitudes and male hormones.

- **MYTH** : Women should not lift heavy objects at all after sterilization.

  FACT : Women can carry out day-to-day activities after a routine sterilization. (Avoiding heavy manual labor for 6 weeks is sufficient). They do not require any additional rest, periodic checkup or scanning.

- **MYTH** : Use of condoms decreases sexual satisfaction in men.

  FACT : Condoms do not decrease sexual satisfaction.

- **MYTH** : One person can have sex with multiple partners, but should wash genitals immediately after having sex to prevent STDs, HIV/AIDS.

  FACT : Washing genitals immediately after sex does not prevent HIV/AIDS or STDs.

- **MYTH** : AIDS is common only among poor people.

  FACT : HIV/AIDS affect all class of people (rich, poor and middle class people).

- **MYTH** : Washing genital with soap immediately after sexual intercourse prevents pregnancy.

  FACT : Washing genitals after sex does not prevent pregnancy.

Myths and Misconceptions - Pretty and Handsome

ACTIVITY MATERIAL - 3.6

STATEMENTS:

PINK CARDS (Myths) AND GREEN CARDS (Facts)

- **MYTH** : Women with smaller breasts are not sexually attractive.

  FACT : Size of breasts alone does not decide the sexual attractiveness of a girl.

- **MYTH** : Application of cream, exercise, consuming pills and injections help in breast enlargement or development.

  FACT : There is no medicine, cream or injections of hormones that enlarge or develop the breast. Advertisements shown on the T.V., newspaper, and magazines about how to increase breast size misguide people. Size of breasts can be changed only by surgery - expensive and has its own risks.

- **MYTH** : Bra is worn by women to look sexier and attract men.

  FACT : Breast is a very soft gland or organ. Bra is used to support the breasts and avoid/prevent sagging.

- **MYTH** : Wearing a tight bra causes breast cancer.

  FACT : One should wear a bra, which is neither too tight nor too loose. Wearing a tight bra does not cause breast cancer.

- **MYTH** : Girls who have a 'sexy figure' with big breasts are sexually more active.

  FACT : Shape of a girl has nothing to do with her being sexually active. It is to do with her urges controlled by hormones and culture too decides the attitude.

- **MYTH** : Big breasts produce more milk than smaller breasts.

  FACT : The breasts are made up of the fatty tissue, which determines the size of the breast. Milk glands, which secret the milk after delivery are not influenced by the amount of fat or size of breasts, but by hormones. So size is not related to secretion of milk.

- **MYTH** : Breast-feeding a baby makes women less attractive and older.

  FACT : Breast-feeding a newborn baby does not make the breast sag. It helps in developing bonding with the baby and the uterus to get back to its original size. Pregnancy increases the size of the uterus.

- **MYTH** : Menstruation is nothing but bad blood going out of the body.

  FACT : Menstrual blood is not impure - it is like saliva or tears. Body does not remove any toxins through menstrual blood. It is a misconception to say it is impure - scientifically not correct.

- **MYTH** : A girl is impure during menstruation.

  FACT : Girls are not dirty during periods. She can have a good bath and be as clean as other persons.

- **MYTH** : Women have more than 2 or 3 menses in a month.

  FACT : Women usually have period or menses only once in a month.

- **MYTH** : A man with a larger penis is sexually stronger than a man with a smaller penis.

  FACT : The size of penis and sexual ability in a man are unrelated.

- **MYTH** : Night emission makes a boy tired, weak and lose his memory. He should consume more food.

  FACT : There is no connection between wet dreams and sexual impotency nor memory. One can consume normal food and doesn't require any extra nourishment. The inadequacy if present may be due to guilt about such act. Memory problems are related to anxiety about semen loss.

- **MYTH** : Loss of semen during masturbation or wet dreams leads to dark circles around the eyes of a boy.

  FACT : Wet dream or night emission is normal among adolescent boys. It does not make one tired, weak or cause dark circle around the eyes.

- **MYTH** : Masturbation is a sin.

  FACT : Masturbation is physiological. It is more in men than women.

- **MYTH** : Only men (not women) practice masturbation. It is more common among young than married people.

  FACT : Masturbation is practiced by both sexes. It is more common among men. Women are taught culturally to suppress sexual needs. This does not mean they have no sexual needs. A woman masturbates by stimulating the clitoris. It is common among young, married and even elderly. It is not a sin as it is physiological.

Empathy - HIV/AIDS - Please Help Us

ACTIVITY MATERIAL - 3.7

Situation :

"PLEASE HELP US"

Rashmi : You know yesterday in village meeting people suggested that Zaved's father should leave the village along with his family members.

Shabana : Why? Did Javed's father commit any sinful act?

Rashmi : No! Javed father has AIDS and it seems his little brother and mother are also infected. People in the village are scared to speak with them.

Shabana : Oh really? That means his father had sex with lots of women.

Rashmi : Look Shabana, Javed is coming towards us along with his little brother Haniff.

Shabana : Rashmi I don't want to stand here and speak with them. I am going. Are you coming with me?

Rashmi : Don't be stupid. HIV/AIDS does not spread through talking, touching, playing with them. I think you should talk with his brother and treat him as a friend rather than running away like this.

Shabana : I can't do this. My parents have told me not speak or play with HIV infected person. They always say that HIV infected people should be kept separately. One woman from the neighboring village was asked to leave the place because she had AIDS. She was not allowed to speak with anybody or visit the temple or public places. She was kept away from every activity in the village. I read about the same type of incident happening in several places in the newspapers. I feel Javed and Haniff should not be allowed to attend school. **" I AM SCARED OF AIDS".**

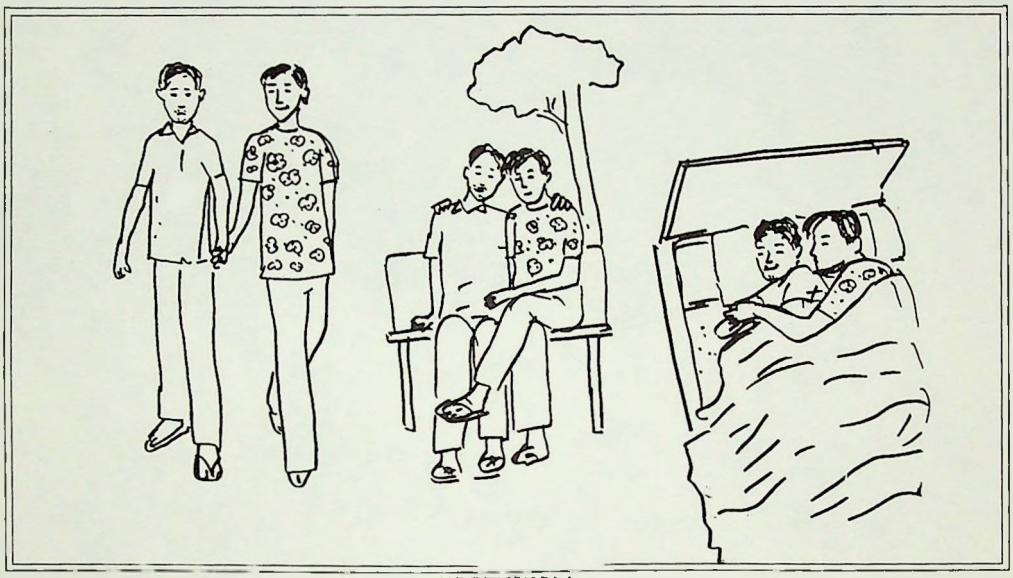
I don't want to speak with them. I am going..... Bye!

Discussion Questions for the Groups :

1. How do you feel after listening to Javed's family condition?
2. Is our attitude same for illness like fever, cancer, tuberculosis, leprosy, etc?
3. Have come across or read similar situations like Javed's family? How did you feel about it?
4. Will you make an attempt to change Shabana's attitude? How?
5. Which are the illnesses which are looked down upon (stigma)?

Homosexuality - Is he OK???????

ACTIVITY MATERIAL - 3.8



PICTURE 1

PICTURE 2

WHO/HPR/HEP/98.4
Distr.: General
Original: English

WHO's Global School Health Initiative

A healthy setting for living, learning and working

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

50 1948 1998
WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

WHO's Global School Health Initiative

This document has been prepared by Mr Jack T. Jones, School Health Team Leader, in cooperation with Mr Matthew Furner, Technical Officer, Health Education and Health Promotion Unit, Division of Health Promotion, Education and Communication, WHO.

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Organizations wishing to contribute to the work of WHO by supporting the WHO Global School Health Initiative and anyone desiring further information about the Initiative should contact Dr Desmond O'Byrne, Chief, Health Education and Health Promotion Unit (HEP), Division of Health Promotion, Education and Communication (HPR), WHO, 1211 Geneva, Switzerland 27, Telephone: (+41 22) 791 25 78; Fax: (+41 22) 791 07 46.

WHO's Global School Health Initiative

BACKGROUND

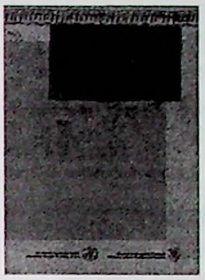
The Division of Health Promotion, Education and Communication is charged with strengthening the World Health Organization's capacities to promote health through schools. It has a clear and comprehensive vision and a strategic plan to do so. The Division's Health Education and Health Promotion Unit maintains a school health team that serves as a secretariat to an intradivisional WHO Working Group on School Health. The school health team, Working Group and WHO Regional Offices work together, and with other relevant organizations, in creating WHO's Global School Health Initiative.

The general direction of WHO's Initiative is guided by the Ottawa Charter for Health Promotion (1986) and the Declaration of the Fourth International Conference on Health Promotion held in Jakarta (1997). It is also guided by the recommendations of WHO's Expert Committee on Comprehensive School Health Education and Promotion (1995).

Ottawa Charter for Health Promotion

The Ottawa Charter focuses WHO's Initiative on creating: 1) healthy public policy; 2) supportive environments; 3) community action; 4) personal skills; and 5) a reorientation of health services. It also focuses the Initiative on *creating* health as well as *preventing* health problems by calling for actions that enable individuals to: care for themselves and others, make decisions and have control over their life circumstances and create conditions that are conducive to health.

Jakarta Declaration for Promoting Health



The Jakarta Declaration focuses WHO's Initiative on creating *sustainable* health promotion programmes. Thus, the WHO Initiative calls for international, national, district and local actions to promote social responsibility, increase investments in schooling, consolidate and expand partnerships, build community capacity, empower individuals and secure an infrastructure for health promotion through schools. Such actions help to unlock the potential for health promotion that is inherent in all schools.

WHO Expert Committee

WHO's Expert Committee on Comprehensive School Health Education and Promotion reviewed barriers to the development of school health programmes as identified by national, district and local education and health workers. Five broad barriers commonly identified at each organizational level are:

1. Inadequate vision and strategic planning.
2. Inadequate understanding and acceptance of programmes.
3. Lack of responsibility and accountability.
4. Inadequate collaboration and coordination among persons addressing health in schools.
5. Lack of programme infrastructure, including financial, human and material resources as well as organizing mechanisms.

Despite the barriers, WHO's Expert Committee found major reasons why school health programmes should be further

developed. The Committee concluded that there is a rich base of knowledge on which to act to develop and improve school health programmes. Furthermore, it concluded that *research in both developing and developed countries demonstrates that school health programmes can simultaneously reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each nation.*

Expert Committee Recommendations

To strengthen each nation's capacity *to improve health as well as education*, the WHO Expert Committee recommended two broad actions that must be supported at the local, national and international levels. They are:

- expanding investments in schooling
- expanding the educational participation of girls.

To promote health through schools, the WHO Expert Committee made three recommendations about what schools must do:

- provide a safe learning and working environment for students and staff
- serve as an entry point for health promotion and a location for health intervention
- enable children and adolescents to learn critical health and life skills.

The WHO Expert Committee also recognized that schools clearly need support to enable them to promote health; thus, they made the following five recommendations:

- policies, legislation and guidelines must be developed to ensure the identification, mobilization and coordination of resources at the local, national and international levels
- teachers and school staff must be valued and provided with the necessary support to enable them to promote health
- communities and schools must work together to support health and education
- school health programmes must be well designed, monitored and evaluated to ensure their successful implementation and their intended outcomes
- international support must be further developed to enhance the ability of countries, local communities and schools to promote health and education.

Together, the Ottawa Charter, the Jakarta Declaration and the recommendations of WHO's Expert Committee on Comprehensive School Health Education and Promotion provide the foundation for WHO's Global School Health Initiative.

WHO'S GLOBAL SCHOOL HEALTH INITIATIVE

WHO's Global School Health Initiative, launched in 1995, seeks to mobilize and strengthen health promotion and education activities at the local, national, regional and global levels. The Initiative is designed to improve the health of students, school personnel, families and other members of the community through schools.

The Goal

The goal of WHO's Global School Health Initiative is to increase the number of schools that can truly be called "Health-Promoting Schools". Although definitions will vary, depending on need and circumstance, a Health-Promoting School can be characterized as **a school constantly strengthening its capacity as a healthy setting for living, learning and working**.

A Health-Promoting School:

- strives to improve the health of school personnel, families and community members as well as students

- fosters health and learning with all the measures at its disposal
- engages health and education officials, teachers and their representative organizations, students, parents and community leaders in efforts to make the school a healthy place
- strives to provide a healthy environment, school health education and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation and programmes for counselling, social support and mental health promotion
- implements policies and practices that respect an individual's self-esteem, provide multiple opportunities for success and acknowledge good efforts and intentions as well as personal achievements.

Four Strategies for Action

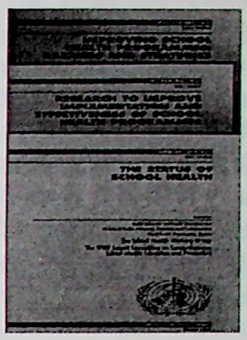
WHO's Global School Health Initiative consists of four broad strategies:

Building capacity to advocate for improved school health programmes

WHO generates technical documents that consolidate research and expert opinion about the nature, scope and effectiveness of school health programmes. The materials are designed to help individuals in international, national and local organizations argue effectively for increased support of efforts to promote health through schools. They are also designed to help policy- and decision-makers justify decisions to increase support for such efforts. Basic documents include:

- *The Status of School Health*, WHO/HPR/HEP/96.1. *The Status of School Health* discusses the role of schools in promoting health and rationales for investing in a comprehensive approach to school health. It discusses major health problems that can be reduced through school health programmes, implementation strategies and components of comprehensive school health programmes.

- *Improving School Health Programmes: Barriers and Strategies*, WHO/HPR/HEP/96.2. This manuscript addresses barriers that impede local, national and international efforts to improve school health programmes. It provides successful examples of specific local, national and international strategies, as well as six general strategies, that can be implemented to improve school health programmes.



- *Research to Improve Implementation and Effectiveness of School Health Programmes*, WHO/HPR/HEP/96.3. This text provides information regarding the kinds of research that can guide practice on school health environments, health education and health services. It discusses other research-relevant information such as indicators that can be used in planning, implementing and monitoring school health programmes, what is known about the cost-effectiveness of school health programmes and specific health-problem interventions that can be delivered through schools.

- *Promoting Health Through Schools: A Summary and Recommendations of WHO's Expert Committee on Comprehensive School Health Education and Promotion*, WHO/HPR/HEP/96.4. This document defines health education in the context of a Health-Promoting School and provides a rationale for each of the ten recommendations of the WHO Expert Committee. The full report of the WHO Expert Committee is available in the WHO Technical Report Series, #870.

To help individuals and groups advocate for the development of Health-Promoting Schools, WHO produces an "Information Series on School Health". Each document in the Series provides strong arguments for addressing one or more important health issues through schools, describes the concept and qualities of a Health-Promoting School and delineates multiple ways in which the health issue(s) is addressed in a Health-Promoting School. While each document in the Series addresses a priority health issue, it also focuses on the positive affects that will be accrued by the education sector if the issue is effectively addressed. Documents in this Series include:

- *Local Action: Creating Health-Promoting Schools*, WHO/HPR/HEP/98. *Local Action* assists school and community leaders in efforts that improve the health and education of young people. It provides practical guidance, tools and "tips" from Health-Promoting Schools around the world.

- *Strengthening Interventions to Reduce Helminth Infections: An Entry Point for the Development of Health-Promoting Schools*, WHO/HPR/HEP/96. Research and case studies have proven that schools are a remarkably efficient means to prevent and reduce helminth (worm) infections. This document describes how helminth reduction interventions can have a positive impact on children's health, learning potential and school attendance.

- *Primary School Physical Environment and Health*, WHO/School/97.2, WHO/EOS/97.15. This document identifies key elements for achieving a healthier school environment. It focuses on adequate services, particularly water and sanitation; operation and maintenance; and local motivation and ownership, with an emphasis on the physical environment of the school.

- *Violence Prevention: An Important Element of a Health-Promoting School*, WHO/HPR/HEP/98.2. This document explains how violence affects the well-being and learning potential of millions of children around the world. It describes how schools can begin to address violence through schools.

- *Healthy Nutrition: An Essential Element of a Health-Promoting School*, WHO/HPR/HEP/98.3. *Healthy Nutrition* describes how nutrition interventions in schools benefit the entire community, and how healthy eating contributes to health and well-being while also decreasing important health risks.

- *Food, Environment and Health: A guide for primary school teachers*, ISBN 92 4 154400 7. This book discusses how teachers can teach their students practical aspects of storing and handling food safely, making water fit to drink, disposing of wastes and maintaining healthy school and home environments.

- *Preventing HIV/AIDS/STDs and Related Discrimination: An Important Responsibility of Health-Promoting Schools*, WHO/HPR/HEP/98. This document includes descriptions of HIV-prevention programmes that are effective in reducing the risk of HIV infection among young people. It explains why schools must accept the responsibility to educate their community members and work with them to determine the most appropriate and effective ways to prevent HIV infection among young people.

- *Active Living: An Essential Element of a Health-Promoting School*, WHO/HPR/HEP/98. This document shows how school age is the optimal time of life for individuals to adopt useful, pleasurable and satisfying physical activities as an integral part of their own daily life.

- *Tobacco Use Prevention: An Important Entry Point for the Development of a Health-Promoting School*, WHO/HPR/HEP/98. *Tobacco Use Prevention* demonstrates that comprehensive tobacco use prevention programmes in schools can effectively reduce tobacco consumption.

- *Life Skills Education: An Essential Element of a Health-Promoting School*, WHO/MNH/98. This document focuses on obtaining maximum results of life skills education by integrating it into the various activities and goals of a Health-Promoting School.

Creating Networks and Alliances for the development of Health-Promoting Schools

WHO's Regional Networks for the Development of Health-Promoting Schools may be the world's most comprehensive and successful international effort to mobilize support for school health promotion. The first Network was initiated by the European Regional Office of WHO, the Council of Europe and the Commission of the European Communities in 1991. This Network has grown in six years to include 34 countries, 500 core schools and 1 600 affiliated schools, reaching about 400 000 students.

In conjunction with the Global School Health Initiative, Regional Networks for the Development of Health-Promoting Schools were started in the Western Pacific (1995), Latin America (1996) and Southern Africa (1996) through joint efforts by WHO/HQ and the respective WHO Regional Offices. In 1997, meetings were held to develop Networks in South East Asia and the northern countries of the Western Pacific. Each Network will be composed of public and private organizations interested in planning and working together toward the goal of helping schools become Health-Promoting Schools.

Additionally, WHO works in alliance with Education International (EI), UNAIDS and UNESCO to enable teachers' representative organizations throughout the world to use their unique capacities and experience to improve health through schools. Special emphasis has been placed in strengthening policies, curricula and training programmes that can help prevent HIV infection and related discrimination. In 1997, teachers' representative organizations in Asia and Central Europe were assisted by the WHO-EI-UNAIDS-UNESCO alliance.

Strengthening national capacities

As part of the development of WHO's Mega-Countries Health Promotion Network, WHO and the Centers for Disease Control and Prevention (USA) periodically brings together persons responsible for health promotion and school health from countries with the world's largest populations. Participants exchange strategies and experience and work together to improve health promotion and school health programmes on a large scale.

In July 1997, meeting at the Fourth International Conference on Health Promotion in Jakarta, Indonesia, school health officials from the Mega-Countries agreed to jointly publish a manuscript describing national strategies for the support of school health promotion in their countries. They called upon WHO to help generate increased commitment for school health promotion by requesting that the Ministers of Education and Health each designate a policy-maker to work together in coordinating the resources of the two ministries in support of school health promotion. They also called upon WHO to convene a meeting of the ministers, their designees and representatives of UN agencies and other relevant international organizations to plan concerted actions that will build national capacities for school health promotion in the

world's largest countries. WHO agreed to seek support for such an effort.

In 1997, WHO also provided technical support for country-level actions to create Health-Promoting Schools. WHO worked with China and South Africa to use priority health issues as entry points for the development of Health-Promoting Schools. WHO worked with China to strengthen national and local capacities for helminth control and prevention and to strengthen HIV/STD prevention efforts in schools. WHO worked with South Africa to use helminth control and prevention and violence prevention as entry points. Experiences gained in these efforts are diffused through the Regional Networks of Health-Promoting Schools.

Research to improve school health programmes

WHO consolidates existing research to strengthen knowledge about interventions that can improve health through schools. It also fosters the development of ways to: 1) assess national capacity for school health promotion; 2) evaluate the extent to which schools become Health-Promoting Schools; and 3) monitor the health status of children and teachers.

WHO's Rapid Assessment and Action Planning Process is being developed by the WHO Collaborating Centre to Promote Health Through Schools and Communities, Education Development Center, Inc., Newton, Massachusetts. The Process helps countries assess national capacity for school health promotion. WHO works with partner agencies to develop methods for evaluating the extent to which schools become Health-Promoting Schools and the extent to which students are practising healthy lifestyles. An evaluation of the extent to which helminth interventions could be used to create Health-Promoting Schools in China was completed in 1997. In the *World Health Report of 1998*, WHO will report on the health status and trends among school-age children and adolescents.

Partnerships and Support

WHO recognizes that the success of the Global School Health Initiative rests on the extent to which partnerships can be formed at local, national and international levels. This will require organizations interested in promoting health through schools to identify individuals with responsibility, time and authority to work in partnerships with others. It will also require them to jointly develop mechanisms that enable their organizations to plan and work together, document their achievements and improve their programmes.

The extent to which each nation's schools become "Health-Promoting Schools" will play a significant role in determining whether the next generation is educated and healthy. Education and health support and enhance each other. Neither is possible alone. Together, they serve as the foundation for a better world.

WHO is taking an active lead to ensure that the health promotion principles of the Ottawa Charter and the health promotion guidelines of the Jakarta Declaration are diffused worldwide and applied in the development of Health-Promoting Schools. The concept of Health-Promoting Schools is a sound vision for a better world. WHO's Global School Health Initiative invites all governmental and nongovernmental organizations, development banks, organizations of the United Nations system, interregional bodies, bilateral agencies, the labour movement and cooperatives, as well as the private sector to help advance health promotion actions as called for in the Jakarta Declaration by helping all schools become Health-Promoting Schools.

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Recommendations of the WHO Expert Committee on Comprehensive School Health Education and Promotion

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1

Investment in schooling must be improved and expanded.

2

The full educational participation of girls must be expanded.

3

Every school must provide a safe learning environment for students and a safe workplace for staff.

4

Every school must enable children and adolescents at all levels to learn critical health and life skills.

5

Every school must more effectively serve as an entry point for health promotion and a location for health intervention.

6

Policies, legislation and guidelines must be developed to ensure the identification, allocation, mobilization and coordination of resources at the local, national and international levels to support school health.

7

Teachers and school staff must be properly valued and provided with the necessary support to enable them to promote health.

8

The community and the school must work together to support health and education.

9

School health programmes must be well-designed, monitored and evaluated to ensure their successful implementation and outcomes.

10

International support must be further developed to enhance the ability of Member States, local communities and schools to promote health and education.

Geneva, Switzerland, 18-22 September 1995

Expand Investment in Schooling

Health-Promoting Schools focus on:

- ✓ Caring for oneself and others
- ✓ Making healthy decisions and taking control over life's circumstances
- ✓ Creating conditions that are conducive to health
  - Policies
  - Services
  - Physical/social conditions
- ✓ Building capacities for:
  - Peace
  - Shelter
  - Education
  - Food
  - Income
  - A stable eco-system
  - Equity
  - Social justice
  - Sustainable development

- ✓ Preventing leading causes of death, disease and disability:
  - Helminths
  - Tobacco use
  - HIV/AIDS/STDs
  - Sedentary lifestyle
  - Drugs and alcohol
  - Violence
  - Nutrition
  - Injuries
- ✓ Influencing health-related behaviours
  - Knowledge
  - Beliefs
  - Skills
  - Attitudes
  - Values
  - Support

Round Table Discussion GOVERNMENTS AND NGOS Partnerships in Health Promotion

Record of a meeting held during the 52nd World Health Assembly Geneva, 19 May 1999

WHO/NMH/HPS/00.2
Distribution: Limited
English only

World Health Organization

WHO/NMH/HPS/00.2

English only
Distribution: Limited

Round Table Discussion
GOVERNMENTS AND NGOS
Partnerships in Health Promotion

This is a record of a Lunchtime meeting held during the 52nd World Health Assembly, in Geneva, on May 19, 1999.

The meeting was organised and chaired by the NGO Ad Hoc Advisory Group on Health Promotion. The objective was to give some Governments the opportunity to show how they are working with NGOs in health promotion and in the follow up to the Jakarta Declaration and thereby encourage others to do the same

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Chairman Mats Ahnlund
International Health Cooperatives Organisation / ICA

We wish you all a very warm welcome at today's Round Table Discussion. I am here representing one of the organisers of this meeting, the International Health Cooperatives Organisation, where I am Secretary General.

An NGO briefing like this during the World Health Assembly is becoming a little bit of a tradition. Last year we held a similar discussion, and the title was the NGO Response to the Jakarta Declaration.

As most of you know, there was a "Call to Action" from the Jakarta Conference and one of the proposals in this document was to create a Global Health Promotion Alliance, inviting different actors in the health sector to be part of this alliance. The NGOs and among them cooperatives, were mentioned as partners. With this as a background, we in the Ad Hoc Group of NGOs represented here today are collaborating with WHO in this health promotion work. The result of last years NGO meeting, which took place in the room next door, one year ago, was a publication, the NGO Response to the Jakarta Declaration. In that the NGOs said yes to this Global Health Promotion Alliance, planned to be founded at the next Global Conference on Health Promotion in Mexico.

Pamela Hartigan who is the Director of the Department of Health Promotion in WHO opens today's discussions.

Dr. Pamela Hartigan
Director Department of Health Promotion, WHO

Thank you for coming to this meeting. I look forward to learning from all of you of the work you are doing in health and development. The work that NGOs carry out at the local, national and global levels is very familiar to me because I, too, come from the NGO world. For the better part of fifteen years, I worked within organizations of the Latino community in Washington, D.C. that were formed by many newly arrived immigrants from Central America who sought to flee the conflict that characterised these nations in the 1980s. Coming to the U.S. in search for better opportunities, they found that they needed their own organizations to represent their legal needs, to respond more appropriately to their health concerns and to ensure the preservation of their cultural heritage in an alien land.

I joined the Pan American Health Organization, or PAHO, the regional office of WHO in the Americas in 1990, precisely with the purpose of facilitating greater linkages between NGOs that worked in health and development in Latin America, and the Ministries of Health. Initially, this was no easy task. Up until very recently, NGOs and governments were hostile to one another. The history of Latin America has been marked by authoritarian rule, and NGOs have been overtly anti-governmental. On the other hand, governments were threatened by NGOs which were growing in number throughout the region. Yet as democracy swept the region, it became increasingly evident that the time had come to build bridges between the two so as to promote health improvements, particularly among the poor. So PAHO set out to bring governments and NGOs closer together.

The work that is carried out by many NGOs is largely promotional in character. They work to build local capacity, empower communities to fully engage in shaping their own future. So whether NGOs call what they do "health promotion" or something else, the work that they carry out on a day by day basis is at the very heart of what promoting health is all about.

Chairman:

Thank you very much Pamela.

It is very much thanks to the Department of Health Promotion that we sit here today. They let us in. As you know, WHO is an organisation of governments and a guerilla force like the NGOs doesn't have automatic access. We have to do very special things to get inside the walls here, but it is thanks to Pamela's department that we have succeeded. And it also thanks to them that we have this good collaboration with WHO.

We are now moving on, but before we start to get news from governments we will have a small presentation about the Mexico Conference and what is going to happen there. We have the Director General of Health Promotion from the Government of Mexico, Prof. Javier Urbina Soria and he will talk about the preparations for the 5th Global Conference on Health Promotion to be held in June next year.

Prof. Javier Urbina Soria
Director General of Health Promotion, Government of Mexico

Thank you for giving me this opportunity to share with you some of the ideas we are planning for the forthcoming conference in Mexico which is being shared with the Government of Mexico, WHO Headquarters, Geneva and PAHO, Washington. They are like three parts of one single whole that together seeks new associates and new partners.

The conference in Mexico City follows the others that have taken place in Jakarta, Sundsvall, Adelaide and Ottowa. Our principal objective is to find new partners for health promotion. One of the basic objectives at Mexico City is that we want to have an open commitment to involve national governments. The conference will have a technical component as in the previous conferences and there will also be a powerful political component. We have invited Ministers of Health to attend and it is our great hope that a maximum number will be able to come to Mexico. Over the last few months we have prepared a draft Ministerial Declaration in the hope that those Ministers of Health who will be present in Mexico City can sign it. This will serve as the prime thrust for the worldwide alliance.

On the technical side there are going to be one or two innovative ideas, which I hope will be very productive. WHO has asked for technical reports to be prepared by specialists. These will cover the health promotion priorities that we defined in Jakarta, and each one of those priorities will be the subject of a report. And then to bring things into the day to day life within our communities there will be presentations of some experiences in community work, such as case studies which show good health promotion practices and successful experiences in this particular field.

So to summarise, I think we can say that the Mexico City Conference will be very enriching from the technical standpoint, as well as serving as a powerful political thrust for health promotion. One of the main participant groups is of course the NGOs. And it is our strong hope that the majority of those here will be with us in Mexico next year. Let me simply say I look forward to seeing you in Mexico City next year. We have a publicity leaflet on the Conference which was handed out to the ministers in the Assembly, and is being distributed now. We will be sending it out to all the organisations and countries throughout the world that are going to be involved. Mexico and its Government is very committed to this conference. We know it is going to be successful and I hope you will be part of that success. Thank you very much.

Chairman:

Thank you very much Prof. Soria. Let's hope that we all will meet there next June.

We are now moving into the main topic of the day and that is how governments look upon NGOs as partners in health work.

At our Round Table last year it was the NGOs that had some ideas on how they could contribute to this partnership work in Health Promotion. This year we have asked some governments to give their views on the usefulness of NGOs in health care work. Of course it would be good if it could be widened in the way Pamela Hartigan mentioned to include also NGOs outside the traditional heath sector that work with empowerment and enabling people as preventive action.

I was asked by one or two of the speakers what they should say or what they should stress and I said the best thing would be of course to say that the NGOs are great partners and we would like them to be included as a complement in their own work, but we will see if they elaborate a bit more on that. We have asked Burkino Faso to start and after that it will be Sweden, and the United States and then we have some others on the list.

Dr. B. Bamouni
Government of Burkino Faso

NGO work is part of the overall activities of Burkino Faso. There is a big health problem in our country. We have development priorities. We suffer from resource shortages, financial and human, which means that the NGOs have become a vital partner in the overall development process. Health promotion is one sphere in which the NGOs have a very considerable role to play. National NGO's work is recognised by the government. The international ones have signed a collaboration agreement with the Ministry of Health and this is the legal framework within which they work.

NGOs have a follow up office which is responsible for managing the work of the NGOs in the country from the diplomatic, administrative and legislative aspects. We also have a permanent NGO secretariat which is responsible for the coordination side, and for providing guidance for the geographic distribution of activities throughout the country. The coordination office brings together the various NGO representatives. They meet regularly and discuss their experiences and exchange views on the way the work is organised.

The Ministry organises an annual conference of partners to take stock of the situation for all partners including NGOs. The NGO objectives are defined by the Ministry of Health and they work to achieve the objectives of the Ministry. Their work focuses on participation in decentralised planning. There is direct community action involving full participation by the communities. Coordination work is also conducted among the NGOs. As to follow up and evaluation, we have health indicators which are jointly defined with the Ministry of Health and these are mutually discussed as well as the use of funds that are allocated to NGOs.

Technical support is provided at the regional and central levels and field activities are funded. Very often therefore the health administration is improved by the assistance given by and to the NGOs. The government provides a certain amount of financial contribution for this work. There is support at the central and district levels and some NGOs are responsible solely for the execution of activities in the field. There is a central office that is responsible for purely vertical management. The principal areas of work are preventative care, combating HIV/AIDS, maternal and child health care, programmes for the elderly and re-education and rehabilitation programmes. The results in the community are measured in terms of availability of care and coverage.

What difficulties do we encounter?

Often there are two organizations working in the same field. Some NGOs tend to focus on specific regions. Then there is irregularity in the provision of funds which sometimes makes planning rather difficult at the operational level. Some NGOs set their own requirements for their work and do not really wish to discuss priority setting at the central levels. Sometimes it is hard to capitalise on what has been achieved because there is no adequate follow up. NGOs sometimes come and work and then disappear without a trace. However we are developing contracts in our country so that it will be possible for NGOs to sign a contract with the government for

implementation of programmes. This should result in improved integration of health activities particularly at the community level.

And then there is the United Nations Initiative for Africa, where NGOs can work in a more closely organised way and that I think will certainly improve things in the future. Thank you very much.

Chairman:

Thank you Dr. Bamouni from the Government of Burkino Faso.

I think in one of your statements you made a good point, namely to choose your NGOs carefully so they don't disappear after a little while. I think if we look at this group of NGOs that has invited you here today, we have together some thousands of years of experience. So we promise not to disappear if you start to work also with us!

We have Dr. Bosse Pettersson who is working for a Swedish authority and is representing the Swedish Government here today. For some of you he may be familiar as he was the Secretary General of the Third Global Health Promotion Conference in Sundsvall in 1991.

Dr. Bosse Pettersson
Government of Sweden

Thank you. Let me start by saying that the potential of the partnership between governmental organisations and NGOs has very much to offer especially in a field like health promotion since it is so inter and multisectorial. A brief history of Sweden tells us that it was NGOs that took the initiative of creating a modern welfare society and social accountability. However, their aim was to transfer those responsibilities to public structures and that meant that they also withdrew some of their own possibilities for being more active players in the present times. The role of NGOs has thus become more of an advocate than an active player and participatory provider for its members. So I would say that we would need much more, and better, partnerships with NGOs in Sweden. To encourage you, I would like to give three very brief examples of successes in which we have been collaborating with them.

We have been working together with the Swedish Cancer Foundation, a Non Smoking Organisation, and Physicians and Nurses Against Tobacco, and have succeeded in passing legislation through parliament for an age limit for purchasing tobacco and for further advertising restrictions.

Secondly, the Swedish Heart and Lung Foundation together with leading cardiologists has chosen physical activity as its priority in an EU funded project to combat coronary heart disease. And it goes hand in hand with a recent national public health priority for getting Sweden on the move.

In the middle of the 1970s breastfeeding was declining in Sweden. That negative was turned into a positive one and now we have much better figures and this is very much due to an NGO working in the breastfeeding field.

To sum up with some principles for partnership, I would like to mention an overall principle that partnership must be built on trust, shared goals and visions and also a reasonable division of roles between NGOs and governmental organisations. Public health and public good must be the core. As an example, NGOs must want to be more disease orientated advocates for patients' groups and define their position in relation to health promotion and disease prevention. Normative function is mainly the role of the governmental organisations. NGOs are in the unique position to be able to empower people and communities for health development and they can often have a comparative advantage in taking initiatives for policy development in health, speaking as a third voice outside formal political and administrative structures.

Chairman:

Thank you, the representative of the Swedish government.

Mohammed Aktar
Executive Director of the American Public Health Association, USA

Thank you Mr. Chairman for inviting me to come here and share some of our experiences from the United States. I bring greetings from the USA to you and best wishes as you plan for the conference in Mexico. We are very interested in health promotion and disease prevention as this is the future of public health. This is the vaccine for the next century and that is why we have put so much emphasis on this particular area.

NGOs in the USA work very closely with the government and that is one of the reasons that as the head of an NGO I am part of the US delegation to the World Health Assembly. With me is Beverly Malone, President of the American Nurses Association, another NGO and she is also part of the US delegation. We work very much together in consultation on various issues relating to public health. We put publications together with the government and share information with the people at large. We play a key role in three areas.

** Education of the health professionals themselves. We have 55 thousand members in the US. And we provide health education and health promotion information to our members so that they can in turn be educated enough to provide to the public at large. And that is a very important responsibility which we can do and which the government cannot do by itself. We start each year in April by celebrating a public health week. In that week we pick an important theme and we start with the Secretary of the Health and Human Services who is our Minister of Health. We celebrate throughout that week and throughout the country that particular theme that we want the public to become aware of and be knowledgeable about. And then we end that week again, with the Secretary or the Surgeon General in Washington. In that way we provide information to the public about the important issues that we want them to focus on during that year.

** Our second area of expertise is in terms of getting assignments from the government for preparing the material ourselves and distributing it to the public. For example, we have the assignment from the government on HIV/AIDS treatment. What are the best treatments? How to make sure the patient will comply with the treatment? Our membership gets together and we prepare the material on behalf of the government and then share it with the public at large to educate them on HIV/AIDS, prevention and treatment. And even more importantly, on maintenance of that treatment because it is very important that when somebody starts to take the medication, they must stay on it to really benefit and not create drug resistant HIV/AIDS. Those are the kinds of things where we take the lead with the government. We do the same thing as what my colleague here from Sweden said in that we are able to bring in all parties with different view points. We offer the table around which people can sit down to discuss and come to consensus where government is unable to do. Sometimes it takes too long for the government and we can do it very fast.

** Our last contribution to collaboration is also very important. We go to our Congress and to our President and ask for more money to be put into health education and health prevention programmes. We go and advocate a lobby for the budgets for our health programmes and that collaboration is absolutely essential, particularly in a democracy because somebody needs to pull from within and someone needs to push from outside and by working together, governments and the NGOs, we can serve our people better. Mr. Chairman that concludes my statement, thank you for this opportunity.

Chairman:

Thank you Mr. Aktar. I think the ultimate proof that you are serious about NGOs as a partner you have shown by including them in your delegation to the WHA. And I think that could be a good model for all of us.

Dr. Elaine Stowers
Director of Nursing, Department of Health, Government of Samoa

Thank you Mr. Chairman. I feel rather privileged to be here, speaking with all these big countries, like the United States, Sweden and so on. I should like to talk of some Samoan experiences in terms of working with NGOs in the health field. This goes way beyond or further back than Jakarta, or even the Alma Ata. We have always worked with communities that are not government paid or funded. These are traditional communities in our villages and we have worked with them in areas like maternal and child health for a long time.

When the NGOs came to our country as an established mechanism from the west, there was some conflict. This was a concept which was introduced as an organised entity into our country which already had its own traditional ways and cultures, and it clashed with governments and established departments.

99% of all the health work, especially health promotion out in the rural areas,was done by nurses. It was fully managed by nurses and it was the nurses who always worked with women's groups out in the community. Then came the new word NGO and the women's groups wanted to be grouped into corporations. This was an indication that our women wanted to have their potential needs recognised. I am a woman and also a member of the Nurses Association so there I see there is a need for this. We had to take into account the cultural and traditional structures so that they can work together.

One traditional example of work was in the area of immunisation - EPI. The way we used to work, is that the women in the village identified the contact points themselves. They had done that for a very long time. We could not enter a village without the women's permission. When the NGOs came in the women were divided under different umbrellas and we found there were conflicting agendas. For a long time NGOs and Government departments wasted a lot of time working out who was following whose agenda instead of pursuing one agenda in health. We found that too much time was spent on trying to analyse what was available and how structures work. Now I think we have matured. About three years ago a central body was set up which now coordinates all the NGOs, men and women, irrespective of gender.

From the health sector point of view for the last three years we have involved the NGOs especially the women's groups working in the villages, around the table in developing our strategic health sector plans at the beginning of every year. This was absent in the past. The Department of Health prepared the programmes and then delegated them, but now the women or the NGOs are involved at the planning table. And since last year foreign donors are now allowing NGOs to go in direct . It is only recently that we have managed to work out our differences.

Chairman:

Thank you. You have pointed out a very important thing, that when we talk about Non Governmental activities it is not only about organisations with rules and statutes registered with the county council or the national government, there are also other more informal non governmental structures that are working since a long time. So thank you very much.

Delegate of the Government of Benin

Thank you very much. When you listen to the various experiences encountered in different countries, it seems to me that much of what I would say simply echoes what my friend from Burkino Faso was talking about. Therefore I would like to just refer to a specific experience that we had with cooperatives which we undertook at the beginning of the 1980s.

There was an economic crisis and less and less public funds were available. The government was no longer systematically recruiting graduates from school, in particular administrative schools and the health sector. The Ministry realised it was simply not possible to entrust health tasks to service providers and we were therefore obliged to try and organise doctors, nurses, midwives, laboratory services and so forth into health cooperatives. The dual purpose was to improve health coverage throughout the country and to cut unemployment among young graduates in the health sector. We were very lucky because we were given technical support from WHO, and UNDP provided us with funds. We were able to organise about 100 young people into cooperatives throughout the country, particularly in rural areas and in destitute semi urban areas. That went back some ten years or so and whilst they encountered some difficulties they nevertheless gained experience of taking stock of their activities, and drawing a kind of balance of the various difficulties. There were basically four difficulties:

* The first was that they had thrown themselves into an experience that they were not prepared for. The provision of health care is very different from managerial tasks and the level of funding they had to work with was not high enough.

* Second, they did not have any kind of formal post graduate training programme. They had not taken any special courses and that in turn led to other problems.

* Third, they were badly equipped. It became increasingly harder to provide for services. More and more human beings were available but the resources were not there for them to be properly equipped and fitted out.

* Fourth, there was a competitive environment. As a result, some of the clinics developed the same type of activities as they were involved in, to have the right set up in the same areas. Over the last seven or eight years solutions have been found for this but there are nevertheless other problems that definitely persist. Thank you very much.

Chairman:

Of course I am very pleased to hear this, working with co-operatives myself. The IHCO newsletter on the table has a description of this specific case on the back page . Its called "possible model for Africa - cooperatives of health professionals in Benin". Thank you very much. We now move in to Namibia.

Dr. S. Shangula
Government of Namibia

Thank you Mr. Chairman for giving me the chance to present our situation.

Namibia has adopted the concept of a primary health care approach that has put us in a position where we cannot exclude the NGOs if we are strictly following this concept as it is. Right from the beginning, since we got our independence eight years ago, the Government has committed itself to improving primary health care and we have worked very closely with the NGOs also in other sectors. A specific area I would like to highlight is child health and development. The policy developed for that specific area has been developed with the involvement of NGOs. The donors supporting the government are also supporting the NGOs and the NGOs that are implementing that aspect in that area, register with the government or the local government. Once they register they are entitled to get what funding is coming through the government in support of NGO activities. That is one area. The government or local government is also giving support in terms of training members from the non governmental organisations in that area.

Secondly regarding women's health and adolescent health. The Ministry of Health in particular has assisted in establishing the regional Planned Parenthood Association in the country which relieves the Ministry of a lot of work in terms of advocating for the womens' health and reproductive health as well as adolescent health. They are currently setting up centers throughout the rural areas to try to help adolescent health and get health services accessible in terms of information and health education.

Thirdly, regarding the control of communicable diseases, particularly HIV and TB control. There are organisations working in that area and recently our own President launched the Mid Term Plan to control HIV. I think that the epidemic in our country has brought us to work closer with NGOs and with the other sectors, the public sectors, the private sectors. The process we have followed by coming up with that Mid Term Plan has involved everybody throughout. It took us almost one and a half years, and every sector was involved in the development of that plan. We have now set up structures for coordinating the activities of controlling HIV throughout the country. NGOs at the regional level work through their regional committees, chaired by the government. At the national level we have set up the national coordinating committee in which all the sectors are represented. We hope by working together we will be able to control this epidemic in our country.

The other area I want to emphasise is the care of the aged. NGOs in my country are fully responsible for taking care of the aged. However, the Government has subsidised these NGOs. They register with the Ministry of Health and they get a small amount of money to be able to carry out their activities. As the government will not be able to take care of everybody due to financial constraints so we entrust the NGOs with a lot of work which the health sector cannot do by itself.

Finally Mr. Chairman, the key areas we are actually involved in as the Government is to provide technical support to NGOs to develop their policies together with the NGOs that are working in our country, and for the Government to provide to some extent the financing of some activities. We are active in producing HIV information, education materials and communication and the Government is expected to coordinate this. However, for the distribution of this information and the education of the public, we expect the NGOs to become very involved in this area. One example is the distribution of condoms to prevent HIV. We also expect them to provide the care of those who are infected and affected. So we are expecting that to happen. We also provide training in whatever technical area the NGOs wish to be supported in. We look forward to strengthening our collaboration with NGOs in my country. Thank you.

Dr. Thomas Bongo
Director of Health, Government of Congo

My friends from Benin and Burkino Faso have said much of what needs to be said about NGOs in our country. NGOs are a necessary partner for the Government of Congo. Today's government is faced with many difficulties. We are going through a severe economic crisis. We have a group of NGOs working in health. They are grouped together under a coordination bureau and that bureau works directly with the Health Ministry Cooperation Department. So that shows how significant we see them as being partners. We have a budget heading within the Health Ministry that is entitled Support to NGOs. The NGOs come to us and ask us for funds and the Government provides a budget heading precisely for that purpose. This is very important.

The Ministry of Health works with NGOs in areas of immunisation. For example we had to relaunch a campaign last year and as part of information, education and communication, NGOs provided about one and a half thousand people throughout the country for this particular campaign. In the fight against HIV/AIDS we have relied on NGOs to a very great extent. Five NGOs are working in that particular field very closely with the Ministry of Health. An interesting point as well is that we have an Association of Unemployed Graduates called AMISAB and the Ministry entrusts them with epidemiological survey work on the basis of pre established protocols and this I think demonstrates just how important all this work is. That is for national NGOs.

There are international NGOs that come into the CONGO as well, but it is quite rare for an NGO to come on their own initiative. Very often they come to our country because they are chosen by donor partners to execute particular programmes. In that particular area the government sometimes experiences difficulties. We have an American NGO in our country that is rehabilitating and reconstructing a hospital. You may recall there was a war in Brazzaville and a good many things need to be rebuilt. But what is difficult for us is to know precisely what budget has been allocated to those operations because sometimes the management of them is fairly impenetrable. It is difficult for me when I have to make a report on health expenditure to the Ministry, if I don't know what the NGOs have spent on health. In these cases, I cannot give a precise figure to my government and this presents some problems. So to respond to your concern I would definitely say that in the CONGO the NGOs are very important partners. We would like to work even more closely together to try and ensure that the population's health is helped as much as possible.

Delegate of the Government of Mali

Burkino Faso and Benin have described very well the importance of NGOs in our various policies. There are more than a 1000 NGOs working in my country and to try and regulate the situation a framework agreement was prepared and has to be signed by every national or international NGO. The contents are precisely the same. Its a kind of NGO visa to work in Mali. So you have to sign that document if you wish to work in Mali.

If an NGO wishes to work in health education or agriculture then another agreement has to be signed with the department concerned. On the subject of health the specific agreement refers to the work to be done in the field. You define what your wishes are and of course this has to have its place in the Five Year Plan, and your activity has to find a place in that Five Year Plan. Once that is done you can sign at the community or regional level. The structure has been put in place to avoid subsequent problems of disagreement on the operational side in the field. But clearly, if you agree with those you are working with in the field the entire operation can be success.

In health itself we have about 200 NGOs working on the subject of collaboration and partnership. The Ministry developed these partnerships through the Dakar Forum which we attended along with many other NGOs. In 1994 we set up the framework for cooperation involving annual meetings with NGOs. We called these "NGO Partnership meetings" and they served to define problems in the field and to seek solutions. These are usually in the form of recommendations addressed to NGOs or to the Ministry.

This year we organised a National Partnership Workshop which discussed a number of problems such as the difficulties that NGOs encounter or when importing tax free equipment. Under the agreement they are meant to be able to do that but there are difficulties and we have signed an agreement with the Ministry of Finance requiring them to find a solution to that importation problem. We do have a good many difficulties, but we have made a great deal of progress. Often in our country young unemployed people get together and set up an NGO but unfortunately they don't have the required level of ability and competence in the health field. This is a problem as the work cannot be done without the proper expertise and skills. Thank you very much.

Dr. Gillian Durham
Government of New Zealand

I would like to give a brief perspective as a policy adviser in a very decentralised health sector. We have a large indigenous population - 14% of our population is Maori and about 6% are from the Pacific islands. The basis of our relationship with NGOs is that we have common goals but different roles. The roles of our NGOs are for advocacy service provision and in some instances research, whereas the government role is around policy advisory regulation and funding. Our partnership arrangements are both formal and informal. The most important formal relationship is the Treaty of Waitangi between the Maoris and the Crown which embraces the principles of partnership, protection and participation. And then we have arrangements whereby NGOs are part of formal advisory groups in the Policy Development process or through consultation. In the reciprocal arrangement government officials are invited to be observers on some NGO groups. So for instance we have agencies for nutrition action and we are observers on that group. We have contractual relationships and in some instances undertake joint research. And we have a number of informal relationships particularly with the smoke free coalition, a coalition of over 20 NGOs and by and large we share the work.

In respect of our experiences of the partnership relationship, from our perspective it rises and falls on mutual understanding. From our perspective - the understanding of NGO's objectives, their funding base and also their decision making processes and time frames. From the NGOs perspective - understanding the machinery of government and the budget cycle. I think the most important thing in a developed country is to get control of the budget.

Where things can improve is in the area of mutual respect and trust and an acceptance of the different environments in which we operate. We like to operate in an environment of no surprises, sharing the information, and what we believe is critical to the whole thing, is having personal relationships between particular government officials who know what is happening and also the key people in NGOs.

Chairman:

This ended this part of the programme and it was the most important part, the views among governments and NGOs. And if this represents an average of views of governments, it would be of course fantastic, but we also understand that those governments who have a positive approach towards NGOs are those governments who are here today.

We now give the floor to the WHO Regional Director for Africa, Dr. Samba, who by reputation, (I never met him before, but I heard about it) is a man very open to collaboration with NGOs.

Dr. E. Samba
WHO Regional Director for Africa

Thank you very much Mr. Chairman. I didn't know about this meeting. I was going to another meeting because we have an epidemic of meetings at this time, and then I saw some of my NGO colleagues and I said what's all this about. An NGO meeting? So I decided to come here today.

I have an officer in AFRO exclusively for NGO collaboration. But why did I come here? At the WHA in 1997 there was a similar meeting. And I heard NGOs complaining that WHO doesn't treat them as equal partners and that they wait until everybody has spoken. I said I am going to correct this. Because before joining WHO I was Director of Medical services in my country and after joining WHO and knowing all African countries I have found out that NGOs are extremely useful. There are maverick NGOs. You know them all. My estimate is very conservative, there are over 30,000 NGOs in Africa, in Angola, Ethiopia, and over 1,500 in South Africa. Therefore we need to work together in better harmony and organisation.

Following that meeting in May 1997 I decided I was going to call up a meeting in Dakar in October 1997. We wrote to the NGOs and were overwhelmed with the responses. So we decided that instead of 1997 we would have it in February 1998, and we did. And some of you here were present. There were 19 governments, 300 NGOs, WHO Africa and Headquarters, and after 3 days we all agreed it was really a good meeting. And it was. But I emphasised to all that its not just enough to meet and say what a wonderful thing and slap each other on the back, there has to be a follow up and we agreed to a protocol and to an agreement. It was not what they complained of in 1997. And we agreed that the NGOs were not going to regard WHO as Father Christmas.

Another thing, we agreed there would be a secretariat in AFRO and somebody to deal exclusively with NGOs We sent a copy of the protocol to all the NGOs, Africans and non Africans. What was the result? I have to say that the African NGOs did very well. They responded and there were far more than we expected. But the international NGOs response was extremely poor. I think only two or three out of 153 respondents. So why did I stop and come to this meeting instead of the other one?. I am convinced that we need each other. Governments cannot do it alone . WHO cannot do it alone. Nor can the NGOs do it alone. Together we can do much better than what we are doing at this moment.

It is not easy bringing NGOs together. It means surrendering certain facilities and taking on more and so I am appealing now to the international NGOs, please respond to the protocol that we agreed on because as you all know most of us attend meetings and then after the meeting we all say what a wonderful meeting that was, and after that we continue as before. So I do hope that we will follow up because you are doing a good job. This is no flattery. If I didn't think so I wouldn't say so. You are doing a very good job but we need more and better organisation. Thank you so much.

Chairman:

Thank you Dr. Samba.

So this positive approach from a Regional Director was a good final speech before the very last one and we shouldn't regard as you say, WHO as a Father Christmas. With the new Director General we should in that case anyway talk about Mother Christmas now.

The very last word is from Desmond O'Byrne, who is our liaison and he is also working and in charge of health promotion at WHO.

Dr. Desmond O'Byrne
Department of Health Promotion, WHO

It really is very encouraging to see such a full attendance at this, the second meeting to be organised during the World Health Assembly by the NGO Ad Hoc Advisory Group on Health Promotion. This NGO Group, as many of you may know, was formed in response to the Jakarta Conference and Declaration. The importance given to the role of NGOs in WHO is underlined by the presence and presentation of Dr. Samba, the Regional Director of WHO in the African Region.

I fully support the previous speakers who stressed that partnerships between Governments, IGOs and NGOs, must be built on mutual respect.

The Jakarta Declaration called for the development of a global alliance in health promotion. This Ad Hoc NGO Group took up the challenge and has been actively promoting collaboration between its many members. It has acted as a catalyst among NGOs in promoting partnership and collaboration.

Dr. Mahler, in speaking to this meeting at the WHA last year, stated that NGOs provide the political dynamite to mobilise action for health. This meeting it is hoped will help to contribute to that motivation.

Dr. Brundtland, Director General of WHO, in her forward to the World Health Report, referred to the importance of NGOs and of the need to reorganise to form more strategic alliances. I am sure we all agree with that. We need to strengthen and build partnerships between NGOs themselves, but also between Governments, NGOs and the private sector. If progress towards health for all is to continue then all sections of society will need to contribute in partnership and mutual respect. NGOs have, and are setting a good example of such partnership. We look forward to this ongoing strengthening of collaboration with Governments and all sectors of society. This meeting is another positive step in the direction.

A Partnership of Committed INGOs

We are an informal group of international NGOs which attended the WHO 4th International Conference on Health Promotion in Jakarta, in July 1997. We saw the need to implement the Jakarta Declaration, and to work in partnership towards the next Global Conference on Health Promotion in Mexico City, June 5-9 2000.

We come from widely different areas of activity -

Education
Health co-operatives,
Traditional health practices
Nursing,
Rural women,
Social welfare,
Women's health.

Our wide diversity of interests, international structures and grass root involvement gives the NGO Ad Hoc Advisory Group on Health Promotion its richness of approach, experience and expertise.

Together we represent many millions of members around the world.

Working together and individually, and in close liaison with the Health Promotion Unit at the WHO headquarters, we have endeavoured to keep the Jakarta and Mexico agendas in the forefront of the NGO community. As a Group we held two successful lunchtime Briefings at the 1998 and 1999 World Health Assemblies, on NGO and Government partnerships in the follow up to Jakarta. As an individual NGO this would not have been possible.

We hope that this example of partnership will encourage others to become involved in health promotion, and that it will serve as an example for NGO Groups in other areas and disciplines.

The Members of the Group

Associated Country Women of the World (ACWW)
Global Alliance of Womens Health (GAWH)
Inter African Committee (IAC)
International Baccalaureate Organisation (IBO)
International Council of Nurses, (ICN)
International Council of Social Welfare (ICSW)
International Health Cooperatives Organisation (IHCO)
International Union of Health Education and Promotion (IUHPE)

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FOCUSING
RESOURCES
ON
EFFECTIVE
SCHOOL
HEALTH

a *FRESH* Start to Improving the Quality and Equity of Education.

WHO, UNESCO, UNICEF, the World Bank and Education International: Partners in taking a FRESH Start to school health

For health to be put high on the agenda of education reform, and given the priority attention it deserves, policymakers, community leaders, teachers, parents and students will need to be convinced that health contributes to the overall goals and purposes of *the education sector*, schools in particular.

In April, 2000, Education International, WHO, UNESCO, UNICEF, and the World Bank jointly organized as strategy session at the World Education Forum in Dakar, Senegal. The strategy session was aimed at raising the education sector's awareness of the value of implementing an effective school health, hygiene and nutrition programme as one of its major strategies to achieve Education for All.

Attached you will find information that is the foundation and reasoning behind our willingness to join in partnership to Focus Resources on Effective School Health (FRESH). This information is concisely written and contains the kind of arguments you may need to call attention to the value of effective school health programmes *to the education sector,* and to justify calls for increased resources to implement and improve them.

Information in this document will help you to make a strong case that an effective school health programme:

- Responds to a new need
- Increases the efficacy of other investments in child development
- Ensures better educational outcomes
- Achieves greater social equity
- Is a highly cost effective strategy.

It also provides information that you can use to clearly argue why the following basic components of a school health programme, should be made available *together,* in all schools:

- Health related school policies
- Provision of safe water and sanitation – the essential first steps towards a healthy physical, learning environment
- Skills based health education
- School based health and nutrition services.

Lastly, it provides concise and sound reasons that you can use to foster effective partnerships between:

- Education and health sectors
- Teachers and health workers
- Schools and community groups
- Pupils and persons responsible for school health programmes.

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. These 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. Effective school health programmes will contribute to the development of child-friendly schools and thus to the promotion of education for all.

This interagency initiative has identified a core group of activities, each already recommended by the participating agencies, that captures the best practices from programme experiences. Focusing initially on these activities will allow concerted action by the participating agencies, and will ensure consistent advice to country programmes and projects. Because of the focused and collaborative nature of this approach, it will increase the number of countries able to implement school health components of child-friendly school reforms, and help ensure that these programmes go to scale. The focused actions are seen as a starting point to which other interventions may be added, as appropriate.

The actions also contribute to existing agency initiatives. They are an essential component of the "health promoting schools" initiative of WHO and of global efforts by UNICEF, UNESCO and the World Bank to make schools effective as well as healthy, hygienic and safe. Overall, the inter-agency action is perceived as Focusing Resources on Effective School Health, and giving a *FRESH* Start to improving the quality and equity of education.

Focusing Resources on the School-Age Child

A child's ability to attain her or his full potential is directly related to the synergistic effect of good health, good nutrition and appropriate education. Good health and good education are not only ends in themselves, but also means which provide individuals with the chance to lead productive and satisfying lives. School health is an investment in a country's future and in the capacity of its people to thrive economically and as a society.

An effective school health, hygiene and nutrition programme offers many benefits:

- ***Responds to a new need***

  The success of child survival programmes and the greater efforts by many governments and communities to expand basic education coverage have resulted both in a greater number of school-age children and in a greater proportion of these children attending school. In many countries, targeted education programmes have ensured that many of these new entrants are girls for whom good health is especially important. Thus, the school is now a key setting where the health and education sectors can jointly take action to improve and sustain the health, nutrition and education of children previously beyond reach.

- *Increases the efficacy of other investments in child development*

School health programmes are the essential sequel and complement to early child care and development programmes. Increasing numbers of countries have programmes that ensure that a child enters a school fit, well and ready to learn. But the school age child continues to be at risk of ill health throughout the years of schooling. Continuing good health at school age is essential if children are to sustain the advantages of a healthy early childhood and take full advantage of what may be their only opportunity for formal learning. Furthermore, school health programmes can help ensure that children who enter school without benefit of early development programmes, receive the attention they may need to take full advantage of their educational opportunity.

- *Ensures better educational outcomes*

Although schoolchildren have a lower mortality rate than infants, they do suffer from highly prevalent conditions that can adversely affect their development. Micronutrient deficiencies, common parasitic infections, poor vision and hearing, and disability can have a detrimental effect on school enrolment and attendance, and on cognition and educational achievement. In older children, avoidance of risky behaviours can reduce dropping out due, for example, to early pregnancy. Ensuring good health at school-age can boost school enrolment and attendance, reduce the need for repetition and increase educational attainment, while good health practices can promote reproductive health and help avoid HIV/AIDS.

- *Achieves greater social equity*

As a result of universal basic education strategies, some of the most disadvantaged children - the girls, the rural poor, children with disabilities – are for the first time having access to school. But their ability to attend school and to learn whilst there is compromised by poor health. These are the children who will benefit most from health interventions, since they are likely to show the greatest improvements in attendance and learning achievement. School health programmes can thus help modify the effects of socioeconomic and gender-related inequities.

- *Is a highly cost effective strategy*

School health programmes help link the resources of the health, education, nutrition, and sanitation sectors in an infrastructure – the school -- that is already in place, is pervasive and is sustained. While the school system is rarely universal, coverage is often superior to health systems and has an extensive skilled workforce that already works closely with the community. The accessibility of school health programmes to a large proportion of each nation's population, including staff as well as students,

contributes to the low cost of programmes. The high effectiveness of these programmes is a consequence of the synergy between the health benefit and the educational benefit. The effectiveness is measurable in terms not only of improved health and nutrition, but also of improved educational outcomes, reduced wastage, less repetition and generally enhanced returns on educational investments.

The Basic Framework for an Effective School Health and Nutrition Programme

The framework described here is the starting point for developing an effective school health component in broader efforts to achieve more child-friendly schools. Much more could be done, but if all schools implement these four interventions then there would be a significant immediate benefit, and a basis for future expansion. In particular, the aim is to focus on interventions that are feasible to implement even in the most resource poor schools, and in hard-to-reach rural areas as well accessible urban areas, that promote learning through improved health and nutrition. These are actions known to be effective, and actively endorsed by all the supporting agencies: this is a framework from which individual countries will develop their own strategy to match local needs.

Core framework for action: Four components that should be made available together, in all schools.

(i) Health-related school policies

Health policies in schools, including skills-based health education and the provision of some health services, can help promote the overall health, hygiene and nutrition of children. But good health policies should go beyond this to ensure a safe and secure physical environment and A positive psycho-social environment, and should address issues such as abuse of students, sexual harassment, school violence, and bullying. By guaranteeing the further education of pregnant schoolgirls and young mothers, school health policies will help promote inclusion and equity in the school environment. Policies that help to prevent and reduce harassment by other students and even by teachers, also help to fight against reasons that girls withdraw or are withdrawn from schools. Policies regarding the health-related practices of teachers and students can reinforce health education: teachers can act as positive role models for their students, for example, by not smoking in school. The process of developing and agreeing upon policies draws attention to these issues. The policies are best developed by involving many levels, including the national level, and teachers, children, and parents at the school level.

(ii) Provision of safe water and sanitation – the essential first steps towards a healthy physical, learning environment.

The school environment may damage the health and nutritional status of schoolchildren, particularly if it increases their exposure to hazards such as infectious disease carried by the water supply. Hygiene education is meaningless without clean water and adequate sanitation facilities. It is a realistic goal in most countries to ensure that all schools have access to clean water and sanitation. By providing these facilities, schools can reinforce the health and hygiene messages, and act as an example to both students and the wider community. This in turn can lead to a demand for similar facilities from the community. Sound construction policies will help ensure that facilities address issues such as gender access and privacy. Separate facilities for girls, particularly adolescent girls, are an important contributing factor to reducing dropout at menses and even before. Sound maintenance policies will help ensure the continuing safe use of these facilities.

(iii) Skills based health education

This approach to health, hygiene and nutrition education focuses upon the development of knowledge, attitudes, values, and life skills needed to make and act on the most appropriate and positive health-related decisions. Health in this context extends beyond physical health to include psycho-social and environmental health issues. Changes in social and behavioural factors have given greater prominence to such health- related issues as HIV/AIDS, early pregnancy, injuries, violence and tobacco and substance use. Unhealthy social and behavioural factors not only influence lifestyles, health and nutrition, but also hinder education opportunities for a growing number of school-age children and adolescents. The development of attitudes related to gender equity and respect between girls and boys, and the development of specific skills, such as dealing with peer pressure, are central to effective skills based health education and positive psycho-social environments. When individuals have such skills they are more likely to adopt and sustain a healthy lifestyle during schooling and for the rest of their lives.

(iv) School based health and nutrition services

Schools can effectively deliver some health and nutritional services provided that the services are simple, safe and familiar, and address problems that are prevalent and recognized as important within the community. If these criteria are met then the community sees the teacher and school more positively, and teachers perceive themselves as playing important roles. For example, micronutrient deficiencies and worm infections may be effectively dealt with by infrequent (six-monthly or annual) oral treatment; changing the timing of meals, or providing a snack to address short term hunger during school – an important constraint on learning - can contribute to school performance; and providing spectacles will allow some children to fully participate in class for the first time.

Supporting Activities

These activities provide the context in which the interventions can be implemented.

(i) Effective partnerships between teachers and health workers and between the education and health sectors

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. These sectors need to identify responsibilities and present a coordinated action to improve health and learning outcomes from children.

(ii) Effective community partnerships

Promoting a positive interaction between the school and the community is fundamental to the success and sustainability of any school improvement process. Community partnerships engender a sense of collaboration, commitment and communal ownership. Such partnerships also build public awareness and strengthen demand. Within the school health component of such improvement processes, parental support and cooperation allows education about health to be shared and reinforced at home. The involvement of the broader community (the private sector, community organizations and women's groups) can enhance and reinforce school health promotion and resources. These partnerships, which should work together to make schools more child-friendly, can jointly identify health issues that need to be addressed through the school and then help design and manage activities to address such issues.

(iii) Pupil awareness and participation

Children must be important participants in all aspects of school health programmes, and not simply the beneficiaries. Children who participate in: health policy development and implementation; efforts to create a safer and more sanitary environment; health promotion aimed at their parents, other children, and community members; and school health services, learn about health by doing. This is an effective way to help young people acquire the knowledge, attitudes, values and skills needed to adopt healthy lifestyles and to support health and Education for All.

WHO/HPR/HEP/95.3

SUPPORTIVE ENVIRONMENTS FOR HEALTH

LES MILIEUX FAVORABLES A LA SANTE

Déclaration de
SUNDSVALL
Statement

World Health Organization
Organisation mondiale de la Santé

SUPPORTIVE ENVIRONMENTS FOR HEALTH

SUNDSVALL
Statement

This Statement on supportive environments for Health was adopted on 15 June 1991 in Sundsvall, Sweden, by participants at the Third International Conference on Health Promotion*

9-15 June 1991, Sundsvall, Sweden

*Co-sponsored by the United Nations Environment Programme, the Nordic Council of Ministers, and the World Health Organization.

SUPPORTIVE ENVIRONMENTS FOR HEALTH

SUNDSVALL Statement

The Third International Conference on Health Promotion: Supportive Environments for Health - the Sundsvall Conference - fits into a sequence of events which began with the commitment of WHO to the goals of Health For All (1977). This was followed by the UNICEF/WHO International Conference on Primary Health Care, in Alma-Ata (1978), and the First International Conference on Health Promotion in Industrialized Countries (Ottawa 1986). Subsequent meetings on Healthy Public Policy, (Adelaide 1988) and a Call for Action: Health Promotion in Developing countries, (Geneva 1989) have further clarified the relevance and meaning of health promotion. In parallel with these developments in the health arena, public concern over threats to the global environment has grown dramatically. This was clearly expressed by the World Commission on Environment and Development in its report Our Common Future, which provided a new understanding of the imperative of sustainable development.

The third International Conference on Health Promotion: Supportive Environments for Health - the first global conference on health promotion, with participants from 81 countries - calls upon people in all parts of the world to actively engage in making environments more supportive to health. Examining today's health and environmental issues together, the Conference pointed out that millions of people are living in extreme poverty and deprivation in an increasingly degraded environment that threatens their health, making the goal of Health For All by the Year 2000 extremely hard to achieve. The way forward lies in making the environment - the physical environment, the social and economic environment, and the political environment - supportive to health rather than damaging to it.

The Sundsvall Conference identified many examples and approaches for creating supportive environments that can be used by policy-makers, decision-makers and community activists in the health and environment sectors. The Conference recognized that everyone has a role in creating supportive environments for health.

A CALL FOR ACTION

This call for action is directed towards policy-makers and decision-makers in all relevant sectors and at all levels. Advocates and activists for health, environment and social justice are urged to form a broad alliance towards the common goal of Health for All. We Conference participants have pledged to take this message back to our communities, countries and governments to initiate action. We also call upon the organizations of the United Nations system to strengthen their cooperation and to challenge each other to be truly committed to sustainable development and equity.

A supportive environment is of paramount importance for health. The two are interdependent and inseparable. We urge that the achievement of both be made central objectives in the setting of priorities for development, and be given precedence in resolving competing interests in the everyday management of government policies.

Inequities are reflected in a widening gap in health both within our nations and between rich and poor countries. This is unacceptable. Action to achieve social justice in health is urgently needed. Millions of people are living in extreme poverty and deprivation in an increasingly degraded environment in both urban and rural areas. An unforeseen and alarming number of people suffer from the tragic consequences for health and well-being of armed conflicts. Rapid population growth is a major threat to sustainable development. People must survive without clean water, adequate food, shelter or sanitation.

Poverty frustrates people's ambitions and their dreams of building a better future, while limited access to political structures undermines the basis for self-determination. For many, education is unavailable or insufficient, or, in its present forms, fails to enable and empower. Millions of children lack access to basic education and have little hope for a better future. Women, the majority of the world's population, are still oppressed. They are sexually exploited and suffer from discrimination in the labour market and many other areas, preventing them from playing a full role in creating supportive environments.

More than a billion people worldwide have inadequate access to essential health care. Health care systems undoubtedly need to be strengthened. The solution to these massive problems lies in social action for health and the resources and creativity of individuals and their communities. Releasing this potential requires a fundamental change in the way we view our health and our environment, and a clear, strong political commitment to sustainable health and environmental policies. The solutions lie beyond the traditional health system.

Initiatives have to come from all sectors that can contribute to the creation of supportive environments for health, and must be acted upon by people in local communities, nationally by government and nongovernmental organizations, and globally through international organizations. Action will predominantly involve such sectors as education, transport, housing and urban development, industrial production and agriculture.

DIMENSIONS OF ACTION ON SUPPORTIVE ENVIRONMENTS FOR HEALTH

In a health context the term supportive environments refers to both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction. Action must be coordinated at local, regional, national and global levels to achieve solutions that are truly sustainable.

The Conference highlighted four aspects of supportive environments:

1. The social dimension, which includes the ways in which norms, customs and social processes affect health. In many societies traditional social relationships are changing in ways that threaten health, for example, by increasing social isolation, by depriving life of a meaningful coherence and purpose, or by challenging traditional values and cultural heritage.
2. The political dimension, which requires governments to guarantee democratic participation in decision-making and the decentralization of responsibilities and resources. It also requires a commitment to human rights, peace, and a shifting of resources from the arms race.
3. The economic dimension, which requires a re-channelling of resources for the achievement of Health for All and sustainable development, including the transfer of safe and reliable technology.
4. The need to recognize and use women's skills and knowledge in all sectors including policy-making, and the economy in order to develop a more positive infrastructure for supportive environments. The burden of the workload of women should be recognized and shared between men and women. Women's community-based organizations must have a stronger voice in the development of health promotion policies and structures.

PROPOSALS FOR ACTION

The Sundsvall Conference believes that proposals to implement the Health for All strategies must reflect two basic principles:

1. Equity must be a basic priority in creating supportive environments for health, releasing energy and creative power by including all human beings in this unique endeavour. All policies that aim at sustainable development must be subjected to new types of accountability procedures in order to achieve an equitable distribution of responsibilities and resources. All action and resource allocation must be based on a clear priority and commitment to the very poorest, alleviating the extra hardship borne by the marginalized, minority groups, and people with disabilities. The industrialized world needs to pay the environmental and human debt that has accumulated through exploitation of the developing world.
2. Public action for supportive environments for health must recognize the interdependence of all living beings, and must manage all natural resources, taking into account the needs of future generations. Indigenous peoples have a unique spiritual and cultural relationship with the physical environment that can provide valuable lessons for the rest of the world. It is essential, therefore, that indigenous peoples be involved in sustainable development activities, and negotiations be conducted about their rights to land and cultural heritage.

IT CAN BE DONE: STRENGTHENING SOCIAL ACTION

A call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control. Examples from all parts of the world were presented at the Conference in relation to education, food, housing, social support and care, work and transport. They clearly showed that supportive environments enable people to expand their capabilities and develop self-reliance. Further details of these practical proposals are available in the Conference report and handbook.

Using the examples presented, the Conference identified four key public health action strategies to promote the creation of supportive environments at community level.

1. Strengthening advocacy through community action, particularly through groups organized by women.
2. Enabling communities and individuals to take control over their health and environment through education and empowerment.
3. Building alliances for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies.
4. Mediating between conflicting interests in society in order to ensure equitable access to supportive environments for health.

In summary, empowerment of people and community participation were seen as essential factors in a democratic health promotion approach and the driving force for self-reliance and development.

Participants in the Conference recognized, in particular, that education is a basic human right and a key element in bringing about the political, economic and social changes needed to make health a possibility for all. Education should be accessible throughout life and be built on the principle of equity, particularly with respect to culture, social class and gender.

THE GLOBAL PERSPECTIVE

People form an integral part of the earth's ecosystem. Their health is fundamentally interlinked with the total environment. All available information indicates that it will not be possible to sustain the quality of life, for human beings and all living species, without drastic changes in attitudes and behaviour at all levels with regard to the management and preservation of the environment.

Concerted action to achieve a sustainable, supportive environment for health is the challenge of our times.

At the international level, large differences in *per capita* income lead to inequalities not only in access to health but also in the capacity of societies to improve their situation and sustain a decent quality of life for future generations. Migration from rural to urban areas drastically increases the number of people living in slums, with accompanying problems - including lack of clean water and sanitation.

Political decision-making and industrial development are too often based on short-term planning and economic gains which do not take into account the true costs to people's health and the environment. International debt is seriously draining the scarce resources of the poor countries. Military expenditure is increasing, and war, in addition to causing deaths and disability, is now introducing new forms of ecological vandalism.

Exploitation of the labour force, the exportation and dumping of hazardous substances, particularly in the weaker and poorer nations, and the wasteful consumption of world resources all demonstrate that the present approach to development is in crisis. There is an urgent need to advance towards new ethics and global agreement based on peaceful coexistence to allow for a more equitable distribution and utilization of the earth's limited resources.

ACHIEVING GLOBAL ACCOUNTABILITY

The Sundsvall Conference calls upon the international community to establish new mechanisms of health and ecological accountability that build upon the principles of sustainable health development. In practice this requires health and environmental impact statements for major policy and programme initiatives. WHO and UNEP are urged to strengthen their efforts to develop codes of conduct on the trade and marketing of substances and products harmful to health and the environment.

WHO and UNEP are urged to develop guidelines based on the principle of sustainable development for use by Member States. All multilateral and bilateral donor and funding agencies such as the World Bank and International Monetary Fund are urged to use such guidelines in planning, implementing and assessing development projects. Urgent action needs to be taken to support developing countries in identifying and applying their own solutions. Close collaboration with nongovernmental organizations should be ensured throughout the process.

The Sundsvall Conference has again demonstrated that the issues of health, environment and human development cannot be separated. Development must imply improvement in the quality of life and health while preserving the sustainability of the environment.

The Conference participants therefore urge the United Nations Conference on Environment and Development (UNCED), to be held in Rio de Janeiro in 1992, to take the Sundsvall Statement into account in its deliberations on the Earth Charter and Agenda 21, which is to be an action plan leading into the 21st century. Health goals must figure prominently in both. Only worldwide action based on global partnership will ensure the future of our planet.

LES MILIEUX FAVORABLES A LA SANTE

Déclaration de SUNDSVALL

La présente déclaration sur les milieux favorables à la santé a été adoptée le 15 juin 1991 à Sundsvall, Suède, par les participants à la Troisième Conférence internationale pour la promotion de la santé*

9-15 Juin 1991, Sundsvall, Suède.

* Co-parrainée par le Programme des Nations Unies pour l'Environnement, le Conseil des Ministres des pays nordiques et l'Organisation mondiale de la Santé.

LES MILIEUX FAVORABLES A LA SANTE

Déclaration de SUNDSVALL

La Troisième Conférence internationale sur la promotion de la santé, ou Conférence de Sundsvall, convoquée sur le thème "des milieux favorables à la santé", s'inscrit dans une suite d'événements qui a débuté avec l'engagement pris par l'OMS, en 1977, d'instaurer la santé pour tous. Cette décision a été suivie par la Conférence internationale de l'UNICEF et de l'OMS sur les soins de santé primaires tenue à Alma-Ata, en 1978, et la première Conférence internationale pour la Promotion de la Santé dans les pays industrialisés, réunie à Ottawa en 1986. Les réunions organisées ensuite à Adélaïde en 1988 sur une politique publique pour la santé, et à Genève en 1989 sur la promotion de la santé dans les pays en développement, ont permis de préciser l'importance et le sens de la promotion de la santé. Parallèlement à cette évolution dans le domaine de la santé, les préoccupations suscitées par les menaces qui pèsent sur notre environnement n'ont cessé de grandir. C'est ce qu'a clairement exprimé la Commission mondiale sur l'environnement et le développement dont le rapport décrit sous un jour nouveau les conditions nécessaires à un développement durable.

La Troisième Conférence internationale pour la promotion de la santé, convoquée sur le thème "des milieux favorables à la santé", a été la première conférence mondiale dans ce domaine avec des participants venus de 81 pays. Ceux-ci ont demandé à tous les peuples du monde de prendre des mesures énergiques pour rendre les milieux plus favorables à la santé. Evoquant ensemble les questions de santé et d'environnement de notre temps, ils ont noté que des millions d'individus vivent dans la pauvreté et le dénuement le plus extrême, dans un environnement de plus en plus dégradé qui menace leur santé, faisant de l'instauration de la santé pour tous d'ici l'an 2000 un objectif très difficile à atteindre. Pour progresser, il faut veiller à ce que l'environnement - physique, social, économique et politique -favorise la santé, au lieu de lui nuire.

La Conférence de Sundsvall a illustré par de nombreux exemples les moyens que pourraient mettre en oeuvre les responsables politiques, les décideurs et les agents communautaires de la santé et de l'environnement pour créer des milieux favorables. Elle a reconnu que chacun avait un rôle à jouer dans cette entreprise.

APPEL A L'ACTION

Cet appel s'adresse aux responsables politiques et aux décideurs dans tous les domaines concernés et à tous les niveaux. Tous ceux qui s'emploient à promouvoir la santé, l'environnement et la justice sociale sont instamment priés de former une alliance pour atteindre l'objectif commun de la santé pour tous. Nous autres, participants à cette Conférence, nous sommes engagés à transmettre ce message à nos communautés, à nos pays et à nos gouvernements pour que soient prises les mesures qui s'imposent. Nous demandons aussi aux organisations du système des Nations Unies de renforcer leur coopération et de s'encourager mutuellement à oeuvrer en faveur d'un développement durable et de l'équité.

L'existence d'un milieu favorable est d'une importance capitale pour la santé. Les deux sont interdépendants et indissociables. Nous demandons instamment que les conditions nécessaires aux deux soient considérées comme des objectifs essentiels lors de l'élaboration des priorités pour le développement, et occupent la première place dans la solution des conflits d'intérêt qui peuvent surgir dans la gestion au jour le jour des politiques des pouvoirs publics.

Le fossé qui se creuse, aussi bien à l'intérieur des pays qu'entre pays riches et pays pauvres, traduit les inégalités qui existent dans le domaine de la santé, et cela est inacceptable. Des mesures s'imposent d'urgence pour instaurer la justice sociale dans le domaine de la santé. Dans les villes comme dans les campagnes, des millions d'individus vivent dans la pauvreté et dans un dénuement extrême dans un milieu qui se dégrade de plus en plus. Un nombre imprévu et alarmant de personnes subissent les conséquences tragiques des conflits armés pour la santé et le bien-être. La croissance démographique rapide compromet sérieusement les chances d'un développement durable. Nombreux sont ceux qui sont obligés de survivre sans eau propre, sans alimentation correcte, sans abri et sans assainissement.

La pauvreté frustre les gens de leurs ambitions et de leurs aspirations à un avenir meilleur, tandis que les limites de l'accès aux structures politiques nuisent à l'autodétermination. Pour beaucoup, l'instruction est inexistante ou insuffisante ou, sous ses formes actuelles, incapable de donner les moyens d'agir. Des millions

d'enfants n'ont pas accès à un enseignement de base et ne peuvent guère espérer en un avenir meilleur. Les femmes, qui représentent la majorité de la population mondiale, sont encore opprimées. Elles sont sexuellement exploitées et les discriminations dont elles sont victimes sur le marché du travail et dans bien d'autres domaines les empêchent de jouer pleinement leur rôle dans la mise en place d'environnements plus favorables.

Dans le monde, plus de un milliard de personnes n'ont pas d'accès adéquat à des soins de santé essentiels. Les systèmes de santé doivent évidemment être renforcés. La solution à ces problèmes considérables réside dans des mesures d'action sociale en faveur de la santé et dans les ressources et les capacités d'innovation des individus et des communautés. Pour tirer parti de toutes ces possibilités, il faudrait que nous modifiions radicalement notre façon de concevoir la santé et l'environnement et que se dégage un engagement politique clair et énergique en faveur de politiques de santé et d'environnement durables. Les solutions doivent être cherchées au-delà des limites du secteur traditionnel de la santé.

Des initiatives doivent être prises dans tous les secteurs qui peuvent contribuer à la création de milieux favorables à la santé et soutenues au niveau local par les membres de la communauté, au niveau national par les pouvoirs publics et les organisations non gouvernementales et au niveau mondial par les organisations internationales. Les secteurs concernés seront essentiellement ceux de l'éducation, des transports, du logement et du développement urbain, de la production industrielle et de l'agriculture.

COMMENT CREER DES MILIEUX FAVORABLES A LA SANTE

Du point de vue de la santé, l'expression milieux favorables désigne les aspects physiques et sociaux de notre environnement, c'est à dire le cadre de vie de l'individu, sa communauté, son foyer, son milieu de travail et ses lieux de détente, mais aussi les structures qui déterminent l'accès aux ressources vitales et les possibilités d'obtenir les moyens d'agir. Ainsi, les dimensions de toute action visant à créer un milieu favorable sont multiples: physiques, sociales, spirituelles, économiques et politiques. Tous ces aspects sont étroitement associés les uns aux autres en une interaction dynamique. Les mesures prises doivent être coordonnées aux échelons local, régional, national et mondial afin que soient mises au point des solutions réellement durables.

La Conférence a évoqué, en particulier, les quatre aspects suivants d'un environnement favorable :

1. La dimension sociale, c'est-à-dire les façons dont les normes, les coutumes et les schémas sociaux influencent la santé. Dans de nombreuses sociétés, l'évolution des relations sociales traditionnelles représente une menace pour la santé, par exemple en renforçant la solitude, en privant la vie de sens et de cohérence et en attaquant les valeurs et l'héritage culturel traditionnels.

2. La dimension politique, qui oblige les gouvernements à garantir une participation démocratique à la prise des décisions et à la décentralisation des responsabilités et des ressources. Elle suppose aussi un engagement en faveur des droits de l'homme, de la paix, et l'abandon de la course aux armements.

3. La dimension économique, qui suppose une redistribution des ressources en faveur de la santé pour tous et d'un développement durable, et notamment le transfert d'une technologie sûre et fiable.

4. La nécessité enfin de reconnaître et d'utiliser les compétences et les connaissances des femmes dans tous les domaines, y compris ceux de la politique et de l'économie, pour mettre en place des infrastructures plus propices à des environnements favorables à la santé. Il faudrait reconnaître que les femmes ont de lourdes tâches et veiller à ce que les hommes assument leur part de ce fardeau. Il faudrait que les associations féminines communautaires aient les moyens d'intervenir plus énergiquement dans l'élaboration de politiques et de structures propres à promouvoir la santé.

ACTIONS PROPOSEES

Pour la Conférence de Sundsvall, les actions envisagées afin de mettre en oeuvre les stratégies de la santé pour tous doivent reposer sur deux grands principes fondamentaux :

1. L'équité doit être un objectif prioritaire fondamental de toute mesure prise pour créer des milieux favorables à la santé et mobiliser les énergies et les imaginations en associant l'humanité toute entière à cette entreprise unique. Toutes les politiques visant à un développement durable seront soumises à de nouvelles règles d'approbation en vue d'une distribution équitable des responsabilités et des ressources. Toute action et toute allocation de ressources sera guidée par le souci, clairement exprimé, de venir en aide aux plus pauvres, d'alléger le fardeau des marginalisés, des groupes minoritaires et des handicapés. Il faut que le monde industrialisé s'acquitte de la dette accumulée, sur les plans écologique et humain, à la suite de l'exploitation du monde en développement.
2. Toute action publique en faveur de milieux propices à la santé doit tenir compte de l'interdépendance de tous les êtres vivants, et bien gérer les ressources naturelles en se préoccupant des besoins des générations futures. Les peuples autochtones entretiennent avec leur environnement physique une relation spirituelle et culturelle unique qui peut être riche d'enseignements pour le reste du monde. Il est donc essentiel de les associer aux stratégies de développement et de prévoir des négociations pour préserver leurs droits à leurs terres et à leur héritage culturel.

UN OBJECTIF REALISTE: RENFORCER L'ACTION SOCIALE

Cet appel pour la mise en place de milieux favorables à la santé peut être un objectif réaliste de l'action de santé publique au niveau local, avec pour cible privilégiée les contextes propices à une large degré de participation et de contrôle de la part de la communauté. Des exemples du monde entier ont été présentés à la Conférence dans les domaines de l'éducation, de l'alimentation, de l'habitat, de la protection sociale, du travail et des transports. Ces illustrations ont très bien montré qu'un milieu favorable permettait aux gens de développer leur capacités et leur autoresponsabilité. Le rapport et le guide de la Conférence contiennent des renseignements détaillés sur ces projets concrets.

A l'aide des exemples ainsi présentés, les participants à la Conférence ont défini comme suit les quatre stratégies clés de santé publique susceptibles de promouvoir la création de milieux favorables au niveau de la communauté.

1. Renforcer l'action de plaidoyer au niveau de la communauté, notamment par le biais de groupes organisés par des femmes.
2. Donner aux communautés et aux individus les moyens de gérer leur propre santé et leur environnement par l'éducation et différentes mesures d'habilitation.
3. Constituer des alliances en faveur de la santé et de milieux favorables afin de renforcer la coopération entre les campagnes et les stratégies de santé et d'environnement.
4. Concilier les intérêts conflictuels de la société pour garantir un accès équitable à des milieux favorables à la santé.

En bref, l'habilitation des individus et la participation des communautés ont été définies comme les facteurs clés d'une action démocratique de promotion de la santé et comme l'élément moteur permettant d'atteindre l'autoresponsabilité et d'assurer le développement.

Les participants à la Conférence ont reconnu, en particulier, que l'éducation est un droit fondamental de l'homme et la clé des changements politiques, économiques et sociaux qui s'imposent pour que tous puissent prétendre à la santé. Chacun devrait avoir accès, tout au long de sa vie, à une éducation conçue sur des principes d'équité, eu égard notamment à la culture, à la classe sociale et au sexe.

UNE PERSPECTIVE MONDIALE

L'humanité fait partie intégrante de l'écosystème de la terre. La santé des hommes est étroitement associée à l'environnement. Toutes les données disponibles montrent qu'il sera impossible de préserver la qualité de la vie des individus et de toutes les espèces vivantes sans modifier partout radicalement les attitudes et les comportements face à la gestion et à la protection de l'environnement.

Le grand dessein de notre époque doit être une action concertée visant à créer un environnement durable, favorable à la santé.

Au niveau international, les énormes disparités du revenu par habitant conduisent à des inégalités du point de vue non seulement de l'accès aux prestations de santé, mais aussi des moyens dont disposent les sociétés pour améliorer leur situation et garantir aux générations futures une certaine qualité de vie. Le dépeuplement des campagnes au profit des villes entraîne la prolifération des bidonvilles et des problèmes qui leur sont liés, notamment le manque d'eau propre et d'installations d'assainissement.

Les décisions politiques et le développement industriel reposent trop souvent sur des plans et sur une volonté de profit à court terme sans qu'il soit tenu compte de leur coût réel pour la santé et l'environnement. La dette mondiale appauvrit sérieusement les maigres ressources des pays pauvres. Les dépenses militaires augmentent et, outre les tribut qu'ils prélèvent en morts et en blessés, les conflits armés représentent maintenant de nouvelles formes de vandalisme écologique.

L'exploitation de la main-d'oeuvre, l'exportation et l'évacuation de déchets et de produits dangereux, en particulier dans les nations les plus faibles et les plus pauvres, et le gaspillage des ressources mondiales témoignent d'une crise de l'approche actuelle du développement. Il est urgent de se doter d'une éthique nouvelle et de parvenir à un accord mondial basé sur la coexistence pacifique pour permettre une distribution et une utilisation plus équitables des ressources limitées de la planète.

POUR UNE RESPONSABILISATION MONDIALE

La Conférence de Sundsvall invite la communauté internationale à élaborer de nouveaux mécanismes de responsabilisation sanitaire et écologique reposant sur les principes d'un développement sanitaire durable. Dans la pratique, cela suppose que les grandes initiatives politiques et programmatiques soient assorties d'études de leur impact sur la santé et l'environnement. L'OMS et le PNUE sont invités à redoubler d'efforts pour élaborer des codes de conduite régissant la commercialisation et l'échange des substances et des produits nocifs pour la santé et l'environnement.

L'OMS et le PNUE sont instamment priés d'élaborer, à l'intention de leurs Etats Membres, des principes directeurs reposant sur l'idée d'un développement durable. Tous les organismes d'aide multilatérale et bilatérale et toutes les institutions de financement, comme la Banque mondiale et le Fonds monétaire international, sont invités à utiliser ces principes directeurs lors de la planification, de l'élaboration et de l'évaluation des projets de développement. Des mesures doivent être prises d'urgence pour aider les pays en développement à trouver des solutions à leurs problèmes. Une collaboration étroite sera maintenue avec les organisations non gouvernementales tout au long de ce processus.

La Conférence de Sundsvall a montré, une fois de plus, que les questions de santé, d'environnement et de développement humain sont indissociables. Le développement doit permettre l'amélioration de la qualité de la vie et de la santé tout en préservant l'environnement.

En conséquence, les participants à la Conférence prient instamment la Conférence des Nations Unies sur l'Environnement et le Développement qui aura lieu à Rio de Janeiro en 1992 de tenir compte de la Déclaration de Sundsvall lorsqu'elle étudiera la Charte sur la terre et le Programme 21 destiné à préparer l'avènement du 21ème siècle. Ces deux documents devront faire à la santé la place importante qui lui revient. Seule une action mondiale basée sur un partenariat international préservera l'avenir de notre planète.

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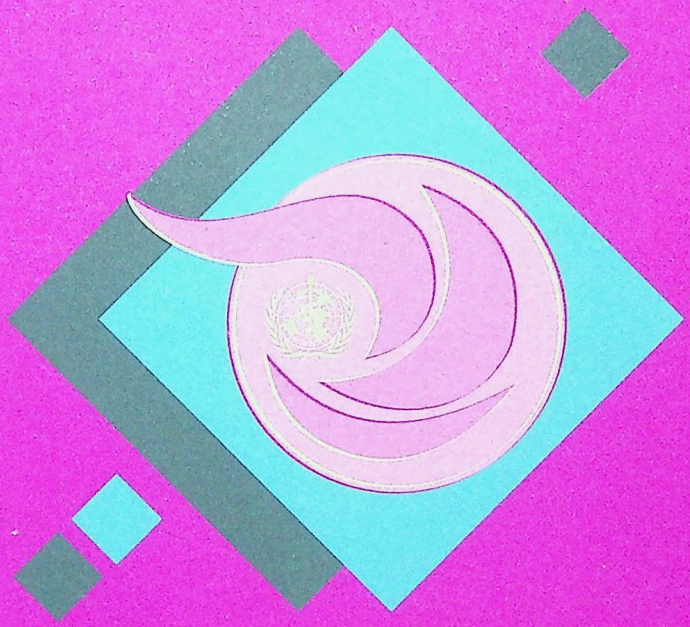
HEALTHY PUBLIC POLICY

POLITIQUES POUR LA SANTE

Les recommandations d'
ADELAIDE
Recommendations



World Health Organization
Organisation mondiale de la Santé

HEALTHY PUBLIC POLICY

ADELAIDE
Recommendations

CONFERENCE STATEMENT OF THE 2ND INTERNATIONAL CONFERENCE ON HEALTH PROMOTION* THE ADELAIDE RECOMMENDATIONS

HEALTHY PUBLIC POLICY

April 5-9, 1988 Adelaide South Australia

*Co-sponsored by the Australian Federal Department of Community Services and Health, Canberra, Australia, and the World Health Organization.

HEALTHY PUBLIC POLICY

CONFERENCE STATEMENT, THE ADELAIDE RECOMMENDATIONS

The adoption of the Declaration of Alma-Ata a decade ago was a major milestone in the Health for All movement which the World Health Assembly launched in 1977. Building on the recognition of health as a fundamental social goal, the Declaration set a new direction for health policy by emphasizing people's involvement, cooperation between sectors of society, and primary health care as its foundation.

THE SPIRIT OF ALMA-ATA

The spirit of Alma-Ata was carried forward in the Charter for Health Promotion which was adopted in Ottawa in 1986. The Charter set the challenge for a move towards the new public health by reaffirming social justice and equity as prerequisites for health, and advocacy and mediation as the processes for their achievement.

- The Charter identified five health promotion action areas:
- build Healthy Public Policy,
- create supportive environments,
- develop personal skills,
- strengthen community action, and
- reorient health services.

These actions are interdependent, but healthy public policy establishes the environment that makes the other four possible.

The Adelaide Conference on Healthy Public Policy continued in the direction set at Alma-Ata and Ottawa, and built on their momentum. Two hundred and twenty participants from forty-two countries shared experiences in formulating and implementing healthy public policy. The following recommended strategies for healthy public policy action reflect the consensus achieved at the Conference.

HEALTHY PUBLIC POLICY

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. It makes social and physical environments health-enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations.

THE VALUE OF HEALTH

Health is both a fundamental human right and a sound social investment. Governments need to invest resources in healthy public policy and health promotion in order to raise the health status of all their citizens. A basic principle of social justice is to ensure that people have access to the essentials for a healthy and satisfying life. At the same time, this raises overall societal productivity in both social and economic terms. Healthy public policy in the short term will lead to long-term economic benefits as shown by the case studies presented at this Conference. New efforts must be made to link economic, social, and health policies into integrated action.

EQUITY, ACCESS AND DEVELOPMENT

Inequalities in health are rooted in inequities in society. Closing the health gap between socially and educationally disadvantaged people and more advantaged people requires a policy that will improve access to health-enhancing goods and services, and create supportive environments. Such a policy would assign high priority to underprivileged and vulnerable groups. Furthermore, a healthy public policy recognizes the unique culture of indigenous peoples, ethnic minorities, and immigrants. Equal access to health services, particularly community health care, is a vital aspect of equity in health.

New inequalities in health may follow rapid structural change caused by emerging technologies. The first target of the European Region of the World Health Organization, in moving towards Health for All is that:

> *by the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups.*

In view of the large health gaps between countries, which this Conference has examined, the developed countries have an obligation to ensure that their own policies have a positive health impact on developing nations. The Conference recommends that all countries develop healthy public policies that explicitly address this issue.

ACCOUNTABILITY FOR HEALTH

The recommendations of this Conference will be realized only if governments at national, regional and local levels take action. The development of healthy public policy is as important at the local levels of government as it is nationally. Governments should set explicit health goals that emphasize health promotion.

Public accountability for health is an essential nutrient for the growth of healthy public policy. Governments and all other controllers of resources are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policy means that governments must measure and report the health impact of their policies in language that all groups in society readily understand. Community action is central to the fostering of healthy public policy. Taking education and literacy into account, special efforts must be made to communicate with those groups most affected by the policy concerned.

The Conference emphasizes the need to evaluate the impact of policy. Health information systems that support this process need to be developed. This will encourage informed decision-making over the future allocation of resources for the implementation of healthy public policy.

MOVING BEYOND HEALTH CARE

Healthy public policy responds to the challenges in health set by an increasingly dynamic and technologically changing world, with is complex ecological interactions and growing international interdependencies. Many of the health consequences of these challenges cannot be remedied by present and foreseeable health care. Health promotion efforts are essential, and these require an integrated approach to social and economic development which will re-establish the links between health and social reform, which the World Health Organization policies of the past decade have addressed as a basic principle.

PARTNERS IN THE POLICY PROCESS

Government plays an important role in health, but health is also influenced greatly by corporate and business interests, nongovernmental bodies and community organizations. Their potential for preserving and promoting people's health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community. New alliances must be forged to provide the impetus for health action.

ACTION AREAS

The Conference identified four key areas as priorities for healthy public policy for immediate action:

SUPPORTING THE HEALTH OF WOMEN

Women are the primary health promoters all over the world, and most of their work is performed without pay or for a minimal wage. Women's networks and organizations are models for the process of health promotion organization, planning and implementation. Women's networks should receive more recognition and support from policy-makers and established institutions. Otherwise, this investment of women's labour increases inequity. For their effective participation in health promotion women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy to ensure its cultural relevance.

This Conference proposes that countries start developing a national women's healthy public policy in which women's own health agendas are central and which includes proposals for:

- equal sharing of caring work performed in society;
- birthing practices based on women's preferences and needs;
- supportive mechanisms for caring work, such as support for mothers with children, parental leave, and dependent health-care leave.

FOOD AND NUTRITION

The elimination of hunger and malnutrition is a fundamental objective of healthy public policy. Such policy should guarantee universal access to adequate amounts of healthy food in culturally acceptable ways. Food and nutrition policies need to integrate methods of food production and distribution, both private and public, to achieve equitable prices.

A food and nutrition policy that integrates agricultural, economic, and environmental factors to ensure a positive national and international health impact should be a priority for all governments. The first stage of such a policy would be the establishment of goals for nutrition and diet. Taxation and subsidies should discriminate in favour of easy access for all to healthy food and an improved diet.

The Conference recommends that governments take immediate and direct action at all levels to use their purchasing power in the food market to ensure that the food-supply under their specific control (such as catering in hospitals, schools, day-care centres, welfare services and workplaces) gives consumers ready access to nutritious food.

TOBACCO AND ALCOHOL

The use of tobacco and the abuse of alcohol are two major health hazards that deserve immediate action through the development of healthy public policies. Not only is tobacco directly injurious to the health of the smoker but the health consequences of passive smoking, especially to infants, are now more clearly recognized than in the past. Alcohol contributes to social discord, and physical and mental trauma. Additionally, the serious ecological consequences of the use of tobacco as a cash crop in impoverished economies have contributed to the current world crises in food production and distribution.

The production and marketing of tobacco and alcohol are highly profitable activities - especially to governments through taxation. Governments often consider that the economic consequences of reducing the production and consumption of tobacco and alcohol by altering policy would be too heavy a price to pay for the health gains involved.

This Conference calls on all governments to consider the price they are paying in lost human potential by abetting the loss of life and illness that tobacco smoking and alcohol abuse cause. Governments should commit themselves to the development of healthy public policy by setting nationally-determined targets to reduce tobacco growing and alcohol production, marketing and consumption significantly by the year 2000.

CREATING SUPPORTIVE ENVIRONMENTS

Many people live and work in conditions that are hazardous to their health and are exposed to potentially hazardous products. Such problems often transcend national frontiers. Environmental management must protect human health from the direct and indirect adverse effects of biological, chemical, and physical factors, and should recognize that women and men are part of a complex ecosystem. The extremely diverse but limited natural resources that enrich life are essential to the human race. Policies promoting health can be achieved only in an environment that conserves resources through global, regional, and local ecological strategies.

A commitment by all levels of government is required. Coordinated intersectoral efforts are needed to ensure that health considerations are regarded as integral prerequisites for industrial and agricultural development. At an international level, the World Health Organization should play a major role in achieving acceptance of such principles and should support the concept of sustainable development.

This Conference advocates that, as a priority, the public health and ecological movements join together to develop strategies in pursuit of socioeconomic development and the conservation of our planet's limited resources.

DEVELOPING NEW HEALTH ALLIANCES

The commitment to healthy public policy demands an approach that emphasizes consultation and negotiation. Healthy public policy requires strong advocates who put health high on the agenda of policy-makers. This means fostering the work of advocacy groups and helping the media to interpret complex policy issues.

Educational institutions must respond to the emerging needs of the new public health by reorienting existing curricula to include enabling, mediating, and advocating skills. There must be a power shift from control to technical support in policy development. In addition, forums for the exchange of experiences at local, national and international levels are needed.

The Conference recommends that local, national and international bodies:

- establish clearing-houses to promote good practice in developing healthy public policy;
- develop networks of research workers, training personnel, and programme managers to help analyse and implement healthy public policy.

COMMITMENT TO GLOBAL PUBLIC HEALTH

Prerequisites for health and social development are peace and social justice; nutritious food and clean water; education and decent housing; a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem. The vision of healthy public policy is the achievement of these fundamental conditions for healthy living. The achievement of global health rests on recognizing and accepting interdependence both within and between countries. Commitment to global public health will depend on finding strong means of international cooperation to act on the issues that cross national boundaries.

FUTURE CHALLENGES

1. Ensuring an equitable distribution of resources even in adverse economic circumstances is a challenge for all nations.
2. Health for All will be achieved only if the creation and preservation of healthy living and working conditions become a central concern in all public policy decisions. Work in all its dimensions - caring work, opportunities for employment, quality of working life -dramatically affects people's health and happiness. The impact of work on health and equity needs to be explored.
3. The most fundamental challenge for individual nations and international agencies in achieving healthy public policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology, and sustainable development around the globe.

4. In most countries, health is the responsibility of bodies at different political levels. In the pursuit of better health it is desirable to find new ways for collaboration within and between these levels.
5. Healthy public policy must ensure that advances in health-care technology help, rather than hinder, the process of achieving improvements in equity.

The Conference strongly recommends that the World Health Organization continue the dynamic development of health promotion through the five strategies described in the Ottawa Charter. It urges the World Health Organization to expand this initiative throughout all its regions as an integrated part of its work. Support for developing countries is at the heart of this process.

RENEWAL OF COMMITMENT

In the interests of global health, the participants at the Adelaide Conference urge all concerned to reaffirm the commitment to a strong public health alliance that the Ottawa Charter called for.

POLITIQUES POUR LA SANTE

Les recommandations d'

ADELAIDE

DECLARATION FINALE DE LA 2EME CONFERENCE INTERNATIONALE SUR LA PROMOTION DE LA SANTE* LES RECOMMANDATIONS D'ADELAIDE

POLITIQUES POUR LA SANTE

5-9 Avril 1988, Adélaïde, Australie du Sud

* Co-parrainée par le Département des Services Communautaires et de Santé, Canberra, Australie et l'Organisation mondiale de la Santé.

POLITIQUES POUR LA SANTE

LES RECOMMANDATIONS D'ADELAIDE

L'adoption de la Déclaration d'Alma-Ata, en 1978, a marqué une étape décisive dans le mouvement en faveur de la Santé pour tous auparavant lancé par l'Assemblée mondiale de la Santé. S'appuyant sur le constat que la santé est un objectif social fondamental, la Déclaration a donné aux politiques de santé une nouvelle orientation en privilégiant la participation de la population, la coopération entre les divers secteurs de la société et les soins de santé primaires.

L'ESPRIT D'ALMA-ATA

L'esprit d'Alma-Ata a trouvé un écho dans la *Charte pour la promotion de la santé* adoptée à Ottawa en 1986. Cette Charte mettait le monde au défi de mener une nouvelle action de santé publique en réaffirmant que la justice sociale et l'équité constituaient les préalables de la santé et qu'une action de plaidoyer et de médiation était le moyen d'y parvenir.

La Charte dégageait cinq domaines d'action pour la promotion de la santé :

- forger des politiques pour la santé,
- créer des environnements favorables,
- développer les aptitudes personnelles,
- renforcer l'action communautaire, et
- réorienter les services de santé.

Ces domaines d'action sont bien sûr interdépendants, mais l'adoption de politiques pour la santé crée l'environnement qui rend possibles les quatre autres types d'action.

La Conférence d'Adélaïde sur la politique publique pour la santé a poursuivi dans la direction esquissée à Alma-Ata et à Ottawa en s'appuyant sur la dynamique alors enclenchée. Deux cent vingt participants venus de quarante-deux pays ont fait part de leur expérience dans l'élaboration et la mise en oeuvre de ce type de politique. Les stratégies ci-après, préconisées en vue de l'établissement de politiques pour la santé, sont l'aboutissement du consensus qui s'est instauré à la Conférence.

LES POLITIQUES POUR LA SANTE

Les politiques pour la santé se caractérisent par le souci explicite de garantir la santé et l'équité dans tous les domaines politiques et par l'obligation de rendre compte des retombées, sur le plan de la santé, des décisions prises dans les divers secteurs. Leur but principal est d'instaurer un environnement propice qui permette à chacun de mener une vie saine. Ces politiques rendent possibles, voire facilitent, les choix des citoyens en faveur de la santé. Elles font en sorte que l'environnement social et physique renforce la santé. Dans cette optique, les secteurs publics responsables de l'agriculture, du commerce, de l'éducation, de l'industrie et des communications doivent tenir compte du rôle essentiel de la santé lorsqu'ils formulent leurs grandes orientations. Ils doivent aussi être tenus pour responsables des conséquences de leurs décisions politiques sur la santé et accorder la même attention à la santé qu'aux problèmes économiques.

LA VALEUR DE LA SANTE

La santé est à la fois un droit fondamental de l'homme et un excellent investissement social. Les gouvernements doivent investir dans les politiques pour la santé et dans la promotion de la santé afin d'améliorer l'état de santé de tous les citoyens. Un principe fondamental de la justice sociale veut que chacun ait accès à tout ce qui est indispensable pour mener une vie saine et satisfaisante. Cela soulève aussitôt la question de la productivité de la société, en termes aussi bien sociaux qu'économiques. Les politiques pour la santé ne tarderont pas à avoir des retombées économiques à long terme, comme l'ont montré les études de cas présentées à la Conférence. Il faut redoubler d'efforts pour lier les politiques économiques, sociales et de santé dans une action intégrée.

EQUITE, ACCES ET DEVELOPPEMENT

Les inégalités face à la santé sont enracinées dans les inégalités au sein de la société. Combler l'écart de santé entre les personnes désavantagées du point de vue social et éducatif et les autres exige une politique qui améliore l'accès aux biens et aux services favorables à la santé et crée des environnements d'appui. Cette politique doit donner la priorité aux groupes défavorisés et vulnérables. D'autre part, elle doit reconnaître le caractère spécifique de la culture des peuples indigènes, des minorités ethniques et des immigrants. L'égalité d'accès aux services de santé, notamment aux soins de santé communautaires, est un aspect décisif de l'équité en matière de santé.

Les évolutions structurelles rapides nées des nouvelles technologies peuvent engendrer de nouvelles inégalités face à la santé. Le tout premier but fixé par la Région européenne de l'Organisation mondiale de la Santé en vue de la santé pour tous est explicite à cet égard :

> *D'ici l'an 2000, les écarts réels d'état de santé entre pays et entre groupes à l'intérieur du même pays devraient avoir été réduits d'au moins 25 %, grâce à une élévation du niveau de santé dans les pays et les groupes défavorisés.*

Etant donné l'importance des écarts de santé entre les pays, phénomène sur lequel s'est penchée la Conférence, les pays développés ont pour devoir de veiller à ce que leurs politiques aient des effets positifs sur la santé des nations en développement. Les participants à la Conférence ont recommandé que tous les pays élaborent des politiques publique pour la santé qui s'attaquent expressément à ce problème.

RESPONSABILITE ET SANTE

Les recommandations de la Conférence ne se concrétiseront que si les autorités nationales, régionales et locales agissent. L'élaboration des politiques pour la santé est aussi importante au niveau local qu'au niveau national. En matière de santé, les gouvernements doivent fixer explicitement des buts qui mettent en valeur la promotion de la santé.

La responsabilité des pouvoirs publics à l'égard de la santé est un facteur indispensable au développement des politiques pour la santé. Les gouvernements et tous ceux qui maîtrisent les ressources sont, en fin de compte, responsables devant le peuple des conséquences de leur politique ou de leur absence de politique en matière de santé. En s'engageant à adopter les politiques pour la santé, les gouvernements doivent mesurer les répercussions que ces politiques auront sur la santé et les faire connaître dans un langage compréhensible par tous. L'action communautaire est vitale pour encourager la politique en faveur de la santé. Des efforts spéciaux, s'appuyant sur l'éducation et l'alphabétisation, doivent être faits pour communiquer avec les groupes spécialement visés par ces politiques.

Les participants à la Conférence soulignent la nécessité d'évaluer l'impact des grandes orientations. Il faut pour cela mettre sur pied des systèmes d'information, ce qui permettra de prendre des décisions en toute connaissance de cause concernant l'affectation ultérieure des ressources pour la mise en oeuvre des politiques.

PAR LES SOINS DE SANTE

Les politiques pour la santé se proposent de relever les défis que pose, pour la santé, un monde de plus en plus dynamique et en pleine mutation technologique, avec ses interactions écologiques complexes et ses interdépendances internationales croissantes. Ces défis ont des conséquences que les systèmes de soins de santé, tels qu'ils sont aujourd'hui et tels qu'ils seront pour la plupart encore demain, ne peuvent assumer. Des efforts de promotion de la santé s'imposent et cela implique une approche intégrée à l'égard du développement économique et social, rétablissant les liens entre réforme sanitaire et réforme sociale principe fondamental vers lequel tendent les politiques de l'Organisation mondiale de la Santé depuis dix ans.

PARTENAIRES DANS L'ACTION POLITIQUE

Les gouvernements jouent un rôle important dans le domaine de la santé, mais celui-ci est aussi fortement influencé par des intérêts commerciaux et industriels, des organismes non gouvernementaux et des organisations communautaires, dont il faut développer le potentiel de protection et de promotion de la santé de la population. Syndicats, milieux commerciaux et industriels, associations universitaires et dirigeants religieux ont bien des occasions d'agir dans l'intérêt de la santé de toute la communauté. De nouvelles alliances sont, par conséquent, nécessaires pour imprimer l'élan voulu à l'action de santé.

DOMAINES D'ACTION

La Conférence a dégagé quatre domaines prioritaires qui appellent une action immédiate et qui fondent les politiques pour la santé.

PROMOTION DE LA SANTE DES FEMMES

Les femmes sont en première ligne pour promouvoir la santé dans le monde et elles travaillent, la plupart du temps, sans rémunération ou pour un salaire minimal. Les réseaux et organisations de femmes sont des modèles pour l'organisation, la planification et la mise en oeuvre des actions de promotion de la santé. Les décideurs et les institutions officielles devraient apprécier à leur juste valeur les réseaux de femmes et leur fournir un appui, faute de quoi cet investissement dans le travail des femmes accentuera les inégalités. Pour pouvoir participer vraiment à la promotion de la santé, les femmes doivent avoir accès à l'information, aux réseaux de communication et à l'argent. Toutes les femmes, notamment dans les groupes ethniques, indigènes et minoritaires, ont droit à l'autodétermination en santé et doivent être des partenaires à part entière dans la formulation des politiques pour la santé : c'est ce qui en garantira la pertinence culturelle.

La Conférence propose que les pays commencent par élaborer, au niveau national, une politique pour la santé des femmes, donnant une place centrale à leurs préoccupations en la matière et comportant notamment des propositions dans les domaines suivants :

- partage, sur une base d'égalité, du travail de soins assuré dans la société;
- pratiques en matière d'accouchement fondées sur les préférences et les besoins des femmes;
- mécanismes appuyant le travail de soins, par exemple aide aux mères, congé parental et congé pour soins aux personnes dépendantes.

ALIMENTATION ET NUTRITION

Eliminer la faim et la malnutrition est un objectif fondamental des politiques, lesquelles doivent garantir l'accès de tous à des quantités suffisantes d'aliments sains selon des modalités culturellement acceptables. Les politiques en matière d'alimentation et de nutrition doivent intégrer des méthodes, tant privées que publiques, de production et de distribution alimentaires à des prix abordables.

Les politiques d'alimentation et de nutrition, qui intègrent les facteurs agricoles, économiques et environnementaux et qui ont un impact positif sur la santé, aux plans national et international, doivent être prioritaires pour tous les gouvernements. La première étape consiste à fixer des buts concernant la nutrition et le régime alimentaire. Taxes et subventions doivent favoriser l'accès à des aliments sains pour tous et l'amélioration du régime alimentaire.

La Conférence recommande que les gouvernements agissent, dès à présent et directement, à tous les niveaux de leur pouvoir d'achat sur le marché de l'alimentation pour veiller à ce que la clientèle des services qu'ils contrôlent (services de restauration des hôpitaux, des écoles, des crèches, des services sociaux et des entreprises, par exemple) puisse accéder aisément à des aliments nutritifs.

TABAC ET ALCOOL

Le tabagisme et l'abus d'alcool sont deux grands problèmes de santé face auxquels il faut agir sans plus tarder en élaborant des politiques pour la santé. Non seulement le tabac est directement préjudiciable à la santé du fumeur, mais on connaît mieux désormais les conséquences du tabagisme passif, particulièrement pour les nourrissons. L'alcool contribue aux dissensions sociales, de même qu'aux traumatismes physiques et psychologiques. De plus, les graves conséquences écologiques de la culture du tabac comme culture de rapport dans des pays économiquement affaiblis ont contribué à la crise mondiale actuelle de la production et de la distribution alimentaires.

La production et la commercialisation du tabac et de l'alcool sont des activités productrices de revenus importants, notamment pour les gouvernements par le biais des taxes. Ceux-ci considèrent souvent que les conséquences économiques d'une réduction de la production et de la consommation de tabac et d'alcool par un changement de politiques seraient d'un prix trop lourd à payer par rapport aux bénéfices engrangés sur le plan de la santé.

La Conférence lance un appel à tous les gouvernements pour qu'ils songent au prix payé en potentiel humain perdu en cautionnant les pertes en vies humaines et les dégradations de l'état de santé attribuables au tabagisme et à l'abus d'alcool. Ils devraient s'engager à développer des politiques favorables à la santé en fixant, au niveau national, des cibles en vue de réduire sensiblement la culture du tabac et la production d'alcool, ainsi que la commercialisation et de la consommation de ces substances d'ici l'an 2000.

MISE EN PLACE D'ENVIRONNEMENTS FAVORABLES

Bien des gens vivent et travaillent dans des conditions préjudiciables à leur santé et sont exposés à des produits dangereux. Or, ces problèmes débordent souvent les frontières nationales. La gestion de l'environnement doit permettre de protéger la santé des hommes des effets délétères, directs ou indirects, des facteurs biologiques, chimiques et physiques et prendre en compte le fait que l'être humain fait partie d'un écosystème complexe. Les ressources naturelles extrêmement diverses mais limitées qui sont source de croissance sont essentielles à la survie, à la santé et au bien-être de l'humanité. Seul un environnement favorable à la conservation des ressources, grâce à des stratégies écologiques mondiales, régionales et locales, permettra d'appliquer des politiques pour la santé.

L'engagement des pouvoirs publics à tous les niveaux est une nécessité. Des efforts intersectoriels coordonnés s'imposent pour que la santé soit considérée comme un préalable essentiel au développement industriel et agricole. Au niveau international, l'Organisation mondiale de la Santé doit jouer un rôle de premier plan pour faire accepter ces principes et appuyer l'idée d'un développement durable.

La Conférence demande, à titre prioritaire, que les mouvements en faveur de la santé publique et de l'écologie s'associent pour mettre au point des stratégies de développement socio-économique et de conservation des ressources limitées dont dispose la planète.

NOUVELLES ALLIANCES POUR LA SANTE

L'engagement en faveur de politiques favorables à la santé exige une approche qui privilégie la consultation et la négociation.

Ces politiques ont besoin de défenseurs énergiques capables d'inscrire la santé au premier plan des préoccupations des décideurs. Cela signifie qu'il faut encourager l'action des groupes de persuasion et aider les médias à interpréter des questions politiques complexes.

Les établissements d'enseignement doivent répondre aux besoins de la nouvelle action de santé en réorientant les programmes d'étude pour y inscrire l'acquisition de moyens d'action, ainsi que l'acquisition de compétences en matière de médiation et de persuasion. Il doit y avoir transfert de pouvoirs, passant du contrôle à l'appui technique, dans l'élaboration des politiques. De plus, il faut des instances où puissent être échangées les données d'expérience aux niveaux local, national et international.

La Conférence recommande que les organismes locaux, nationaux et internationaux prennent les mesures suivantes :

- création de centres d'échange pour promouvoir les bonnes pratiques en matière d'élaboration de politiques pour la santé;
- mise en place de réseaux de chercheurs, de formateurs et de gestionnaires de programmes pour aider à analyser et mettre en oeuvre ces politiques.

ENGAGEMENT A L'EGARD DE LA SANTE DANS LE MONDE

Il existe plusieurs préalables indispensables à la santé et au développement social : la paix et la justice sociale, une alimentation nutritive et une eau propre, l'éducation et un logement décent, un rôle utile dans la société et un revenu suffisant, la conservation des ressources et la protection de l'écosystème. La vision qu'incarnent les politiques est la concrétisation de ces aspirations fondamentales à une vie saine. Instaurer la santé partout dans le monde suppose que l'on reconnaisse et que l'on accepte l'interdépendance à l'intérieur des pays et entre les pays. Pour s'engager à l'égard de la santé dans le monde, il faudra trouver des moyens efficaces de coopération internationale permettant d'agir face à des problèmes qui ignorent les frontières.

DEFIS POUR L'AVENIR

1. La répartition équitable des ressources même dans des situations économiques défavorables pose un défi à toutes les nations.
2. La santé pour tous ne deviendra réalité que si l'instauration et la préservation de conditions de vie et de travail favorables à la santé deviennent une préoccupation centrale de tous les hommes politiques. Le travail sous tous ses aspects - travail de soins, possibilités d'emploi, qualité de la vie professionnelle - a d'immenses répercussions sur la santé et le bien-être des individus. Il faut donc étudier l'impact du travail sur la santé et l'équité.
3. Encourager la collaboration (ou forger des partenariats) pour la paix, les droits de l'homme et la justice sociale, l'écologie et un développement durable dans le monde est le défi le plus essentiel que doivent relever les nations et les institutions internationales dans des politiques favorables à la santé.
4. Dans presque tous les pays, les responsabilités en matière de santé incombent à des organismes situés à des niveaux politiques différents. Dans l'intérêt de l'amélioration de la santé, il est souhaitable de trouver de nouvelles modalités de collaboration à chaque niveau et entre ces niveaux.
5. Les politiques pour la santé doivent veiller à ce que les progrès de la technologie médico-sanitaire soient un moteur et non pas un frein au progrès qui doit conduire à l'équité.

La Conférence recommande vivement que l'Organisation mondiale de la Santé poursuive, avec dynamisme, l'action de promotion de la santé fondée sur les cinq stratégies énoncées dans la Charte d'Ottawa. Elle invite instamment l'Organisation mondiale de la Santé à développer cette initiative dans toutes ses régions, comme faisant partie intégrante de son activité. L'appui aux pays en développement est au coeur de ce processus.

REAFFIRMATION DE L'ENGAGEMENT

Dans l'intérêt de la santé mondiale, les participants à la Conférence d'Adélaïde invitent instamment toutes les parties concernées à réaffirmer leur détermination de forger la solide alliance de santé publique, voulue par la Charte d'Ottawa.

WHO • OMS

H P R

Division of Health Promotion, Education and Communication
Division de la Promotion de la Santé, de l'Education et de la Communication pour la Santé

H E P

Health Education and Health Promotion Unit
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The 6th Global Conference on Health Promotion

7-11 August 2005
United Nations Conference Centre
Bangkok, Thailand

World Health Organization

Ministry of Public Health, Thailand

CONTENTS

GENERAL INFORMATION

Program on 7 August 2005

- Conference Registration is opened from 09.00 – 17.00 hrs. at Ground Floor
- The Opening Ceremony of the Conference is held at ESCAP Hall at 17.00 hrs.
- The Opening Ceremony of the Exhibition is held at the first floor at 17.45 hrs.
- "Sawasdee Night Reception" hosted by the Ministry of Public Health, Thailand at Royal Thai Navy Convention Hall during 18.30 – 20.30 hrs.
    - Shuttle buses depart from UNCC at 18.00 hrs. and back from Royal Thai Navy Convention Hall at 20.30 hrs.
    - Delegates should inform Hotel to arrange the hotel shuttle bus.

Field Trip Program on 10 August 2005

- The booking counter is opened on 7 – 8 August 2005 from 9.00 – 17.00 hrs.
- Coaches depart from UNCC at 13.00 hrs.
- Delegates should inform Hotel to arrange the hotel shuttle bus.

Program on 11 August 2005

- Bangkok Charter
- Closing Ceremony at ESCAP Hall

Free of charge buffet lunch will be provided from 8 - 11 August 2005 at Dining Room, First Floor and Reception Area.

CONFERENCE AGENDA

The 6th Global Conference on Health Promotion
"Policy and Partnership for Action : Addressing the Determinants of Health"

Sunday, 7 August 2005

09.00 – 17.00 hrs. Registration at UNCC
17.00 – 18.00 hrs. Opening Session at UNCC
18.30 – 20.30 hrs. "Sawasdee Night Reception" at Royal Thai Navy Convention Hall by Ministry of Public Health (MOPH),Thailand

Monday, 8 August 2005

08.30 – 18.30 hrs. Plenary Sessions & Discussions
18.30 – 20.00 hrs. WHO Reception

Tuesday, 9 August 2005

08.30 – 20.00 hrs. Plenary Sessions & Discussions

Wednesday, 10 August 2005 (Thai Day)

08.30 – 12.00 hrs. Keynote & Technical Sessions
12.00 – 13.00 hrs. Lunch
13.00 – 17.30 hrs. Field Trip Program

Thursday, 11 August 2005

08.30 – 12.30 hrs. Feed Back Bangkok Charter Plenary
11.00 – 12.30 hrs. Welcome to 7th Global Conference on Health Promotion
14.00 – 14.30 hrs. Bangkok Charter

FIELD TRIPS PROGRAM

There are 13 routes of the field trips. Delegates are invited to register on 7 – 8 August 2005 from 09.00 – 17.00 hrs. at Ground Floor, UNCC. Limited numbers are reserved on the first come first served basis. For more information, please contact Field Trips Counter, Ground Floor.

Route # 1 Health Promoting School

Route # 2 Healthy Community

Route # 3 Healthy Market Place

Route # 4 Healthy Day Care Centre (for pre-school children)

Route # 5 Thai Traditional Medicine and Health Care

Route # 6 Health Promotion / Treatment / Rehabilitation of Narcotic Addicts

Route # 7 Health Promoting Hospital

Route # 8 Health Care for AIDS patients

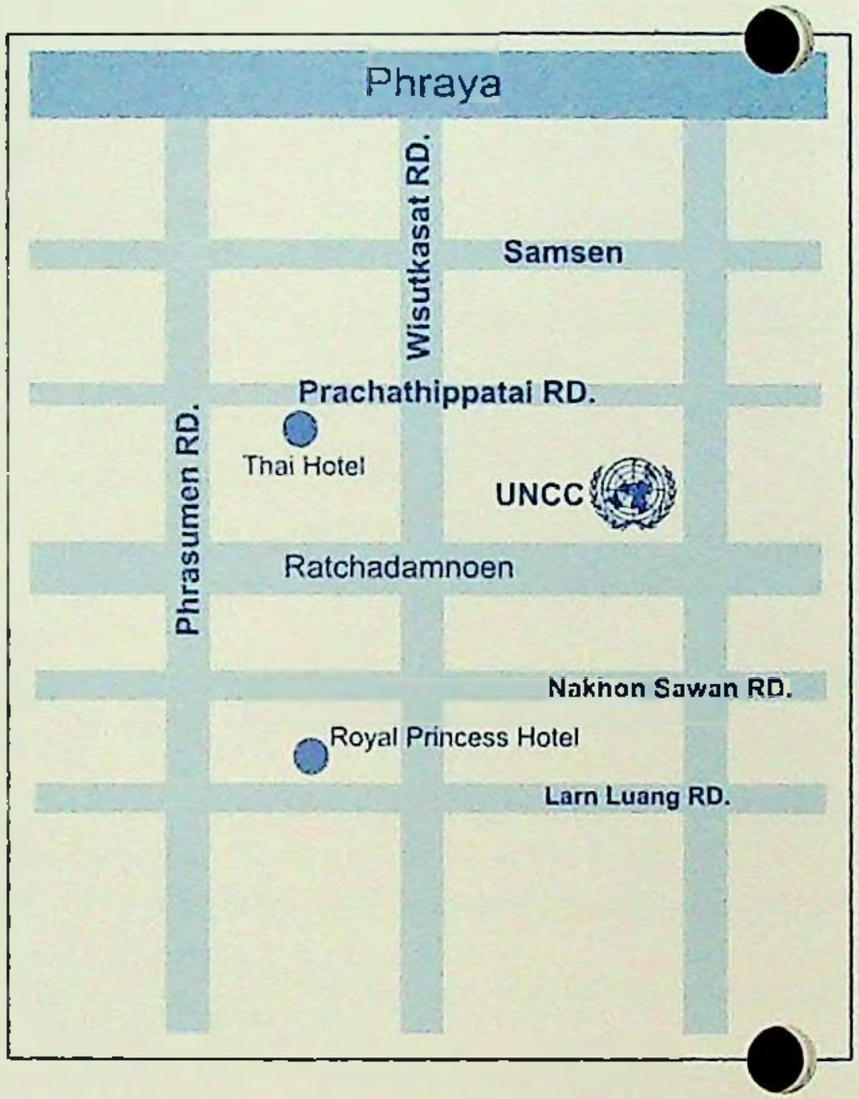
Route # 9 Mental Health Promotion in Community

Route # 10 Healthy Municipality

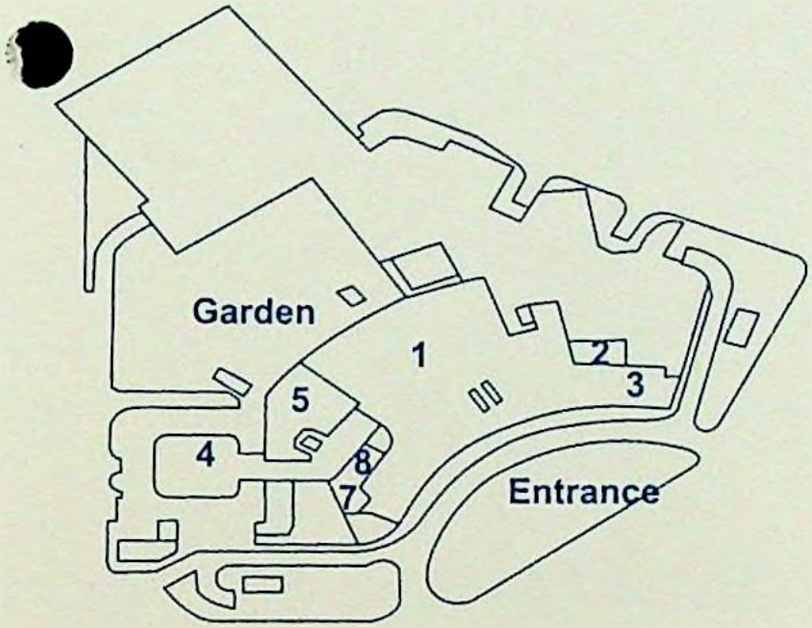
Route # 11 Healthy Hospital / Healthy Community

Route # ~~12~~ 13 Health Promoting School / Day Care Center

Route # ~~13~~ 12 Civil Network and Health Promotion



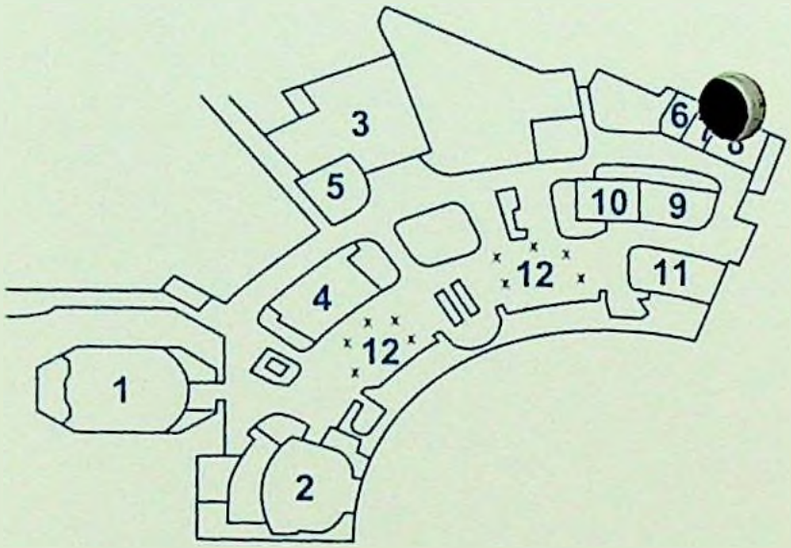
Ground Floor



Ground Floor

1. Reception Hall
2. Registration Counter and Information Centre
3. UN Stamps and Souvenir Counter
4. Public Foyer
5. Press Centre
6. Press Briefing Room
7. Post Office
8. First-aid room

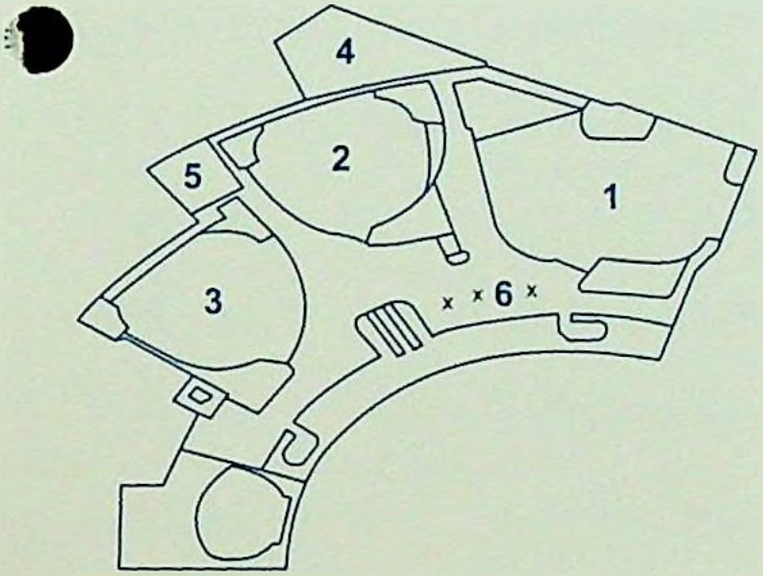
First Floor



First Floor

1. Conference Room 3
2. Conference Room 4
3. Dining Room
4. Meeting Room A
5. Meeting Room B
6. Meeting Room C
7. Meeting Room D
8. Meeting Room E
9. Meeting Room F
10. Meeting Room G
11. Meeting Room H
12. Exhibition Area

Second Floor



Second Floor

1. ESCAP HALL
2. Conference Room 1
3. Conference Room 2
4. Executive Office Suite (EOS)
5. Chairperson Office Suite (COS)
6. Exhibition Area

IMPORTANT TELEPHONE NUMBERS

Official Hotel :

1. Prince Palace Hotel	0 2628 1111
2. Royal Princess Hotel	0 2281 3088
3. Trang Hotel Bangkok	0 2282 2141
4. Thai Hotel	0 2282 2833
5. Viengtai Hotel	0 2280 5434
6. Grand China Princess	0 2224 9977
7. Siam City Hotel	0 2247 0123
8. Bangkok Palace Hotel	0 2253 0510

Emergency Call	191
Tourist police	1155
Immigration Division	0 2287 3101
Hospital	0 2632 0550
BTS Sky Train	0 2617 7300, 0 2617 7340

UNCC TELEPHONE NUMBERS

Telephone Number : 0 2288 1174, 0 2288 1140-1

Telephone Number : 0 2288 1140 Ext : 2403

Telephone Extensions:

Registration Counter	1282,1298,2111
First Aid	2282
Post office	1256,1260
Press Centre	2424, 2425, 2429
ESCAP Hall	2394
Executive Office Suite (EOS)	2397
Chairperson Office Suite (COS)	2417
Conference Room 1	2411
Conference Room 2	2357
Conference Room 3	2336
Conference Room 4	2339
Meeting Room A	2320
Meeting Room B	2321
Meeting Room C	2322
Meeting Room D	2323
Meeting Room E	2324
Meeting Room F	2325
Meeting Room G	2326
Meeting Room H	1141
Dining Room	2210, 2090

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Action for Public Health

Action pour la santé publique

SUNDSVALL STATEMENT ON SUPPORTIVE ENVIRONMENTS FOR HEALTH

9-15 JUNE 1991, SUNDSVALL, SWEDEN

DECLARATION DE SUNDSVALL SUR LES MILIEUX FAVORABLES A LA SANTE

9-15 JUIN 1991, SUNDSVALL, SUEDE

UNITED NATIONS ENVIRONMENT PROGRAMME
PROGRAMME DES NATIONS UNIES POUR L'ENVIRONNEMENT

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

NORDIC COUNCIL OF MINISTERS
CONSEIL DES MINISTRES DES PAYS NORDIQUES

SUNDSVALL STATEMENT ON SUPPORTIVE ENVIRONMENTS FOR HEALTH

The Third International Conference on Health Promotion: Supportive Environments for Health - the Sundsvall Conference - fits into a sequence of events which began with the commitment of WHO to the goals of Health For All (1977). This was followed by the UNICEF/WHO International Conference on Primary Health Care, in Alma-Ata (1978), and the First International Conference on Health Promotion in Industrialized Countries, in Ottawa (1986). Subsequent meetings on Healthy Public Policy, in Adelaide (1988) and a Call for Action: Health Promotion in Developing Countries, in Geneva (1989) have further clarified the relevance and meaning of health promotion. In parallel with these developments in the health arena, public concern over threats to the global environment has grown dramatically. This was clearly expressed by the World Commission on Environment and Development in its report ***Our Common Future****, which provided a new understanding of the imperative of sustainable development.*

The Third International Conference on Health Promotion: Supportive Environments for Health - the first global conference on health promotion, with participants from 81 countries - calls upon people in all parts of the world to engage actively in making environments more supportive to health. Examining today's health and environmental issues together, the Conference pointed out that millions of people are living in extreme poverty and deprivation in an increasingly degraded environment that threatens their health, making the goal of Health For All by the Year 2000 extremely hard to achieve. The way forward lies in making the environment - the physical environment, the social and economic environment, and the political environment - supportive to health rather than damaging to it.

The Sundsvall Conference identified many examples and approaches for creating supportive environments that can be used by policy-makers, decision-makers and community activists in the health and environment sectors. The Conference recognized that everyone has a role in creating supportive environments for health.

A CALL FOR ACTION

This call for action is directed towards policy-makers and decision-makers in all relevant sectors and at all levels. Advocates and activists for health, environment and social justice are urged to form a broad alliance towards the common goal of Health For All. We Conference participants have pledged to take this message back to our communities, countries and governments to initiate action. We also call upon the organizations of the United Nations system to strengthen their cooperation and to challenge each other to be truly committed to sustainable development and equity.

A supportive environment is of paramount importance for health. The two are interdependent and inseparable. We urge that the achievement of both be made central objectives in the setting of priorities for development, and be given precedence in resolving competing interests in the everyday management of government policies.

Inequities are reflected in a widening gap in health both within our nations and between rich and poor countries. This is unacceptable. Action to achieve social justice in health is urgently needed. Millions of people are living in extreme poverty and deprivation in an increasingly degraded environment in both urban and rural areas. An unforeseen and alarming number of people suffer from the tragic consequences of armed conflicts for health and welfare. Rapid population growth is a major threat to sustainable development. People must survive without clean water or adequate food, shelter and sanitation.

Poverty frustrates people's ambitions and their dreams of building a better future, while limited access to political structures undermines the basis for self-determination. For many, education is unavailable or insufficient, or, in its present forms, fails to enable and empower. Millions of children lack access to basic education and have little hope of a better future. Women, the majority of the world's population, are still oppressed. They are sexually exploited and suffer from discrimination in the labour market and many other areas which prevents them from playing a full role in creating supportive environments.

More than a billion people worldwide have inadequate access to essential health care. Health care systems undoubtedly need to be strengthened. The solution to these massive problems lies in social action for health and the resources and creativity of individuals and their communities. Releasing this potential requires a fundamental change in the way we view our health and our environment and a clear, strong political commitment to sustainable health and environmental policies. The solutions lie beyond the traditional health system.

Initiatives have to come from all sectors that can contribute to the creation of supportive environments for health, and must be acted on by people in local communities, nationally by government and nongovernmental organizations, and globally through international organizations. Action will involve predominantly such sectors as education, transport, housing and urban development, industrial production and agriculture.

DIMENSIONS OF ACTION ON SUPPORTIVE ENVIRONMENTS FOR HEALTH

In a health context the term **supportive environments** refers to both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction. Action must be coordinated at local, regional, national and global levels to achieve solutions that are truly sustainable.

The conference highlighted four aspects of supportive environments:

1. The **social** dimension, which includes the ways in which norms, customs and social processes affect health. In many societies traditional social relationships are changing in ways that threaten health, for example, by increasing social isolation, by depriving life of a meaningful coherence and purpose, or by challenging traditional values and cultural heritage.

2. The **political** dimension, which requires governments to guarantee democratic participation in decision-making and the decentralization of responsibilities and resources. It also requires a commitment to human rights, peace, and a shifting of resources from the arms race.

3. The **economic** dimension, which requires a re-channelling of resources for the achievement of Health For All and sustainable development, including the transfer of safe and reliable technology.

4. The need to recognize and use **women's skills and knowledge** in all sectors, including policy-making, and the economy, in order to develop a more positive infrastructure for supportive environments. The burden of the workload of women should be recognized and shared between men and women. Women's community-based organizations must have a stronger voice in the development of health promotion policies and structures.

PROPOSALS FOR ACTION

The Sundsvall Conference believes that proposals to implement the Health For All strategies must reflect two basic principles:

1. **Equity** must be a basic priority in creating supportive environments for health, releasing energy and creative power by including all human beings in this unique endeavour. All policies that aim at sustainable development must be subjected to new types of accountability procedures in order to achieve an equitable distribution of

responsibilities and resources. All action and resource allocation must be based on a clear priority and commitment to the very poorest, alleviating the extra hardship borne by the marginalized, minority groups, and people with disabilities. The industrialized world needs to pay the environmental and human debt that has accumulated through exploitation of the developing world.

2. Public action for supportive environments for health must recognize the **interdependence** of all living beings, and must manage all natural resources taking into account the needs of coming generations. Indigenous peoples have a unique spiritual and cultural relationship with the physical environment that can provide valuable lessons for the rest of the world. It is essential therefore that indigenous peoples be involved in sustainable development activities and negotiations be conducted about their rights to land and cultural heritage.

IT CAN BE DONE: STRENGTHENING SOCIAL ACTION

A call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control. Examples from all parts of the world were presented at the Conference in relation to education, food, housing, social support and care, work and transport. They clearly showed that supportive environments enable people to expand their capabilities and develop self-reliance. Further details of these practical proposals are available in the Conference report and handbook.

Using the examples presented, the Conference identified four key public health action strategies to promote the creation of supportive environments at community level.

1. **Strengthening advocacy** through community action, particularly through groups organized by women.

2. **Enabling communities** and individuals to take control over their health and environment through education and empowerment.

3. **Building alliances** for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies.

4. **Mediating** between conflicting interests in society in order to ensure equitable access to supportive environments for health.

In summary, empowerment of people and community participation were seen as essential factors in a democratic health promotion approach and the driving force for self-reliance and development.

Participants in the Conference recognized in particular that education is a basic human right and a key element to bring about the political, economic and social changes needed to make health a possibility for all. Education should be accessible throughout life and be built on the principle of equity, particularly with respect to culture, social class and gender.

THE GLOBAL PERSPECTIVE

Humankind forms an integral part of the earth's ecosystem. People's health is fundamentally interlinked with the total environment. All available information indicates that it will not be possible to sustain the quality of life, for human beings and all living species, without drastic changes in attitudes and behaviour at all levels with regard to the management and preservation of the environment.

Concerted action to achieve a sustainable, supportive environment for health is the challenge of our times.

At the international level, large differences in per capita income lead to inequalities not only in access to health but also in the capacity of societies to improve their situation and sustain a decent quality of life for future generations. Migration from rural to urban areas drastically increases the number of people living in slums, with accompanying problems including a lack of clean water and sanitation.

Political decision-making and industrial development are too often based on short-term planning and economic gains, which do not take into account the true costs to our health and the environment. International debt is seriously draining the scarce resources of the poor countries. Military expenditure is increasing, and war, in addition to causing deaths and disability, is now introducing new forms of ecological vandalism.

Exploitation of the labour force, the exportation and dumping of hazardous waste and substances, particularly in the weaker and poorer nations, and the wasteful consumption of world resources all demonstrate that the present approach to development is in crisis. There is an urgent need to advance towards new ethics and global agreement based on peaceful coexistence to allow for a more equitable distribution and utilization of the earth's limited resources.

ACHIEVING GLOBAL ACCOUNTABILITY

The Sundsvall Conference calls upon the international community to establish new mechanisms of health and ecological accountability that build on the principles of sustainable health development. In practice this requires health and environmental impact statements for major policy and programme initiatives. WHO and UNEP are urged to strengthen their efforts to develop codes of conduct on the trade and marketing of substances and products harmful to health and the environment.

WHO and UNEP are urged to develop guidelines based on the principle of sustainable development for use by Member States. All multilateral and bilateral donor and funding agencies such as the World Bank and International Monetary Fund are urged to use such guidelines in planning, developing and assessing development projects. Urgent action needs to be taken to support developing countries in developing their own solutions. Close collaboration with nongovernmental organizations should be ensured throughout the process.

The Sundsvall Conference has again demonstrated that the issues of health, environment and human development cannot be separated. Development must imply improvement in the quality of life and health while preserving the sustainability of the environment.

The Conference participants therefore urge the United Nations Conference on Environment and Development (UNCED), to be held in Rio Janeiro in 1992, to take the Sundsvall Statement into account in its deliberations on the Earth Charter and Agenda 21, which is to be an action plan leading into the 21st century. Health goals must figure prominently in both. Only worldwide action based on global partnership will ensure the future of our planet.

This Statement is the first of three outcomes from the Sundsvall Conference. The Conference report and handbook will expand the principles of the Statement in the form of practical guidelines for action for the future at all levels. Together, the three documents provide a coherent way forward.

LA DECLARATION DE SUNDSVALL: DES MILIEUX FAVORABLES A LA SANTE

La Troisième Conférence internationale sur la promotion de la santé, ou Conférence de Sundsvall, convoquée sur le thème "des milieux favorables à la santé", s'inscrit dans une suite d'événements qui a débuté avec l'engagement pris par l'OMS, en 1977, d'instaurer la santé pour tous. Cette décision a été suivie par la Conférence internationale de l'UNICEF/OMS sur les soins de santé primaires tenue à Alma-Ata en 1978 et la première Conférence internationale pour la Promotion de la Santé dans les Pays industrialisés, réunie à Ottawa en 1986. Les réunions organisées ensuite à Adélaïde (1988) sur des politiques publiques saines, et à Genève (1989) sur la promotion de la santé dans les pays en développement ont permis de préciser l'importance et le sens de la promotion de la santé. Parallèlement à cette évolution dans le domaine de la santé, les préoccupations suscitées par les menaces qui pèsent sur notre environnement n'ont cessé de grandir. C'est ce qu'a clairement exprimé la Commission mondiale sur l'environnement et le développement dont le rapport décrit sous un jour nouveau les conditions nécessaires à un développement durable.

La Troisième Conférence internationale pour la promotion de la santé, convoquée sur le thème "des milieux favorables à la santé", a été la première conférence mondiale dans ce domaine avec des participants venus de 81 pays. Ceux-ci ont demandé à tous les peuples du monde de prendre des mesures énergiques pour rendre les milieux plus favorables à la santé. Evoquant ensemble les questions de santé et d'environnement de notre temps, ils ont noté que des millions d'individus vivent dans la pauvreté et le dénuement le plus extrême dans un environnement de plus en plus dégradé qui menace leur santé, faisant de l'instauration de la santé pour tous d'ici l'an 2000 un objectif très difficile à atteindre. Pour progresser, il faut veiller à ce que l'environnement – physique, social, économique et politique – favorise la santé au lieu de lui nuire.

La Conférence de Sundsvall a illustré par de nombreux exemples les moyens que pourraient mettre en oeuvre les responsables politiques, les décideurs et les agents communautaires de la santé et de l'environnement pour créer des milieux favorables. Elle a reconnu que chacun a un rôle à jouer dans cette entreprise.

UN APPEL A L'ACTION

Cet appel s'adresse aux responsables politiques et aux décideurs dans tous les domaines concernés et à tous les niveaux. Tous ceux qui s'emploient à promouvoir la santé, l'environnement et la justice sociale sont instamment priés de former une alliance pour atteindre l'objectif commun de la santé pour tous. Nous autres, participants à cette Conférence, nous sommes engagés à transmettre ce message à nos communautés, pays et gouvernements pour que soient prises les mesures qui s'imposent. Nous demandons aussi aux organisations du système des Nations Unies de renforcer leur coopération et de s'encourager mutuellement à oeuvrer en faveur d'un développement durable et de l'équité.

Un milieu favorable revêt une importance capitale pour la santé. Les deux sont interdépendants et indissociables. Nous demandons instamment que les conditions nécessaires aux deux soient considérées comme des objectifs essentiels lors de l'élaboration des priorités pour le développement, et occupent la première place dans la solution des conflits d'intérêt qui peuvent surgir de la gestion au jour le jour des politiques des pouvoirs publics.

Le fossé qui se creuse, aussi bien à l'intérieur des pays qu'entre pays riches et pays pauvres, traduit les inégalités dans le domaine de la santé, et cela est inacceptable. Des mesures s'imposent d'urgence pour instaurer la justice sociale dans le domaine de la santé. Dans les villes comme dans les campagnes, des millions d'individus vivent dans la pauvreté et le dénuement extrême dans un milieu qui se dégrade de plus en plus. Un nombre imprévu et alarmant de personnes subissent les conséquences tragiques, pour la santé et le bien-être, de conflits armés. La croissance démographique rapide compromet sérieusement les chances d'un développement durable. Nombreux sont ceux qui sont obligés de survivre sans eau propre, sans alimentation correcte, sans abri et sans assainissement.

La pauvreté frustre les gens de leurs ambitions et de leurs aspirations à un avenir meilleur, tandis que les limites de l'accès aux structures politiques nuisent à l'autodétermination. Pour beaucoup, l'instruction est inexistante ou insuffisante ou, sous ses formes actuelles, incapable de donner les moyens d'agir. Des millions d'enfants n'ont pas accès à un enseignement de base et ne peuvent guère espérer en un avenir meilleur. Les femmes, qui représentent la majorité de la population mondiale, sont encore opprimées. Elles sont sexuellement exploitées et les discriminations dont elles sont victimes sur le marché du travail et dans bien d'autres domaines les empêchent de jouer pleinement leur rôle dans la mise en place d'environnements plus favorables.

Dans le monde, plus d'un milliard de personnes n'ont pas d'accès adéquat à des soins de santé essentiels. Les systèmes de santé doivent évidemment être renforcés. La solution à ces problèmes considérables réside dans des mesures d'action sociale en faveur de la santé et dans les ressources et les capacités d'innovation des individus et des communautés. Pour tirer parti de toutes ces possibilités, il faudrait que nous modifiions radicalement notre façon de concevoir la santé et l'environnement et que se dégage un engagement politique clair et énergique en faveur de politiques de santé et d'environnement durables. Les solutions doivent être cherchées au-delà des limites du secteur traditionnel de la santé.

Il faut que des initiatives soient prises dans tous les secteurs qui peuvent contribuer à la création de milieux favorables à la santé et soutenues au niveau local par les membres de la communauté, au niveau national par les pouvoirs publics et les organisations non gouvernementales, et au niveau mondial par les organisations internationales. Les secteurs concernés seront essentiellement ceux de l'éducation, des transports, du logement et du développement urbain, de la production industrielle et de l'agriculture.

DIMENSIONS DE L'ACTION TENDANT A CREER DES MILIEUX FAVORABLES A LA SANTE

Du point de vue de la santé, l'expression **milieux favorables** désigne les aspects physiques et sociaux de notre environnement, c'est à dire le cadre de vie de l'individu, sa communauté, son foyer, son milieu de travail et ses lieux de détente mais aussi les structures qui déterminent l'accès aux ressources vitales et les possibilités d'obtenir les moyens d'agir. Ainsi, les dimensions de toute action visant à créer un milieu favorable sont multiples : physiques, sociales, spirituelles, économiques et politiques. Tous ces aspects sont étroitement associés les uns aux autres en une interaction dynamique. Les mesures prises doivent être coordonnées aux échelons local, régional, national et mondial afin que soient mises au point des solutions réellement durables.

La Conférence a évoqué en particulier les quatre aspects suivants d'un environnement favorable :

1. La dimension **sociale**, c'est-à-dire les façons dont les normes, les coutumes et les schémas sociaux influencent la santé. Dans de nombreuses sociétés, l'évolution des relations sociales traditionnelles représente une menace pour la santé, par exemple en renforcant la solitude, en privant la vie de sens et de cohérence et en attaquant les valeurs et l'héritage culturel traditionnels.

2. La dimension **politique**, qui oblige les gouvernements à garantir une participation démocratique à la prise des décisions et à la décentralisation des responsabilités et des ressources. Elle suppose aussi un engagement en faveur des droits de l'homme, de la paix, et l'abandon de la course aux armements.

3. La dimension **économique**, qui suppose une redistribution des ressources en faveur de la santé pour tous et d'un développement durable, et notamment le transfert d'une technologie sûre et fiable.

4. La nécessité enfin de reconnaître et d'utiliser **les compétences et les connaissances des femmes** dans tous les domaines, y compris ceux de la politique et de l'économie, pour mettre en place des infrastructures plus propices à des environnements favorables à la santé. Il faudrait reconnaître que les femmes ont de lourdes tâches et veiller à ce que les hommes assument leur part de ce fardeau. Il faudrait que les associations féminines communautaires aient les moyens d'intervenir plus énergiquement dans l'élaboration de politiques et de structures propres à promouvoir la santé.

ACTIONS PROPOSEES

Pour la Conférence de Sundsvall, les actions envisagées pour mettre en oeuvre les stratégies de la santé pour tous doivent reposer sur deux grands principes fondamentaux :

1. **L'équité** doit être un objectif prioritaire fondamental de toute mesure prise pour créer des milieux favorables à la santé et mobiliser les énergies et les imaginations en associant l'humanité toute entière à cette entreprise unique. Toutes les politiques visant à un développement durable seront soumises à de nouvelles règles d'approbation en vue d'une distribution équitable des responsabilités et des ressources. Toute action et toute allocation de ressources sera guidée par le souci clairement exprimé de venir en aide aux plus pauvres, d'alléger le fardeau des marginalisés, des groupes minoritaires et des handicapés. Il faut que le monde industrialisé s'acquitte de la dette accumulée, sur les plans écologique et humain, à la suite de l'exploitation du monde en développement.

2. Toute action publique en faveur de milieux propices à la santé doit tenir compte de l'**interdépendance** de tous les êtres vivants, et bien gérer les ressources naturelles en tenant compte des besoins des générations futures. Les peuples autochtones entretiennent avec leur environnement physique une relation spirituelle et culturelle unique qui peut être riche d'enseignements pour le reste du monde. Il est donc essentiel de les associer aux stratégies de développement et de prévoir des négociations pour préserver leurs droits à leurs terres et à leur héritage culturel.

UN OBJECTIF REALISTE : RENFORCER L'ACTION SOCIALE

Cet appel pour la mise en place de milieux favorables à la santé peut être un objectif réaliste de l'action de santé publique au niveau local, avec pour cible privilégiée les contextes propices à une participation et à un contrôle importants de la communauté. Des exemples du monde entier ont été présentés à la Conférence dans les domaines de l'éducation, de l'alimentation, de l'habitat, de la protection sociale, du travail et des transports. Ces illustrations ont très bien montré qu'un milieu favorable permet aux gens de développer leurs capacités et leur autoresponsabilité. Le rapport et le guide de la Conférence contiennent des renseignements détaillés sur ces projets concrets.

A l'aide des exemples ainsi présentés, les participants à la Conférence ont défini comme suit les quatre stratégies clefs de santé publique susceptibles de promouvoir la création de milieux favorables au niveau de la communauté.

1. **Renforcer l'action de plaidoyer** au niveau de la communauté, notamment par le biais de groupes organisés par des femmes.

2. **Donner aux communautés et aux individus les moyens** de gérer leur propre santé et leur environnement par l'éducation et différentes mesures d'habilitation.

3. **Constituer des alliances** en faveur de la santé et de milieux favorables afin de renforcer la coopération entre les campagnes et stratégies de santé et d'environnement.

4. **Concilier** les intérêts conflictuels de la société pour garantir un accès équitable à des milieux favorables à la santé.

En bref, l'habilitation des individus et la participation des communautés ont été définies comme des facteurs clefs d'une action démocratique de promotion de la santé et comme l'élément moteur permettant d'atteindre l'autoresponsabilité et d'assurer le développement.

Les participants à la Conférence ont reconnu en particulier que l'éducation est un droit fondamental de l'homme et la clé des changements politiques, économiques et sociaux qui s'imposent pour que tous puissent prétendre à la santé. Chacun devrait avoir accès tout au long de sa vie à une éducation conçue sur des principes d'équité, eu égard notamment à la culture, à la classe sociale et au sexe.

UNE PERSPECTIVE MONDIALE

L'humanité fait partie intégrante de l'écosystème de la terre. La santé des hommes est étroitement associée à l'environnement. Toutes les données disponibles montrent qu'il sera impossible de préserver la qualité de la vie des individus et de toutes les espèces vivantes sans modifier partout radicalement les attitudes et les comportements face à la gestion et à la protection de l'environnement.

Le grand dessein de notre époque doit être une action concertée visant à créer un environnement durable, favorable à la santé.

Au niveau international, les énormes disparités du revenu par habitant conduisent à des inégalités, du point de vue non seulement de l'accès aux prestations de santé, mais aussi des moyens dont disposent les sociétés pour améliorer leur situation et garantir aux générations futures une certaine qualité de vie. Le dépeuplement des campagnes au profit des villes entraine la prolifération des bidonvilles et des problèmes qui leur sont liés, notamment le manque d'eau propre et d'installations d'assainissement.

Les décisions politiques et le développement industriel reposent trop souvent sur des plans et la volonté de profit à court terme sans qu'il soit tenu compte de leur coût réel pour la santé et l'environnement. La dette mondiale appauvrit sérieusement les maigres ressources des pays pauvres. Les dépenses militaires augmentent et, outre les morts et les blessés, les conflits armés représentent maintenant de nouvelles formes de vandalisme écologique.

L'exploitation de la main-d'oeuvre, l'exportation et l'évacuation de déchets et de produits dangereux, en particulier dans les nations les plus faibles et les plus pauvres, et le gaspillage des ressources mondiales témoignent d'une crise de l'approche actuelle du développement. Il est urgent de se doter d'une éthique nouvelle et de parvenir à un accord mondial basé sur la coexistence pacifique pour permettre une distribution et une utilisation plus équitables des ressources limitées de la planète.

POUR UNE RESPONSABILISATION MONDIALE

La Conférence de Sundsvall invite la Communauté internationale à élaborer de nouveaux mécanismes de responsabilisation sanitaire et écologique reposant sur les principes d'un développement sanitaire durable. Dans la pratique, cela suppose que les grandes initiatives politiques et programmatiques soient assorties d'études de leur impact sur la santé et l'environnement. L'OMS et le PNUE sont invités à redoubler d'efforts pour élaborer des codes de conduite régissant la commercialisation et l'échange des substances et des produits nocifs pour la santé et l'environnement.

L'OMS et le PNUE sont instamment priés d'élaborer, à l'intention de leurs Etats Membres, des principes directeurs reposant sur l'idée d'un développement durable. Tous les organismes d'aide multilatérale et bilatérale et institutions de financement comme la Banque mondiale et le Fonds monétaire international sont invités à utiliser ces principes directeurs lors de la planification, de l'élaboration et de l'évaluation des projets de développement. Des mesures doivent être prises d'urgence pour aider les pays en développement à trouver des solutions à leurs problèmes. Une collaboration étroite sera maintenue avec les organisations non gouvernementales tout au long de ce processus.

La Conférence de Sundsvall a montré une fois de plus que les questions de santé, d'environnement et de développement sont indissociables. Le développement doit permettre l'amélioration de la qualité de la vie et de la santé tout en préservant l'environnement.

En conséquence, les participants à la Conférence prient instamment la Conférence des Nations Unies sur l'Environnement et le Développement qui aura lieu à Rio de Janeiro en 1992 de tenir compte de la Déclaration de Sundsvall lorsqu'elle étudiera la Charte sur la terre et le Programme 21 destiné à préparer l'avènement du 21^{e} siècle. Ces deux documents devront faire à la santé la place importante qui lui revient. Seule une action mondiale basée sur un partenariat international préservera l'avenir de notre planète.

Cette Déclaration est le premier des trois documents issus de la Conférence de Sundsvall. Le rapport et le guide qui seront établis développeront les grandes idées exposées dans la Déclaration sous la forme de principes directeurs pour des actions concrètes à tous les niveaux. Ces trois documents représentent ensemble un moyen cohérent d'aller de l'avant.

This Statement was adopted on 15 June 1991 in Sundsvall, Sweden, by participants at the Third International Conference on Health Promotion: Supportive Environments for Health, the first global conference on the interdependence between health and environment in its physical, cultural, economic and political dimensions.

The Conference was attended by 318 participants from 81 countries. They represented a wide range of sectors, disciplines, agencies and organizations.

The Conference was able to achieve an equitable gender balance. It was the first of these conferences on health promotion in which half of the participants came from developing countries.

At the Conference more than 700 references on supportive environments were submitted and 200 case histories presented.

The full outcome from the Conference will be presented in a report and a handbook demonstrating different ways of creating supportive environments.

The Sundsvall Conference was held from 9 to 15 June 1991 and jointly organized by the World Health Organization and the Nordic Countries in association with the United Nations Environment Programme.

* * *

La présente Déclaration a été adoptée le 15 juin 1991 à Sundsvall, Suède, par les participants à la Troisième Conférence internationale sur la promotion de la santé. Axée sur la création d'environnements favorables à la santé, cette première Conférence mondiale a traité de l'interdépendance de la santé et de l'environnement, dans ses aspects physiques, culturels, économiques et politiques.

La Conférence a réuni 318 participants venus de 81 pays. Ils représentaient un très large éventail de secteurs, de disciplines, d'institutions et d'organisations.

La Conférence a été caractérisée par un juste équilibre et a été la première de ces conférences sur la promotion de la santé dont les participants venaient pour moitié de pays en développement.

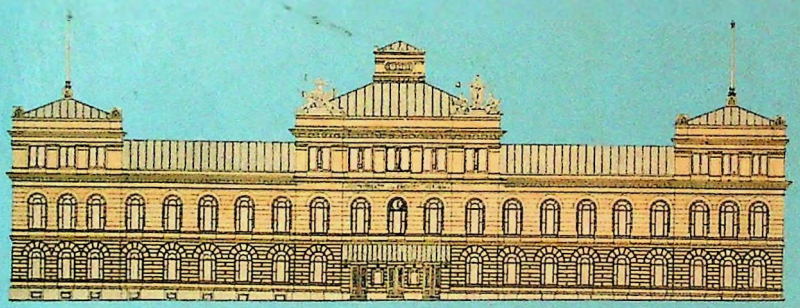
Au total, plus de 700 références sur les environnements favorables ont été soumises et 200 études de cas ont été présentées.

Les travaux de la Conférence seront consignés dans un rapport et un guide illustrant différents moyens de créer des milieux favorables.

Réunie du 9 au 15 juin 1991, la Conférence de Sundsvall était organisée conjointement par l'Organisation mondiale de la Santé et les Pays nordiques en association avec le Programme des Nations Unies pour l'Environnement.

The Sundsvall Conference on supportive environments for health fits into a sequence of events which began with the commitment of the WHO to the goals of Health For All (1977); it was followed by the Declaration of Alma-Ata on Primary Health Care (1978); and An International Conference on Health Promotion, in Ottawa (1986). Subsequent conferences on Healthy Public Policy, in Adelaide (1988), and A Call for Action: Health Promotion in Developing Countries, in Geneva (1989) have further developed the relevance and meaning of health promotion. In parallel with these developments in the health arena, there has been growth in public concern over the threats to the global environment. This was clearly expressed by the World Commission on Environment and Development in its report Our Common Future which developed a new understanding of the imperative of sustainable development.

La Conférence de Sundsvall sur des milieux favorables à la santé s'inscrit dans une suite d'évènements qui a debuté avec l'engagement pris par l'OMS d'instaurer la santé pour tous (1977); cette décision a été suivie par la Déclaration d'Alma Ata sur les soins de santé primaires (1978) et une conférence internationale pour la promotion de la santé, réunie à Ottawa en 1986. Les réunions organisées ensuite à Adélaïde (1988) sur des politiques publiques saines, et à Genève (1989) sur la promotion de la santé dans les pays en développement ont permis de clarifier l'importance et le sens de la promotion de la santé. Parallèlement à cette évolution dans le domaine de la santé, les préoccupations suscitées par les menaces qui pèsent sur notre environnement n'ont cessé de grandir. C'est ce qu'a clairement exprimé la Commission mondiale sur l'environnement et le développement dont le rapport décrit sous un jour nouveau les conditions nécéssaires à un développement durable. .



The Sundsvall Town Hall was the conferencecenter
La conférence s'est réunie dans l'hôtel de ville de Sundsvall

The national Swedish organizers were
Les organisateurs suédois étaient les suivants

Socialstyrelsen
Karolinska Institutet
Landstinget Västernorrland
Sundsvalls kommun

CONTENT

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560001

FROM 1988 - JUNE 1993

SCHOOL HEALTH PROGRAMME BUDGET

Date	Name	Currency	Rupees
8/88	Trust for Human and Community Development/Mysore/India		25,000
1/89	- do -		25,000
	Total		50,000

Date	Name	Currency	Rupees
11/89	Aid Organisation 'Help to Help Yourself' Liechtenstein/Europe	S.Fr. 5,000	52,313
5/90	- do -	8,000	97,645
9/91	- do -	14,000	2,42,634
4/92	- do -	16,000	3,03,776
5/93	- do -	16,000	3,32,000
	Total	59,000	10,28,368
5/93	Hanni Bubendorfer's Fund Liechtenstein/ Europe	S.Fr. 3,000	62,342
		S.Fr. 62,000	
		Rs. 50,000	

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560021

FROM 1988 - JUNE 1993

DONATIONS TO SCHOOL HEALTH PROGRAMME

Date	Name	Currency		Rupees
6/88	Doselli/ Italy			750
7/88	Doselli/Italy			300
7/88	Bertuletti/Italy			500
9/88	Mignani/Italy			500
8/89	Friends of India	U.S.$	780	12,833
7/90	Consonni/Italy	$	100	1,715
7/90	Van Putten/Belgium			14,186
7/90	Lugli/Italy	$	200	3,430
3/91	Cavalli/ Italy			10,000
44/91	Spelgatti/Italy			4,000
5/91	Dr.Sarala/USA	$	100	2,000
5/91	Barchiesi/Italy			5,000
8/91	Moro/Italy	S.Fr.	400	6,435
11/91	Barchiesi/Italy			2,000
11/91	H&P Bubendorfer/Liechtenstein			7,650
2/92	Maria.G.Zilioli/Italy			400
3/92	Maria.G.Zilioli/Italy			5,000
8/92	Friends of India/Italy	$	887	24,672
8/92	Friends of India/Italy	$	576	15,928
10/92	Dr.Velo/Italy	$	100	2,765
10/92	Liverani/ Italy	$	100	2,765
10/92	Kaufmann/Liechtenstein			5,000
3/93	Karstin/Germany	D.M.	70	1,440
4/93	Ferrari/Italy	$	200	5,863
				1,35,132

U.S.$	3043
D.M.	70
S.Fr.	400
Rs.	55286

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560001

FROM 1988 - JUNE 1993

DONATIONS TO SCHOOL HEALTH PROGRAMME

Date	Name	Currency	Rupees
7/91	H&P Bubendorfer/Liechtenstein for Equipment	S.Fr.1,500	24,752
11/91	- do -		7,650
	Total		32,402
	For Furniture		
8/92	Aid Organisation 'Help to Help Yourself' Liechtenstein/Europe	S.Fr.3,444.75	71,843
8/92	H&P Bubendorfer/Liechtenstein	S.Fr.4,555.25	95,057
	Total		1,66,900
			18,213
	Co-Curriculam Activities	Pass Book -	1,85,113
6/92	Br. Rik Merens CARITAS CISTERCIENSIS V.Z.W. Antwerpse/ Belgium	B.Fr.100.000	35,828
	- do - Drinting Water for Seva Ashram School		48,569
	Total		84,397

S.Fr.9.500
B.Fr.100.000
Rs. 7,650

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560021

FROM 1988 - JUNE 1993

SCHOOL HEALTH PROGRAMME ENDOWMENT FUND

DATE	NAME	CURRENCY	RUPEES
1/89	Bertuletti/Italy		5,000
1/89	Dr.Richard Silvia/Switzerland		4,550
1/89	Rota/ Italy		1,000
1/89	Mignani Andreina/Italy		3,000
2/89	Saetti & Conti/Italy		2,000
4/89	Martinelli Alfio/Italy		10,000
4/89	Belingheri/Italy		10,000
4/89	Simonini/Italy		2,000
7/89	Maria.G.Zilioli/Italy		15,070
7/89	Dr.Weber	S.Fr. 300	3,000
7/89	Jochheim Helene/Germany	D.M. 5000	43,078
8/89	Friends of India/Italy	U.S.$ 4000	66,000
8/89	Fr. Paul/Belgium		1,000
11/89	Martinelli Alfio/Italy		4,055
11/89	Paterno/Italy		4,980
12/89	Rorary Club,Pinerolo/Italy	$ 1000	16,759
1/90	Saetti & Conti/Italy	$ 250	4,187
1/90	Lugli Alfonso/Italy	$ 100	1,670
1/90	Ferrari/Italy	$ 50	692
3/90	Odette Bonfils/France		868
5/90	Collegues of Conti/Italy	$ 350	5,998
5/90	Collegues of Saetti/Italy	$ 250	4,289
5/90	Manessi Claudio/Italy	$ 400	6,855
12/90	Galvan Lucia/Italy	$ 400	7,250
12/90	Galatron SRL/Italy	$ 1,800	32,623
4/92	Scaglia/Italy	$ 400	11,168
4/92	Simonini/Italy	$ 320	8,934
8/92	Friends of India/Italy	$ 7,245	201,689
10/92	Rorary Club Pinerolo/Italy	$ 1,000	28,000
			5,05,715

U.S.$	17,565
S.Fr.	300
D.M.	5,000
Rs.	63,523

DEENA SEVA SANGHA SCHOOL HEALTH PROGRAMME ENDOWMENT FUND

Date	Name	Rupees
1988-1992	Donation Through Maria.G.Zilioli	5,04,715
1988	Action Aid/ England	1,00,000
	Interest	12,320
1990	CEBEMO/ Holand	1,35,570
1988 -1991	Accumulated Interest	1,72,000
1992	Interest	77,800
		10,02,405

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560001

FROM 1988 - JUNE 1993

SCHOOL FOR SPECIAL EDUCATION ENDOWMENT FUND

Date	Name	Currency	Rupees
2/92	Bertuletti/Italy	U.S.$ 500	12,675
2/92	Scaglia/Italy		500
	Total		13,175
3/90	Marilda & Bruno/Italy	$ 100	1,680
3/90	Altemani Maurizio/Italy		2,500
3/90	Consonni/ Italy	$ 400	6,760
3/90	Santagada/Italy	$ 100	1,690
12/91	H&P Bubendorfer/Liechtenstein	S.Fr. 1000	18,231
1/92	School Children/Italy	$ 1000	25,907
9/92	Belgium Friends	B.Fr.51000	42,840
	Total		99,608

U.S.$ 2100
S.Fr. 1000
B.Fr. 51000
Rs. 3000

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM -5TH MAIN, SRIRAMPURAM, BANGALORE - 560001

FROM 1988 - JUNE 1993

SCHOOL HEALTH PROGRAMME BUILDING FUND

DATE	NAME	CURRENCY	RUPEES
12/90	Friends of India/Italy		1,90,308
12/90	Rotary Club Pinerolo/Italy	U.S.$ 1,000	17,945
12/90	Mignani Mario/Italy		42,265
12/90	Saetti Conti/Italy	$ 1,500	27,186
12/90	Lugli Alfonso	$ 100	1,780
12/90	Mattiuz/ Italy	$ 450	8,156
12/90	Giacomina/Italy		1,427
1/91	Saetti Conti & Friends/Italy	$ 1,300	23,952
1/91	Spelgatti/Italy		3,000
11/91	Fr. Murata/Japan		7,200
1/91	Fr. Werners Johanni/Germany		28,725
9/91	Pius Koppal/Switzerland	S.Ff. 5,000	86,021
9/91	Pfarrgen St.Martin/Germany	D.M. 8,000	1,25,167
12/91	Rotary Club/Italy	$ 1,000	25,900
12/91	Galvon Lucia	$ 843	21,839
12/91	Roveda Palmira	$ 4,200	1,08,808
12/91	Vaccari Patrizia	$ 85	2,202
12/91	Bettoli Franco/ Italy	$ 300	7,590
1/92	Lugli Alfonso/Italy	$ 100	2,345
1/92	Friends of India/Italy	$ 3,500	89,225
1/92	Ulf B.Felt/Sweden		500
1/92	Moriggi Bruno/Italy	$ 200	5,060
2/92	Martinelli Alfio/Italy	$ 654	16,844
8/92	L.E.D./Liechtenstein	S.Fr. 9,000	1,87,650
8/92	Gina Zilioli/Italy	$ 887	24,672
11/92	H&P Bubendorfer/Liechtenstein	S.Fr. 2,400	46,440
11/92	Barbara Fronmelt/Liechtenstein	S.Fr. 3,000	58,050
	Total		11,60,257

U.S. $ 16,119
S.Fr. 19,400
D.M. 8,000
Rs. 2,73,425

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM -5TH MAIN, SRIRAMPURAM, BANGALORE - 560001

FROM 1988 - JUNE 1993

SCHOOL BUILDING FUND

Date	Name	Currency	R Rupees
2/92	EMMAUS INTERNATIONAL/FRANCE	U.S.$ 40,000	10,36,269
4/92	EMMAUS INTERNATIONAL/FRANCE	$ 40,000	11,50,011
	Total	80,000	21,86,280

HIGH SCHOOL

BUILDING FUND

Date	Name	Currency	Rupees
12/92	Pharrgem St.Martini/Germany	D.M.6,000	1,06,366
2/93	Jochheim Helene/Germany	D.M.5,000	88,400
1/93	Beschi Martino/Italy	U.S.$ 350	10,190
1/93	Golven Lucia/Italy	$ 700	20,380
1/93	Saetti Conti Nadia/Italy	$ 750	21,834
1/91	Maria.G.Zilioli/Italy		36,575
	Total		2,83,745

U.S.$ 1,800
D.M. 11,000
Rs. 36,575

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE -560001

FROM 1988 - JUNE 1993

CONTRIBUTIONS TO DEENA SEVA SANGHA

Date	Name	Currency	Rupees
8/89	Maria.G. Zilioli/Italy (Towards Electronic Typewriter)		5,000
3/91	Maria.G. Zilioli/ Italy (Towards High School Building)		5,000
6/91	EMMAUS/ Japan (Towards Electric Cyclostiling Machine)	U.S.$ 1.500	24,580
	Total		34,580

CONTRIBUTION TO CHIL[illegible]N

4/89	Iris Follimi/Switzerland Deena Seva Sangha Scholarship		900
12/90	Voltolin/ Italy Girls Education	$ 100	1,780
12/90	Rina/ Italy Girls Education		793
8/90	Franca Zilioli/ Italy Girl's Marriage	$ 45	1,239
			4,712
	Total		39,292

U.S. $ 1.600
Rs. 12,932

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G. ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE -560001

SPONSORS FOR CHILDREN

ST. ANDALS GIRLS HOME

Date	Name	Currency	Rupees
1/90	Garbati Luigi/ Italy	US $ 261	4,809
3/91	" "		1,900
8/91	" "	245	6,313
1/92	" "	720	18,259
4/92	" "	40	1,116
4/92	" "		20
8/92	" "	300	8,370
1/93	" "	300	8,610
1/93	" "		1,420
		1,866	50,817
1/91	Dr. Galli Emilio/ Italy	261	4,809
8/91	" "	225	5,741
1/92	" "	250	6,335
8/92	" "	244	6,790
1/93	" "	190	5,453
		1,170	29,128
1/91	Bertola Baldreghi/ Italy	250	4,606
8/91	" "	250	6,442
1/92	" "	250	6,335
8/92	" "	244	6,790
1/93	" "	280	8,036
		1,274	32,209
1/91	Mario Cattaneo/Italy	250	4,606
8/91	" "	250	6,442
1/92	" "	250	6,335
8/92	" "	244	6,790
1/93	" "	190	5,453
		1,184	29,626

.....2

Date	Name	Currency	Rupees
8/92	Luisa Nocentini/ Italy	US $ 265	7,390
6/93	" "		7,500
		265	14,890
8/92	Mariglia Chiavai/ Italy	265	7,390
	Total		1,64,060

US $ 6,024
Rs. 3,340

DONATIONS TO DEENA SEVA SANGHA THROUGH MARIA.G. ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE - 560 021

FROM 1988 - JUNE 1993

A SUMMARY OF THE SUB - TOTALS AND GRAND TOTALS

1. School Health Programme Budget 1988 - 1994	Rs.	50,000	Rs. 50,000
	S.Fr.	62,000	10,90,710
			11,40,710
2. Donations to School Health Programme	U.S.$	3,043	71,971
	D.M.	70	1,440
	S.Fr.	400	6,435
	Rs.	55,286	55,286
			1,35,132
3. Donations to School Health Programme	S.Fr.	9,500	1,91,652
	B.Fr.	100.000	84,397
	Rs.	7,650	7,650
			2,83,699
4. School Health Programme Endowment Fund	U.S.$	17.565	3,96,114
	S.Fr.	300	3,000
	D.M.	5.000	43,078
	Rs.	63,523	63,523
			5,05,715
5. School For Special Education Endowment Fund	U.S.$	2,100	48,712
	S.Fr.	1,000	18,231
	B.Fr.	51,000	42,840
	Rs.	3,000	3,000
			1,12,783

.....2

6. School Health Programme Building Fund	U.S.$	16,119	3,83,504
	S.Fr.	19,400	3,78,161
	D.M.	8,000	1,25,167
	Rs.	2,73,425	2,73,425
			11,60,257
7. Seva Ashram School Building Fund	U.S.$	80.000	21,86,280
8. Seva Ashram High School Building Fund	U.S.$	1.800	52,404
	D.M.	11.000	1,94,766
	Rs.	36,575	36,575
			2,83,745
9. Sponsors for St. Andal's Girls Home	U.S.$$	6,024	1,60,720
	Rs.	3,340	3,340
			1,64,060
10. Sponsors for Sadhananda Boys Home (Amount transferred to another Institution)	U.S.$	10.487	2,90,197
11. Contribution to Deena Seva Sangha	U.S.$	1.500	24,580
	Rs.	10.000	10,000
			34,580
12. Contribution to Children	U.S.$	145	3,019
	Rs.		1,693
			4,712

...3

DONORS TO DEENA SEVA SANGHA THROUGH MARIA.G.ZILIOLI

SEVA ASHRAM - 5TH MAIN, SRIRAMPURAM, BANGALORE -560021

FROM 1988 - JUNE 1993

GRAND TOTAL

U.S. $	1.38.783	36,17,501
Swiss Fr.	92.600	16,88,189
D.M.	24.070	3,64,451
Belgium Frs.	1.51.000	1,27,237
		57,97,378
Rupees	5,04,492	5,04,492
	Total	63,01,870

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DEENA SEVA SANGHA SCHOOL HEALTH PROGRAMME

1992 - 1993 A REPORT

THE DEENA SEVA SANGHA SCHOOL HEALTH PROGRAMME AIMS AT PROVIDING A COMPREHENSIVE HEALTH CARE FOR CHILDREN FROM LOWER SOCIO-ECONOMIC STRATA. THE OBJECTIVES OF THIS PROGRAMME ARE OUTLINED BELOW.

1. TO PROVIDE PRIMARY HEALTH CARE FOR CHILDREN
2. IDENTIFY AND TREAT ANY MENTAL HEALTH PROBLEMS IN CHILDREN
3. TO PROVIDE HEALTH EDUCATION TO CHILDREN
4. TO PROVIDE SPECIAL CARE FOR DISABLED CHILDREN
5. TO PROVIDE OPPORTUNITIES FOR DEVELOPMENT OF CREATIVITY IN CHILDREN
6. TO DEVELOP AS A MODEL SCHOOL HEALTH PROGRAMME AND A RESOURCE CENTRE

IT MAY BE NOTED THAT THE ABOVE OBJECTIVES HAVE EMERGED AS A NEED AND NOT IN COMPLIANCE WITH ANY SET PLAN FOR THE SCHOOL HEALTH PROGRAMME.

EXPANSION OF WORK IN ACCORDANCE WITH THE OBJECTIV OUTLINED

1. PROVIDE PRIMARY HEALTH CARE TO SCHOOL CHILDREN

a. REGULAR TREATMENT OF MINOR WOUNDS/AILMENTS DAILY IN FORM OF A SMALL OUTPATIENT DEPARTMENT

b. MEDICAL EXAMINATION OF ALL PRIMARY/MIDDLE SCHOOL CHILDREN ANNUALLY

c. A NUTRITION REHABILITATION PROGRAMME FOR 120 MALNOURISHED CHILDREN

d. ANNUAL IMMUNISATION AGAINST TETANUS

e. SCREENING THE CHILDREN FOR REFRACTIVE ERRORS AND OTHER OCULAR PROBLEMS

f. SCREENING, EARLY DETECTION/AND TREATMENT OF LEPROSY CASES

g. DEWORMING OF PRIMARY/MIDDLE SCHOOL CHILDREN TWICE A YEAR.

h. DENTAL CLINICS IN SCHOOL

2. HEALTH EDUCATION FOR CHILDREN

a. INTRODUCTION OF REGULAR HEALTH EDUCATION CLASSES

b. IMPLEMENTATION OF CHILD-TO-CHILD PROGRAMME

c. HEALTH EDUCATION TO TEACHERS

d. HEALTH EDUCATION TO COMMUNITY/PARENTS

3. TO IDENTIFY AND IMPROVE MENTAL HEALTH PROBLEMS IN CHILDREN

a. PSYCOLOGICAL ASSESMENT

b. COUNSELLING

c. STIMULATION PROGRAMME FOR 'SLOW LEARNERS'

d. TRAINING OF VOLUNTEERS IN SKILLS FOR COUNSELLING

4. TO PROVIDE SPECIAL CARE FOR THE DISABLED CHILDREN

a. MENTALLY RETARDED - SPECIAL SCHOOL

ORTHOPAEDICALLY HANDICAPPED (IN COLLABORATION WITH THE ASSOCIATION OF THE PHYSICALLY HANDICAPPED) PHYSIOTHERAPY/APPLIANCES/SURGERIES

VISUALLY IMPAIRED - ATTEMPT TO TRAIN THEM IN BRAILLE

5. TO PROVIDE OPPORTUNITIES FOR DEVELOPMENT OF CREATIVITY IN CHILDREN

a. HOLIDAY CAMPS - MAY '92 AND OCTOBER '93
b. OUTINGS FOR CHILDREN
c. PAINTING COMPETITION

6. TO DEVELOP AS A MODEL SCHOOL HEALTH PROGRAMME CENTRE

a. TRAINING PROGRAMME FOR HEALTH WORKERS/HEALTH VOLUNTEE
b. DEVELOP RELEVANT HEALTH EDUCATION MATERIAL AND STRATEGIES
c. SENSITIZE MEDICAL STUDENTS/HEALTH WORKERS TO THE SCHOOL HEALTH PROGRAMME POTENTIAL
d. CHILD-TO-CHILD PROGRAMME RESOURCE CENTRE FOR KARNATAKA
e. TRYING FOR GOVERNMENT RECOGNITION

SOME BASIC CONCEPTS

1. AIMING TO BUILD THE CHILDS ABILITY TO BE AND REMAIN HEALTHY IN THEIR SOCIO-ECONOMIC AND CULTURAL ENVIRONMENT.

2. HEALTH IS NOT JUST THE ABSENCE OF SICKNESS, BUT IS A REALISATION OF THE CHILD'S FULL POTENTIAL, THE ASPECTS OF WHI ARE PHYSICAL, MENTAL, SOCIO AND SPIRITUAL ASPECT.

3. THIS PROCESS HAS LITTLE TO DO WITH DOCTORS, DRUGS AND DISPENSARIES WHO PLAY THEIR PART WHEN HEALTH BREAKS DOW

4. THIS PROGRAMME HAS A LOT TO DO WITH EDUCATIONAL PROGRAMMES FOR HEALTH IN WHICH LIFE WORKERS, TEACHERS AND CHILDREN WILL PLAY A MAJOR PART.

5. OUTSIDE RESOURCES SHOULD BE DRAWN UP TO PROVIDE INFORMATION AND SKILLS FOR THIS PROCESS.

COMPONENTS OF THE PROGRAMME

1. <u>THE SCHOOL ENVIRONMENT</u> – PROVISION OF BASIC FACILITIES LIKE- SAFE DRINKING WATER, CLEAN, SIMPLE AND USABLE LATRINES.

2. <u>THE TEACHERS</u> – A COMMITMENT TO PREPARE CHILDREN FOR LIVING NOT ONLY TO SUBJECTS OR EXAMS.

   a. THEY MUST HAVE A BASIC UNDERSTANDING OF
   - HEALTH AND HEALTHY LIVING
   - COMMON MINOR ILLNESSES OF CHILDREN
   - NORMAL MENTAL, PHYSICAL, PSYCOLOGICAL AND SOCIAL DEVELOPMENT AND PROBLEMS ASSOCIATED WITH IT

   b. THEY MUST HAVE SKILLS IN IDENTIFYING PROBLEMS RELATED TO THE ABOVE.

   c. THEY MUST BE ABLE TO MANAGE SIMPLE PROBLEMS EITHER ON THEIR OWN OR REFER IT TO THE NECESSARY AGENCY.

3. <u>CHILDREN</u> – TO BE ANIMATED IN GROUPS BY TEACHERS TO DISCUSS/ UNDERSTAND HEALTH ISSUES USING METHODOLOGY GIVEN IN

   a. THE CHILD TO CHILD PROGRAMME (TALC)
   b. HELPING HEALTH WORKERS LEARN

   HEALTH ISSUES CAN ALSO BE UNDERSTOOD THROUGH GROUP ACTIVITIES LIKE NUTRITION GARDEN, MARKET SURVEYS, VISITS TO INSTITUTIONS, DISCUSSIONS WITH GUEST RESOURCE PEOPLE ETC.

4. MEDICAL SUPPORT -

a. REGULAR SCREENING PROGRAMMES TO IDENTIFY EARLY DISEASE DISABILITY PROBLEM THROUGH

i. REGULAR MEDICAL CHECK UP.

ii. SPECIALIST CAMPS: EYE, TB, ENT, DENTAL, SKIN AND LEPROSY ETC.

b. REGULAR IMMUNISATIONS: DT/TT/TABC ETC.

c. FOLLOW UP OF ILLNESSES/PROBLEMS DETECTED BY THE ABOVE METHOD

5. HEALTH EDUCATION -

REGULAR LARGE GROUP OR CLASSROOM LEVEL SESSIONS OF HEALTH EDUCATION ON RELEVANT THEMES IDENTIFIED BY ABOVE ACTIVITIES CAN BE INTRODUCED INTO SCHOOL CURRICULUM.

THESE COULD BE FILM SHOWS, EXHIBITIONS, TALKS AND DEMONSTRATIONS BY TRAINED PERSONNEL FROM OTHER AGENCIES.

6. COUNSELLING SERVICES -

FOR PSYCOLOGICAL AND SOCIAL PROBLEMS INVOLVING CHILDREN AND THEIR PARENTS.

CMH PROGRAMME

CLINICAL PSYCOLOGIST

STIMULATION (2) TEACHERS

CMH PROGRAMME

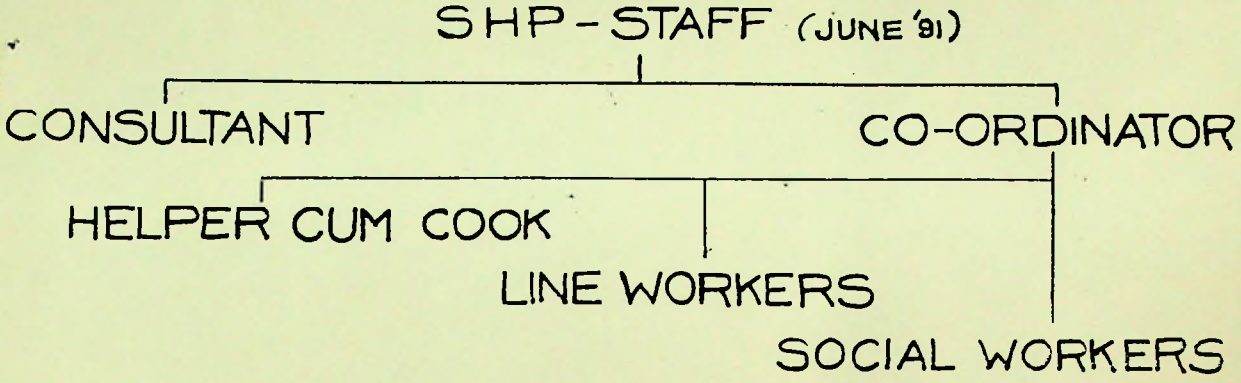
CLINICAL PSYCOLOGIST

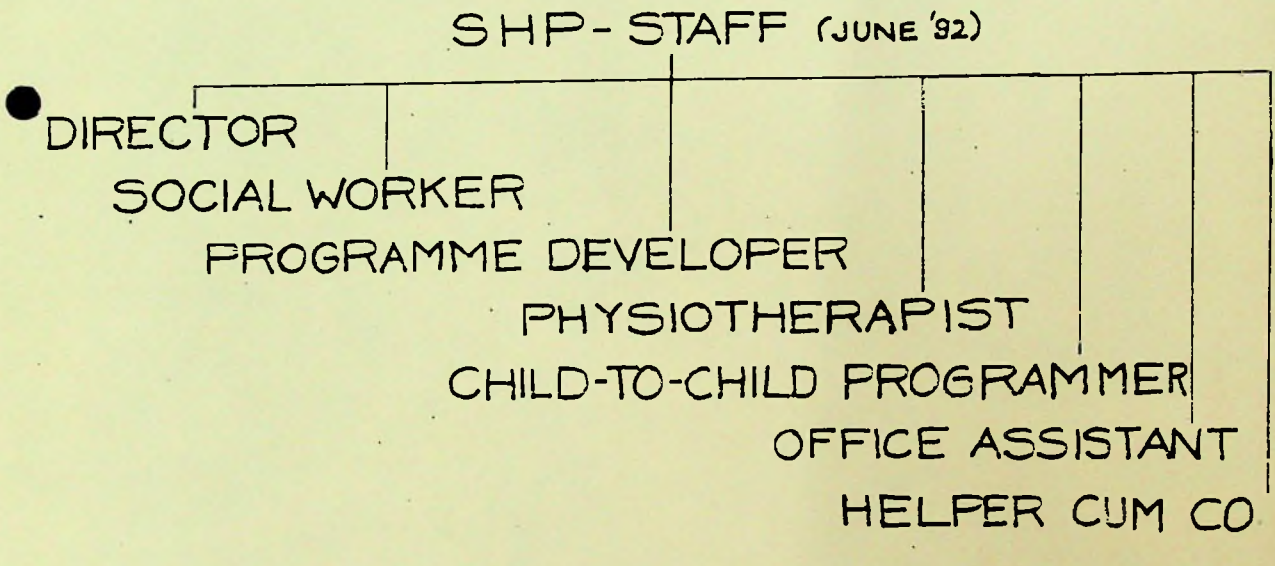
ASSISTANT PSYCOLOGIST

STIMULATION TEACHER

SCHOOL FOR SPECIAL EDUCATION

- HEADMISTRESS
- SPECIAL TEACHER
- ASSISTANT
- HELPER


SHP - STAFF (JUNE '91)
CONSULTANT
CO-ORDINATOR
HELPER CUM COOK
LINE WORKERS
SOCIAL WORKERS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Gesundheitsförderung Schweiz
Promotion Santé Suisse
Promozione Salute Svizzera

Health Promotion Switzerland: Model for Outcome Classification

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Guidelines for the classification of outcomes in Health Promotion and Prevention

Berne, July 2004

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1.0 Introduction

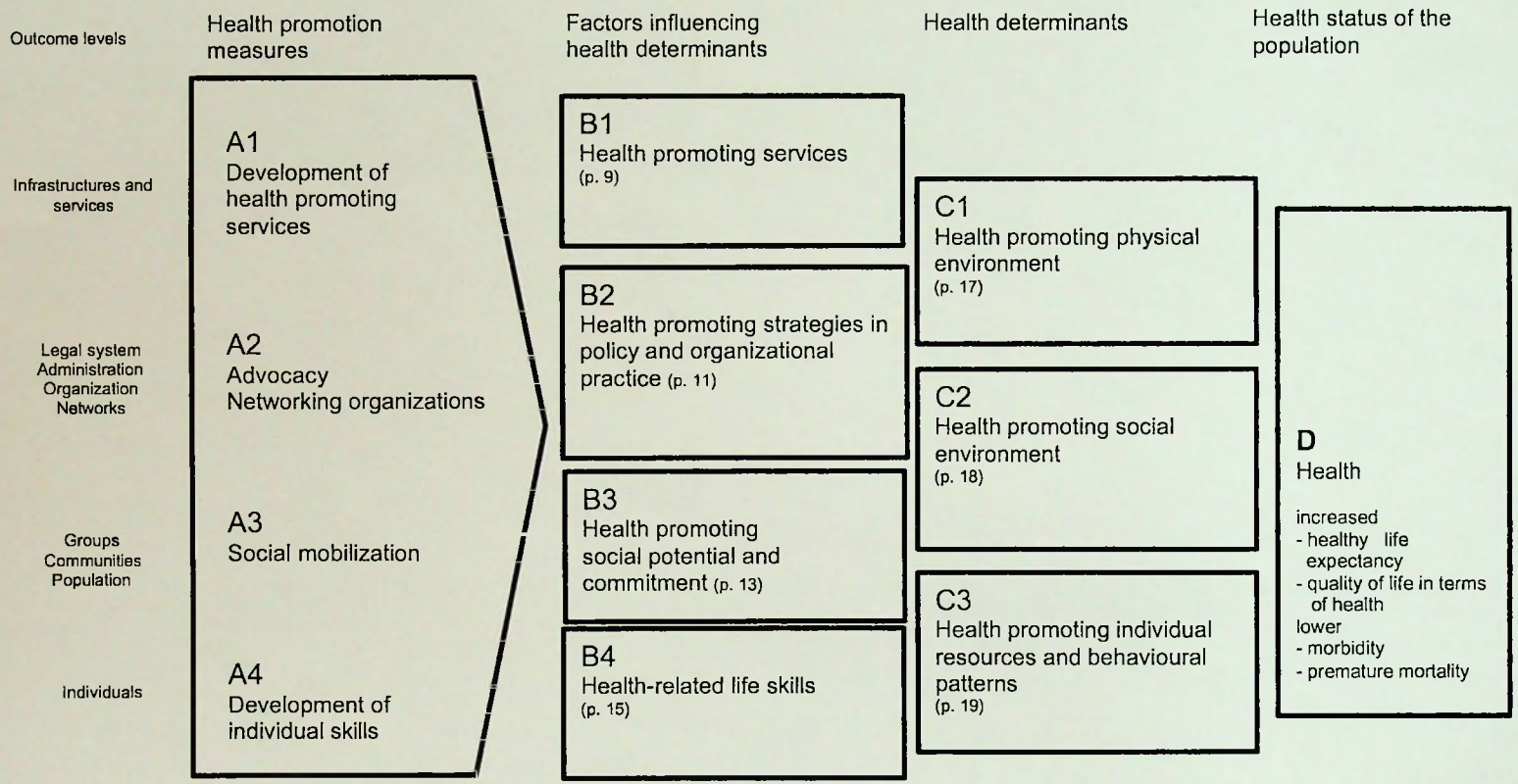
It is generally held that projects and measures of health promotion will influence a population's health in a positive way. The way this works is extremely complex and cannot be explained in terms of simple correlations between cause and effect. Some of the reasons put forward are the following:

- Generally, health promotion aims at improving the health of the population or of individual population groups. This is normally done by exerting a positive influence on health determinants and other relevant factors.
- It is rare to see immediate effects of health promotion projects, as they only become apparent after some time.
- A multitude of external influences makes it difficult to directly attribute health outcomes to implemented measures.
- As a result, it is generally not possible to provide direct epidemiological evidence of individual health promotion projects.

Nevertheless, in order to facilitate the systematic recording of project outcomes, a system of categories has been developed. It is called the ' Model for Outcome Classification in Health Promotion and Prevention' and has been developed on the basis of the well-known outcome model for health promotion by Don Nutbeam[1]. It is based on the basic assumption that health, as the ultimate goal of prevention and health promotion, cannot be achieved directly, but is attained through intermediate stages.

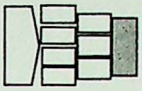
[1] Nutbeam, Don (2000): Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Promotion International 15, 259-267.

2.0 Overview of the model of outcome categories



3.0 The four columns of the model of outcome categories

Since health promotion always aims at the improvement of health, we begin by explaining the right side of the outcome model, i.e. by focussing on the improvement of health (Column D).



Improvement in the health of a population (Column D)

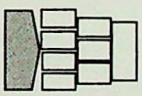
In terms of a bio psychosocial understanding of health, this is the place for recording the actually intended, ultimate goal of health promotion. Results such as an increased healthy life expectancy for the population or a lower rate of preventable (or premature) morbidity depend on many factors (behaviour and circumstances), which interact in a complex manner. Such outcomes can only be achieved over an extended period of time and can be supported by epidemiological evidence.

Changes in health determinants (Column C)

Changes in health determinants are recorded in this column. This is the field to register indicators that cover conditions that research has shown to affect public health directly or significantly, as the case may be. Results shown in this column must have a broad impact range. In most cases, they also have to show a long-term impact, i.e. they must remain stable over time. Outcomes on this level may, in general, be verified through epidemiological data.

Change in factors influencing health determinants (Column B)

This is the field into which direct results of health promotion strategies are entered. The categories and sub-categories offer room for indicators that have the potential to exert a positive impact on the health determinants.

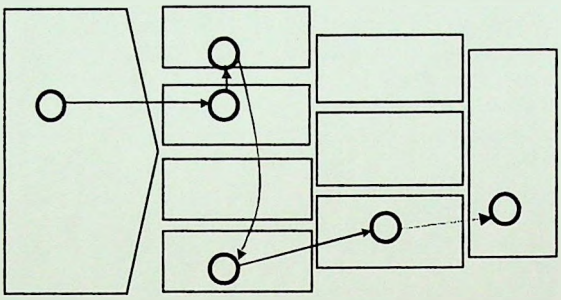


Measures for health promotion (Column A)

Measures constitute actions that are directed towards reaching the goals of the project, which thus render the project possible, and enable it to progress. It is not absolutely necessary to consider this column when documenting the goals and outcomes.

When assigning a place for the recording of planned, and actually obtained outcomes of health promotion projects (as well as for unintentional results) both column B and C are important. Each one of these columns is further divided into categories and sub-categories. Demonstrable improvements in the population's health are to be recorded in column D.

Simple associations of effects, for example A2 to B2 to C2 to D, may be the exceptions; more complicated associations are to be expected. For example, advocacy measures (A2) can lead directly to a binding engagement on the part of decision makers (B2), which may be followed by the creation of structures and services (B1). These, in turn, can strengthen the individual health-related life skills (B4), which, over time, can lead to enhanced individual health resources (C3). These enhanced health resources, in turn, demonstrably contribute to the improvement of health (D):



The model provides a system for the recording of both *planned* outcomes (project goals) and actually *achieved* results. It thus provides a basis for further reflection. It may point to concentrations or gaps, facilitates the estimation of effects and their association with each other, and is also an aid for the correct recording of relevant theoretical and empirical findings. Thus, the model serves, on the one hand, to guide programs and projects systematically, and, on the other hand, to justify the employed means to the public. A further benefit for individual projects consists in the fact that the model facilitates a comparison of their particular outcomes with other projects.

4.0 What is an outcome?

An outcome is a clearly detectable change of a determinant or a characteristic following a measure applied within a project. In the case of positive outcomes, it means the following:

- The presence of a desired characteristic which did not exist before
- The change of an existing characteristic in the desired manner
- The diminution or disappearance of a pre-existing unwanted characteristic

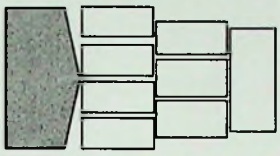
This may be with regard to determinants and characteristics relevant to the health of individuals, population groups or organizations; legal regulations, public opinions, physical or social, natural or man-made environments can be equally affected. As a rule, outcomes refer to the project's intended goals. Yet, outcomes, whether of positive or negative nature, can be unintended as well. The question of reaching the target group is of particular importance for the discussion of the outcome: it is important that the outcomes appear within the targeted groups or structures, and not at random (e.g. in persons who are easy to reach but for whom a change is not urgent). It is important to distinguish between outcome and measures. In this sense, we are not concerned with the intended or accomplished measures (interventions and activities), but with the intended and actually achieved results (outcome).

5.0 Application of the model

The model is applied in both the planning phase and the evaluation phase of a project. The following steps are guidelines for both phases:

- Even though the model focuses on the results, it allows for the main implemented measures to be placed in the measures categories A1-A4 (there are no sub-categories in this column).
- Each one of the health-relevant project outcomes (planned or achieved) is placed in one (and only one) of the sub-categories. The descriptions of the categories and sub-categories, as well as the examples, are intended as help for the correct assignment of outcomes.
- Column B is the starting point. It is here that any health promotion project must show outcomes. In most cases, if there are no outcomes in column B, no outcomes in column C are possible.
- After recording the essential outcomes in the appropriate spaces, the process of reflection begins. The following questions may be helpful:
  - In which of the categories and sub-categories are the outcomes accumulating? Do potential accumulations correspond to intended goals?
  - Which of the categories and sub-categories are lacking outcomes? Does this correspond with the planning?
  - How do different outcomes correlate (outcome models, associations of effects)? Are these associations theoretically or empirically based, or are they mere guesswork?

6.0 The measure categories



This is the level where the measures implemented by a project can be recorded. The distinction between measures and goals/outcomes is pivotal. In this sense, the 'training course of vocational skills teachers' is a measure, whereas an outcome could be formulated like this: '45 teachers successfully finished their training course '.
This model focuses on the outcome dimension. The option to differentiate or sub-divide the measure categories was therefore not taken. Users may find it helpful to assign the measures to the measure categories, but it is not absolutely necessary. The model, as it is used by Health Promotion Switzerland, allows for the systematic listing of project results but has dispensed with the listing of measures.

A1 Development of health-promoting services

→ The planning and implementation of infrastructure services and provision for health promotion and prevention belong to this category. These may be aimed at the population and/or professionals.

Examples
- Development of a range of counselling and advice services
- Implementation of programmes which promote physical activity
- Training of disseminators
- Creation of a user-friendly and publicly accessible data bank about health-related subjects, health-promotion projects and players

A2 Advocacy, cooperation of organizations

→ This deals with measures aimed at spreading and sustaining health promotion concerns in politics, administration and organizations.
→ Measures may include advocacy and lobbying, coordination and cooperation.

Examples
- Development of institutional/organizational networks
- 'Lobbying' and 'Advocacy'
- Creation of national/regional coordination centres or platforms

A3 Social mobilization

→ In contrast to A2, these measures do not address formal organizational units, but aim at the ultimate beneficiaries of health promotion, i.e. the public, or certain population groups.

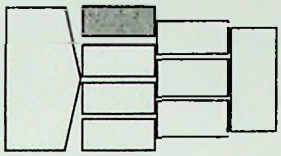
Examples
- Initiation of self-help groups
- Community work/work within a neighbourhood
- Participation procedures in communities
- The 'Slow-up Movement' is promoted to further nationwide coverage

A4 Development of individual skills

→ These measures address individuals directly. They include health-related information, education, advice, promotion and training, and they are aimed at the development of health-related personal life skills.

Examples
- Organizing programs which promote physical activity compatible with daily life
- Stress management programs
- Nutrition and exercise advice
- Public information event relating to 'Agenda 21'
- Information campaigns dealing with social influences on health

7.0 Outcome categories and sub-categories



7.1 Health-promoting services - B1

We understand the term 'provision' to mean the provision of services or products, which are developed, operated and/or distributed by health promotion and prevention practitioners.

- 'Provision of services' could mean: Information and advice centres, counselling services, platforms for exchange between professionals
- 'Products' could mean: leaflets, brochures and other printed material, internet platforms, video games, articles warning against harmful influences, tools for exercising health-favourable behaviour etc.

Projects often begin with the development of such provisions. Thus, the first result is often the creation of services and products. The outcome model, however, only accounts for results relating to effects and benefits (outcomes), and not to the mere availability of services and products (outputs).

Provisions can be directed at specific target groups in the population, at mediators (i.e. at persons who convey these services to population groups) and at health promotion professionals.

B1-1 Awareness of the service

→ Awareness of the service and its characteristics by all relevant target groups
→ To distinguish: the characteristics of the service will be recorded in this category, as compared with the characteristics of the person in B 4-1,.

Examples

- The potential users know the name and the appearance of the service
- They remember the type of service being provided
- They know when and how they can make use of the service
- Mediators (such as specialized centres, the mass media) know the service, and draw the attention of potential users to it
- Key players know about the service (e.g. local authorities or the media)

B1-2 Accessibility of the service and reaching of target groups

→ Temporal accessibility (opening times)
→ Local accessibility (distance from the service)
→ Attractiveness (appearance and image which is adapted to the target group psychologically, socially and culturally)
→ Affordability
→ Congruence between intended and actually reached target group

Examples

- The target group is able to handle the internet game without problems
- The opening times of the advice centre are convenient for the target group
- The internet platform appeals to the members of the network
- The campaign reached 85% of the intended target groups

B1-3 Use of the service and satisfaction with it

- → Number and profile of the service users
- → Frequency, length of time, and type of use of services
- → Satisfaction of the users refers here to a subjective, "intuitive" evaluation (as opposed to B1-2 and B1-3, which is more concerned with "objective facts."
- → This refers to both the global satisfaction with the service and specific elements
- → This, too, refers to the satisfaction with outcomes and effects of provided services, and not to the satisfaction with process indicators

Examples

- The persons making use of an information system are part of the defined target group
- The service is used to 85% of its capacity
- 20% increase in telephone information given by the advice and counselling service, as compared with the previous year
- High satisfaction with a course in a continuing education programme
- 95% of the clients are willing to recommend the service

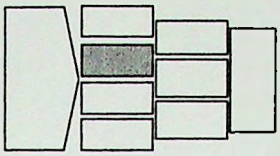
B1-4 Sustainability of the service

- → Secure and stable organizational basis
- → Networking with potential mediators and other providers in the area of activity
- → Take-over or continuation of the service or of its idea by other providers

Examples

- The exercise program is integrated into an existing organisation or institution
- The providers of the continuous education program are networking with others
- The service is designed for long-term use (e.g. financing is assured, local/temporal aspects etc.)
- The public recognizes the range of available services as meaningful and necessary
- Further specialized centres have taken over the concept of the service, and now offer it as well

7.2 Health-promoting public policy and organizational practice – B2



Policy in the present context includes strategies and efforts

- by the state sector (communities, cantons and federal government).
- by the public and private sector (institutions, organizations, federations and networks)

It intends to direct national or corporate structures. It includes at least targets and goals, measures, personnel and material resources, as well as regulations for the interaction between all concerned players. The main players of such a policy are not primarily experts in health promotion and prevention. The experts only motivate these main actors to strive for self-organization and activity, with the goal to achieve conditions favourable to health.

B2-1 Binding engagement of decision-makers and/or key persons

→ A key person has influence in certain areas and institutions and may act as spokesperson
→ Influence, power, and prestige may take effect politically, publicly or through private connections
→ Thus, influence can be exerted by public figures (from politics, economy, culture, sports, sciences)
→ Binding, i.e. public or written endorsements

Examples

- The management pledges publicly to become involved in the subject of health promotion
- A written consent exists concerning plans to develop a health promotion project for the company
- Parliament (federal, cantonal or communal level) has submitted a postulate to the government, demanding the drafting of a programme for the prevention of violence
- Several well-known personalities from different sectors of public life pledged publicly to support this cause
- Several organisations and institutions decided to create a network towards achieving certain common goals

B2-2 Action-relevant, binding documents

→ This refers to the drawing-up of documents such as basic principles, models, plans, concepts, laws, ordinances, regulations and similar proposals
→ These products are finalized, negotiated and agreed upon by decision-makers, and are ready to be implemented

Examples

- The management has implemented guidelines for company-specific health promotion
- The local council approved the plan proposing measures for the promotion of quality of life in the community
- The trade association agreed upon basic principles and procedures concerning the promotion of health within the affiliated companies
- The network of health-promoting hospitals opted for the creation of a coordination centre and made a decision as to the method of its funding
- A decision was made by the contracting parties in favour of the cantonal AIDS Prevention Program

B2-3 Successful organizational changes

→ Financial, material and personnel resources are invested in the HP project
→ Working conditions, working relationships or work procedures were changed

Examples

- A group concerned with health in the workplace started to operate in a institution or organisation
- The Commission for Health Promotion was granted a yearly credit of SFR 10,000 by the municipal council
- There are new, more flexible working time regulations making it easier to maintain the work-life balance
- There are new regulations facilitating the complaints procedure regarding mobbing in the work-place
- The ban on using building material harmful to health is being enforced
- Threshold values for the use of loud speaker systems are being upheld
- The person in charge of implementing the national HP initiative within the company has the necessary resources at his disposal

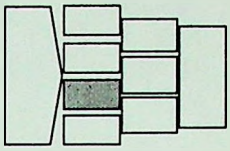
B2-4 Successful exchange and cooperation

→ This category refers to the existence of information exchange and cooperation in the context of health promotion concerns
→ An important aspect consists in the collaboration between sectors

Examples

- The transport authority now collaborates regularly with the health authority
- The cantonal delegate for health promotion is regularly invited to participate in consultations of other departments
- The inter-sectoral network for health promotion receives efficient support from its coordination centre
- The systematic, trans-sectoral information exchange operates in a satisfactory manner for all concerned

7.3 Health-promoting social potential and commitment – B3



Social potential refers to the ability of small or larger population groups to stand up for their concerns in a competent manner, or more generally, to find solutions for collective problems. These are the main points signalling 'empowerment'. The term 'commitment' refers to the motivational aspect of these abilities, namely the willingness to become active, and the confidence that this commitment to a common cause is worth the effort.
The development of these abilities through the use of interventions, in particular campaigns with the mass media, can be divided into the following levels: Knowing – Accepting – Supporting – Adopting –Participating. The first phases of this process are also termed "Sensitizing".
This category refers exclusively to population groups, and not to health promotion professionals!

B3-1 Existence of active groups focusing on health-promoting concerns or themes

→ This concerns interest groups or bottom-up citizen initiatives These groups are capable of functioning autonomously without external intervention
→ They are able to externalise activities

Examples
- A self-help group was set up
- The parent initiative for 'Safe Ways to School' holds its inaugural session
- The initiative decided to adopt an action program for the coming year
- The informal working group of the region's decision-makers meets regularly in order to exchange health-relevant social topics
- The neighbourhood group discusses health concerns repeatedly

B3-2 Enlisting of new players

→ This refers to participation in the sense of cooperation, co-development and co-management
→ As a result of the mobilization efforts, persons who were inactive until now, start to enlist in the project. On the one hand, these should be members of groups who used to be underprivileged/underrepresented in this sector (e.g. women, migrant women, marginalized people). On the other hand, this could be private commitment on behalf of public figures (e.g. a community leader, a well-known female athlete,...)

Examples
- Persons who were inactive until now, became involved in the concern
- The executive board includes two representatives each of three previously underprivileged groups
- Young people helped to review and redesign the program for an event

B3-3 Awareness of the concern by population groups

- → Here the concern includes ideas, statements of needs, propositions, requests, programs
- → This is about the external effects of the subject matter, in that as many as possible of those concerned know about it, discuss it and form an opinion about it
- → The concern may be propagated by official agencies (e.g. local authorities), private organizations (e.g. health groups) or grass-roots groups
- → To distinguish: This is about public awareness of a topic; the awareness of a service (provision of a service, product) is attributed to B1-1

Examples

- The topic of health promotion is repeatedly taken up and debated in the local newspaper and radio
- 45% of the residents know that the subject is presently discussed in public and that it is a very important topic
- During an event focusing on the subject of HP, all essential positions were expressed
- The topic is regularly discussed in the different daily newspapers

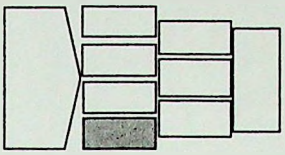
B3-4 Acceptance of a concern by population groups

- → This concerns the social norm, i.e. what is generally considered to be right
- → A health promotion concern should at least be recognized as being legitimate or as something 'to be taken seriously' by the majority of the population
- → Ideally, it should be seen as being a priority by a majority of the population
- → To distinguish: The concern is here the characteristic of a population group as compared to the characteristic of an individual as in B4-2.

Examples

- 80% of the residents think the topic is at least quite important
- The essential opinion leaders/the most important peers among the students stress the concern repeatedly and publicly
- The number of active requests from the population for information about the topic (submitted to the initiators or other competent bodies/organizations) has markedly increased

7.4 Individual health-related life skills – B4



By health-related life skills we understand knowledge, attitudes, beliefs or values, as well as skills that are significant for one's own health. Included are skills dealing with oneself as a bio-psychosocial being, and skills dealing with one's social and physical environment. That means that an individual would act in a health promoting way if he/she had the motivation and the ability to do so.

B4-1 Factual health-relevant knowledge and capacity to act on knowledge

- → On the one hand, this refers to concrete knowledge of facts, topics and contents that improve the individual's capacity to act
- → On the other hand, it is also about knowledge of procedures, methods and strategies
- → To distinguish: Here it is the characteristic of the person as compared to the characteristic of the service in B1-1

Examples
- Students know where to get specialized advice and counselling
- Employees know the nutrition slogan of "5 a day"
- City residents know which of the social factors in their neighbourhood have an impact on their health
- Parents and teachers know that the "Children's Health" initiative was started in their city

B4-2 Positive attitudes towards a health-relevant topic

- → In order to act on knowledge, the gained information has to be judged positively and appear sufficiently worthwhile and useful
- → The same goes for conduct to be avoided; there needs to be a positive attitude towards alternatives
- → To distinguish: Here it is the characteristic of the person as compared to the characteristic of a population group in B3-4

Examples
- Young men assess the messages about nutrition aimed at them as being positive
- Women recognize the benefit of regular preventive medical check-ups
- Party-goers accept the fact that saying No to unknown party drugs is beneficial to their health
- Men (e.g. from migrant populations) have a positive attitude towards the use of condoms
- 40% of the adult population feel that the procedures of 'Agenda 21' are important for their health

B4-3 New personal and/or social skills

- → Personal skills refer to the performing of actions which one can do by oneself alone and for oneself (e.g. to make a difficult decision or to clarify one's feelings)
- → Social skills refer to interactions or communications with other persons, thus they require a counterpart (individual or group)
- → See also "life skills"
- → To distinguish: collective changes in B2-4

Examples
- The apprentices are able to apply a problem-solving model to a topic relevant to themselves
- The course participants decline invitations to join others in drinking alcohol, when they intend to drive a car
- In conflict situations, the course participants are able to take steps to avoid escalation
- With support, the course participants are able to follow the steps of the stop-smoking program

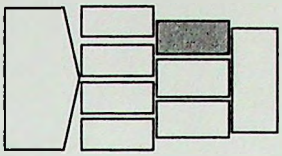
B4-4 Strengthened self-confidence regarding a health-relevant topic or an activity

→ This concerns the trust in one's ability to effect change with a positive outcome, i.e. the trust that a certain action in my specific case will indeed be effective and that I will also be able to accomplish it in my every day life
→ In general, it is the feeling of having enough knowledge for informed decision-making, and to be really able to assess the pros and cons for oneself
→ To distinguish: In contrast to B3-4, this refers to the self-confidence of the individual

Examples

- Visitors to the open-air swimming pool feel reassured that the skin protection measures taken against sun radiation are effective
- The course participants of the stop-smoking program are convinced that the program is effective, and feel confident that they can carry it through
- Young women trust themselves to be able to decline unprotected sex during a future encounter
- Each target person is convinced that the recommended action will indeed result in the desired positive effect for him/herself

7.5 Health-promoting physical environment - C1



By material environment we understand

- the natural physical environment as well as
- the man-made and altered environment

C1-1 Reduction of pollution caused by physical-chemical influences

→ The production or the discharge is reduced at source or the target group will benefit from effective protective measures
→ The issues here are actual radiation such as electromagnetic waves, sound and noise but also other harmful substances such as ozone and fine dust particles in the air, nitrate in the water, additives or residues in foodstuffs

Examples

- People living on a main thoroughfare are less exposed to noise due to speed limits, noise-proof windows, protective walls and a tunnel
- Noise exposure inflicted on club-goers was reduced
- The threshold values for mobile phone antennae were not exceeded

C1-2 Conservation and improvement of natural resources

→ Here natural resources refer to basic life sustaining resources such as water, air, forest, sufficient living space, recreational areas close to residential areas
→ To distinguish: This refers to outcomes in the holistic ecological sense, in contrast to C1-1, where the central factor is the reduction of the individual exposure

Examples

- The grassland area within the urban agglomeration was preserved and did not fall victim to a planned building project
- The water quality of a lake used by swimmers has improved
- A forest close to the city was officially declared a recreational area and was cleaned up by the local school children, thus becoming a place for rest and recreation

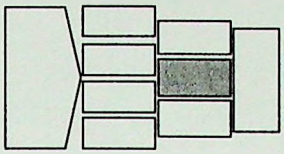
C1-3 Health-promoting installations and products

→ This refers to services, installations and products which sustain health and well-being
→ They go beyond purely preventive effects and offer health-favourable possibilities for recreation, relaxation, life-balance, activities or challenge
→ It is established that they promote more health-favourable choices
→ Generally, the service and product providers are not experts in the field of health promotion and prevention (in contrast to B1)
→ To distinguish: This refers to man-made material resources in contrast to C1-2, which deals with 'naturally present' resources (nature).

Examples

- An interconnected network of safe bike paths prompting bike traffic away from the road
- Playgrounds and sports fields in a neighbourhood are aimed at different target groups, which results in additional use
- Sports- and exercise-friendly measures and installations in a company (e.g. showers for joggers or bicycle riders) are taken up

7.6 Health-promoting social environment – C2



By the term social environment, we understand widely available social support services, and the climate in which social interactions take place (social climate). In other words, the whole social structure (community, company) is involved and not just some selected and isolated features.

C2-1 Social support, social networks, social integration

- → Improvement of social support in the target groups
- → Events, services and installations are available throughout the social structure. They
  - promote contact, encounters and exchange with other people, and encourage mutual help,
  - facilitate the utilization of professional support and assistance and/or
  - promote the integration of marginalized population groups
- → In contrast to B1, these services are offered by non-professional health promoters

Examples
- The support of socially disadvantaged people in the community has improved
- Community centres in neighbourhoods are being used by different population groups
- The residents of an area are being socially supported and are aware of the support

C2-2 Social climate

- → The social climate is the expression of the dominant mood in a social structure (a company or a community,...)
- → Changes in the social climate of a company or community can manifest themselves in several ways: the nature of the interaction between partners at different levels in a hierarchy (supervisors - co-workers, politicians – citizens), in the degree of trust, and the identification with the community or company (feeling of togetherness, see also "Social Capital")
- → To distinguish: This refers to collective changes of a social structure. Similar changes in knowledge, attitude and conduct of individual persons or small groups are assigned to B4

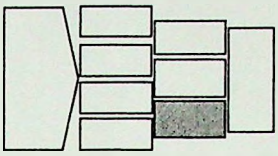
Examples
- A positive psychosocial culture is increasingly prevalent in Swiss companies. This promotes well-being in the work place and lowers the stress level
- The residents of the city feel generally safe
- There are visible manifestations of solidarity
- Community life is marked by mutual esteem and acceptance

C2-3 Equal opportunity for good health

- → Equal opportunity for good health means having equal access to health-promoting resources in terms of social health determinants
- → In this context, it could mean access to work, education, income, status, appreciation,...

Examples
- Differences in income and education are less marked
- Unemployment in the target groups is declining
- Access for migrants to educational services is improved

7.7 Health-promoting individual resources and behavioural patterns – C3



Individual resources here mean internal psychological strengths and abilities. The term behaviour 'pattern' suggests that particular modes of behaviour are interconnected with each other and must always be considered in context.

C3-1 Dealing appropriately with risks

- → Reduction and/or cessation of a harmful risk behaviour
- → Reinforcement of behaviour modes, orientations, attitudes and feelings which promote prevention
- → Increased personal protection against risks

Examples
- The proportion of smokers has decreased
- The population opts for better protection against direct sun radiation
- More drivers tend to slow down in a residential area
- More bicycle riders wear helmets

C3-2 Coping with the demands of daily life

- → Appropriate strategies when dealing with strain and stress. These might occur in connection with material problems or other persons
- → Rules applied in conflict situations, the willingness to make compromises and to find common solutions as well as the appropriate kind of cooperation - particularly in cases of conflicting interests and differences in power within the hierarchy (e.g. between superiors – co-workers, or politicians – citizens)

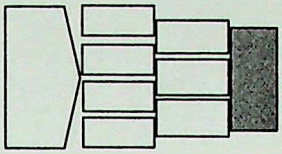
Examples
- Stress-coping strategies are increasingly applied in daily life
- Increasingly, students resolve their conflicts in school without resorting to violence
- The elderly can continue (without discomfort) to climb stairs, visit friends,...
- Parents are physically able to play and romp with their children, and go on bicycle tours,...

C3-3 Improvement of health-relevant behaviour and behavioural patterns

- → Healthy modes of behaviour such as exercise, relaxation, appropriate nutrition, ability for social contact
- → Positive attitudes towards life such as optimism, ability to experience pleasure, zest for life, sense of coherence

Examples
- More and more young men opt for health-conscious nutrition
- Elderly people in Switzerland exercise more in their daily lives
- It can be demonstrated that high school students in Switzerland smoke less

8.0 Health



Ultimately, health promotion and prevention always aim at improving the health of the population or individual population groups. According to the definition of health by the WHO, it refers to a sustained improvement of the mental, physical and social well-being. Today's state of knowledge of the health sciences supports such an understanding of health as well.
Here, indicators to be measured are, on the one hand, a higher healthy life expectancy of the population, or a greater number of years without illnesses and disabilities, as well as indicators of the higher health-related quality of life. On the other hand, these are indicators of a decreasing rate of preventable (or premature) morbidity as well as premature mortality.

In this sense, it is rarely possible to directly attribute measurable, lasting changes in the health of the population to individual health-promoting projects. Such changes are rather the result of a great number of health-impacting factors, i.e. factors stemming from both the sector of individual behaviour and the (living, learning and working...) conditions. Thanks to numerous studies, we know today which of these factors are proven to have a negative or positive impact on the health of the population. These are the so-called health determinants. Changes of these determinants as outcomes of health-promoting interventions are recorded in column C. At the same time, it should be noted that positive outcomes reached in the area of one or several health determinants can be 'neutralized' by simultaneous, negative impact of other interventions and sectors on these or other health determinants.

Example

- The healthy life expectancy of the Swiss population has risen
- The proportion of 75 year old persons without chronic illness or disability has risen
- Older people show a consistently good level of fitness
- The proportion of 40 to 50 year old people with back problems interfering with their everyday lives, decreased significantly
- The suicide rate of young people is declining

9.0 Empowerment and participation in the model of outcome categories

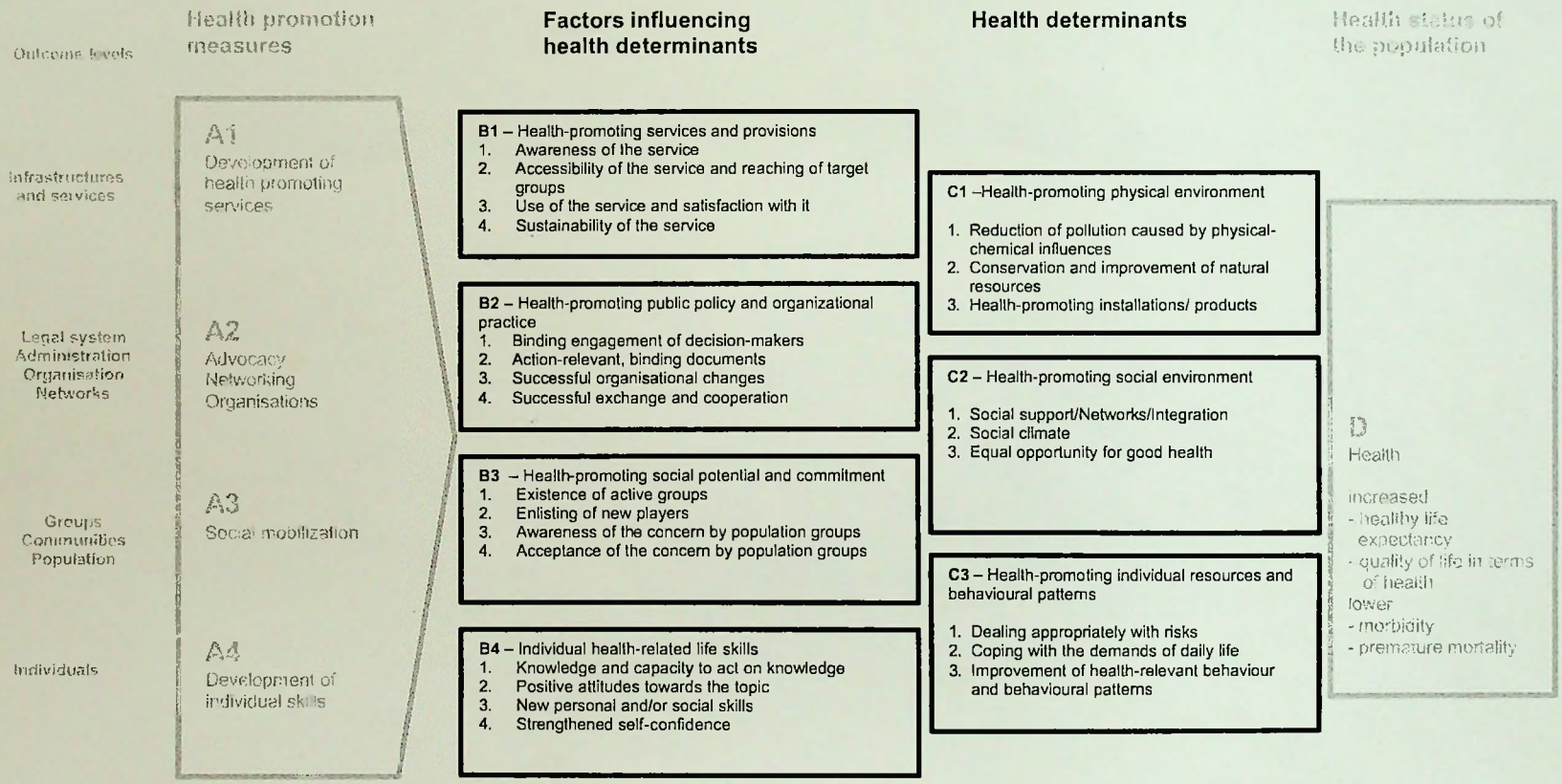
As so far described, the basic principles of empowerment and participation have not appeared in the outcome model. The reason for this is that these terms cannot be assigned unambiguously to one outcome category of the model. This will be explained as follows:

Empowerment
Empowerment designates not only the outcome of an intervention, but, in the first place, an approach to intervention, or even more generally, an attitude present at the time of intervention[2]. On the one hand, empowerment should be recorded in the same space as the measures, but it will also appear in some of the outcome categories, which refer to the population (in particular in B3 and B4).

Participation
It is very similar in the case of participation. This has become an important element or sign of quality of health promotion measures. Beyond that, it may then also become an outcome in the sense that willingness and ability to participate in social activities and to exert influence becomes manifest or has been reinforced (e.g.B4).

[2] See: Stark, W (2003) Empowerment. In Bundeszentrale für gesundheitliche Aufklärung (Hrsg.) Leitbegriffe der Gesundheitsförderung. Schwabenheim a.d.Selz: Fachverlag Peter Sabo, 28-31.

10.0 Annexe: Concise overview of the outcome columns B and C



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Networking Session August 9, 17.30 Room D

NGO Ad Hoc Advisory Group on Health Promotion

Session Outcome: Agree on the way forward, including the mechanisms and processes to achieve effective outreach and partnership involving health promotion

AGENDA

1. Introduction of NGO Ad-Hoc Advisory Group on Health Promotion

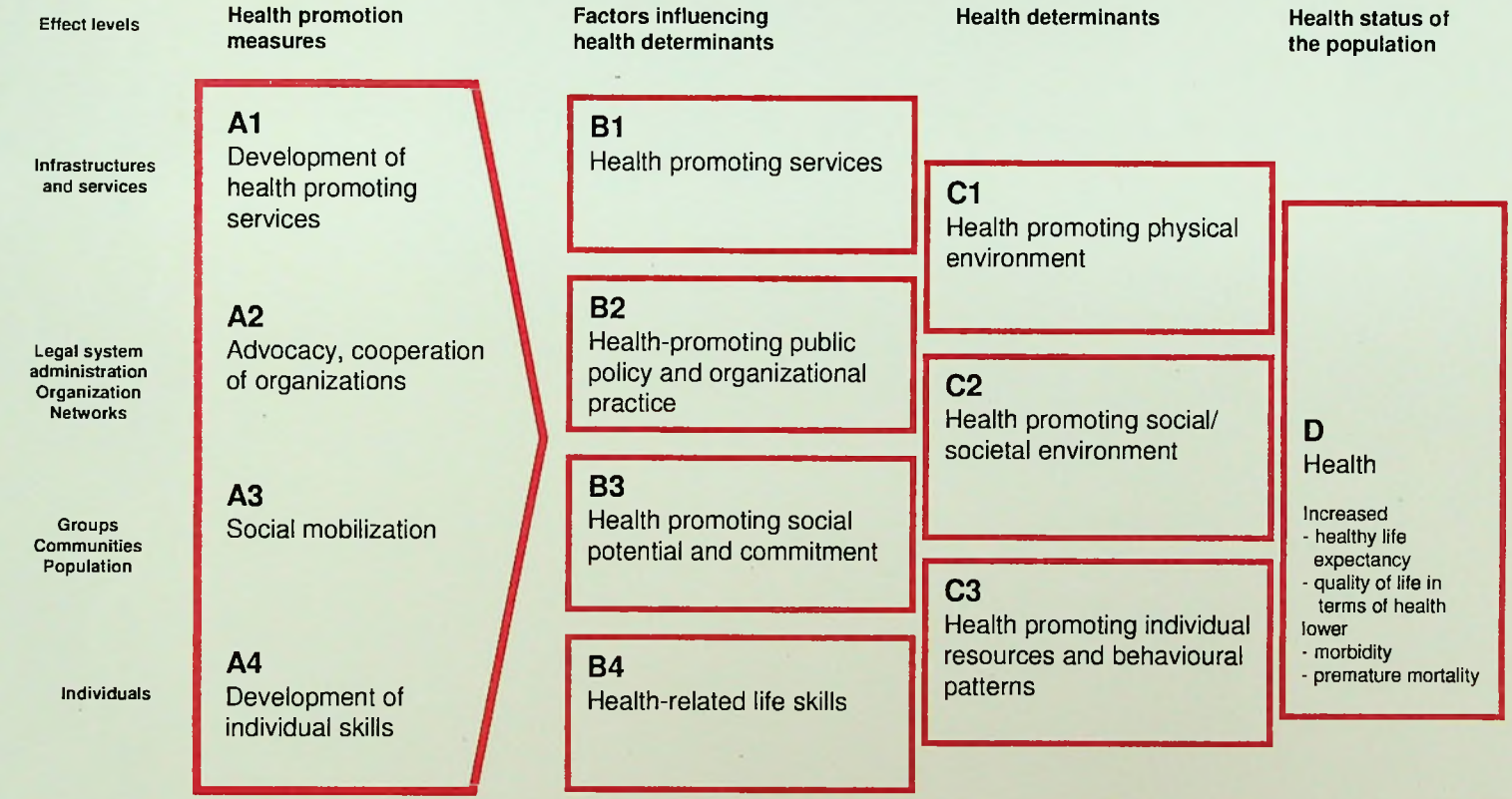
2. Outreach to the Regions, Countries, Community Grassroots
   - Examples from Advisory Group members

3. The Way Ahead Partnerships for the future
   - Identify issues which impact on health and on which we can work in partnership (Expanding and Consolidating our Network)

4. Conclusions and Recommendations

Overview of the model for results classification

Gesundheitsförderung Schweiz
Promotion Santé Suisse
Promozione Salute Svizzera



Authors: Cloetta, Bernhard; Spencer, Brenda; Ackermann, Günter; Broesskamp-Stone, Ursel; Ruckstuhl, Brigitte; Spörri-Fahrni, Adrian

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NEWSLETTER
Volume 1 August 9, 2005

THE 6TH GLOBAL CONFERENCE ON HEALTH PROMOTION

NEWSLETTER ONE

Welcome to the first edition of the Newsletter at the 6th Global Conference on Health Promotion. I'm sure you will support our idea of giving an opportunity to some of our 'New Generation' young people present with us in Bangkok to provide an early snapshot of what is happening both in and around the conference. Their short articles are not meant to be 'definitive, strategic imperatives!', but rather their *personal* reports on some of highly successful, challenging work that is being achieved in Health Promotion and reported at the conference. They will be trying to capture some of the commitment, energy, passion and delivery that are at the top of all our agendas. Please enjoy their reports in the spirit in which they are written. We will have more tomorrow.

Mike Shaw

GENDER AND HEALTH PROMOTION: A MULTISECTORAL APPROACH

Gender biases in health promotion may impact on the effectiveness of health promotion projects for women. Such biases have been successfully addressed in several countries. To overcome health promotion messages being targeted at women as the primary caregiver, which may lead to lower than expected health promotion outcomes, immunisation education in Ghana has targeted both men and women. As a result men have taken greater responsibility for children's health. Vaccination rates have increased, as has earlier vaccination of children. In Pakistan, the Women's Health Project has addressed the lack of female health care personnel, which may act as a significant barrier to women's health. In four provinces, thousands of village women have been recruited and trained as 'Lady Health Workers', expanding the availability of workers who may understand the specific problems of women and may provide greater access and acceptability for women.

Dale Bampto

HEALTH OF THE MARGINALIZED

Marginalization is a term used to cover a broad range of peoples such as the displaced, disabled and indigenous peoples. The key themes that overlap each of the marginalized people are the poor health status of these groups.

One effective health promotion intervention to assist the marginalized occurred for the indigenous people of New Zealand, the Maori people. In response to the concerns for the well being of marginalized Maori women and their babies, the Women's Health League established *Tipu Ora*.

The activities of the program include family support and advocacy and building relationships with health professionals. The philosophy for *Tipu Or*a is for "Maori to be healthy as Maori". Many Maori health models and principles including self-determination, Maori cultural affirmations, interconnected-ness, extended family relationships and empowerment.

This program has led to significant health gains and has improved Maori health outcomes. The health of a city is the sum total of all citizens, including marginalized groups.

Braden Leonard

BACK TO THE FUTURE

A previous understanding in development countries (e g Malaysia, Indonesia) was that "If I don't do development my child will die at the age of three, but if I do development people will die from cancer at the age of 30." This mentality is however changing towards a more positive understanding that there is reason for taking human health into consideration. "Good governance" is complex but important, not least at the local level. There is need to develop a conscious leadership that influence governance and decision making. The key issues are to learn from the past, everything goes back to the eco system, be creative, and change takes time but timing is even more important.

Asa Pettersson

EMERGING HEALTH ISSUES

This informative presentation on the widening spectrum of tasks which health promotion faces in today's world since the Ottawa Charter tried to make clear what emerging health risks and trends would soon be at the forefront, an especially crucial topic in a world where the "the spectrum and scale of influences on population health is widening."

This was primarily done by showing the important interplay of personal initiatives, healthy environments and support systems, a synergy of which is required for a sustainable global society in an era of globalisation. The problems of SARS and the Avian bird-flu were addressed, the question being how health promotion can help to counter-act these pandemics.

Several solutions were proposed: the creation of Development preparedness plans and a institutional infrastructure to deal with these issues, collaboration with the media to prevent the spread of panic in emergency situations, an emphasis on developing an inter-sectoral collaborative approach with synergistic arrangements, and finally, raising this awareness through the Bangkok Charter by handing it to Kofi Annan at the approaching Millennium summit.

Kirk W. Duthler

HEALTH IN NEW URBAN SETTINGS

Mr Dinesh Mehta proposed his idea for a "Healthy Slums" program. He established in his presentation that health standards in urban slum areas are vastly inferior to standards in poor rural areas despite the availability of better health facilities. Yet, people living in the urban slums are not necessarily poor. Quite contrary to that, they sometimes have incomes twice the level of the poverty line, but even with more money, they are unable to afford an appropriate level of health care and are therefore relegated to living in slums. The proposed program would stress the importance of targeting the slums with a well-focused education campaign in areas such as prevention, diagnosis, and treatment and to strengthen capacity of local government and stakeholders. Mr Mehta also highlighted the idea of sustainable finances for health promotion as many past programs he had worked in are now non-existent due to inadequate funding.

Napatr Thanesnant

DRAFT BANGKOK CHARTER

Process for Receiving feedback.

1. Feedback to be channeled through discussion groups and summarized by chair and rapporteurs.

2. All suggested additions to be balanced by suggested deletions.

3. Feedback to be received by secretariat at wolbangk@who.int by 19.30 Monday and Tuesday.

4. Finalisation group to meet Monday, Tuesday and Wednesday evening at 18.30 at Prince Palace Hotel.

5. Next version available early morning Wednesday. Comments on this version to be provided electronically (as above) or placed in boxes at reception at Prince Palace Hotel or Royal Princess Hotel by 19.30.

6. "Final" version to be available early Thursday morning.

7. Final version to be read to Plenary Thursday 14.00.

****

Your chance to witness tangible evidences of "Healthy Thailand"

Gain insight into Thailand's healthy initiatives and enjoy Thai hospitality.

Join one of the inspiring study tours in Bangkok and selected provinces specially arranged for all delegates of the 6th Global Conference on Health Promotion. Come and visit our health-promoting school, healthy community, healthy marketplace, healthy day care center, Thai traditional medicine, and comprehensive health promotion/ treatment/ rehabilitation program.

Depart from UNCC on Thursday, 10 August 2005 at 13.00 hrs.
Please REGISTER NOW! at field trip counter on Ground floor for more information.

HEALTH PROMOTION FOUNDATION ACT,

B.E. 2544 (2001)

ThaiHealth
Thai Health Promotion Foundation

(Tentative Translation)

HEALTH PROMOTION FOUNDATION ACT, B.E. 2544 (2001)

BHUMIBOL ADULYADEJ, REX.
Given on the 27th Day of October, B.E. 2544
Being the 56th Year of the Present Reign;

His Majesty King Bhumibol Adulyadej is graciously pleased to proclaim that:

Whereas it is expedient to have a law on the Health Promotion Foundation;

Whereas it is aware that this Act contains certain provisions in relation to the restriction of rights and liberties of persons, in respect of which section 29 in conjunction with section 31 and section 48 of the Constitution of the Kingdom of Thailand so permit by virtue of the provisions of the law;

Be it, therefore, enacted by the King, with the advice and consent of the National Assembly, as follows:

Section 1. This Act is called the "Health Promotion Foundation Act, B.E. 2544 (2001)".

Section 2. This Act shall come into force as from the day following the date of its publication in the Government Gazette.

Section 3. In this Act:

"alcoholic beverages" means alcoholic beverages under the law on alcoholic beverages;

"tobacco" means tobacco under the law on tobacco;

"tax" means taxes under the law on alcoholic beverages and tobacco stamp duties under the law on tobacco;

"health promotion" means any act which is aimed at the fostering of a person's physical, mental and social conditions by means of supporting personal behaviours, social conditions and environments conducive to physical strength, a firm mental condition, a long life and a good quality of life;

"Foundation" means the Health Promotion Foundation;

"Committee" means the Committee of the Health Promotion Foundation;

"Performance Appraisal Committee" means the Performance Appraisal Committee for the Foundation's performance;

"Manager" means the General Manager of the Health Promotion Foundation;

"Ministers" means the Ministers having charge and control of the execution of this Act.

Section 4. The Prime Minister, Minister of Finance, and Minister of Public Health shall have charge and control of the execution of this Act.

CHAPTER I
Establishment of the Foundation

Section 5. There shall be established a Foundation called the "Health Promotion Foundation".

The Foundation shall be a juristic person having the following objectives:

(1) to promote and encourage health promotion in the population of all ages in accordance with the national health policy;

"tobacco" means tobacco under the law on tobacco;

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CHAPTER I
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The Foundation shall be a juristic person having the following objectives:

(1) to promote and encourage health promotion in the population of all ages in accordance with the national health policy;

(2) to create awareness of hazardous behaviour from the consumption of alcoholic beverages, tobacco or other health-deteriorating substances and to create belief in health promotion amongst people of all classes;

(3) to support campaigns for the reduction in the consumption of alcoholic beverages, tobacco and other health-deteriorating substances, and create public awareness of the relevant legal provisions;

(4) to conduct studies and research, or encourage the conduct of the study and research, training or organisation of meetings with regard to health promotion;

(5) to develop the ability of a community in fostering health promotion by the community or private organisations, public-benefit organisations, Government Agencies, State enterprises or other State Agencies;

(6) to support campaigns for health promotion by various activities as a means by which members of the public can improve their health, spend spare time fruitfully and reduce their consumption of alcoholic beverages, tobacco and other health-deteriorating substances.

Section 6. The Foundation shall consist of the following money and property:

(1) Foundation levy collected under section 11;

(2) money and property received and transferred under section 43;

(3) Government subsidy;

(4) subsidies from the private sector or other organisations, including foreign sources or international organisations and money and property donated to it;

(5) fees, maintenance charges, remuneration, service charges or incomes from its operation;

(6) fruits of the money or income accruing from the properties of the Foundation.

Section 7. The activities of the Foundation are not subject to the law on labour protection, law on labour relations, law on State enterprise labour relations, law on social insurance and law on monetary compensation, but the Manager, officials and employees of the foundation shall receive remuneration of not less than that prescribed by the law on labour protection, law on social insurance and law on monetary compensation.

Section 8. The Foundation shall have its principal office in Bangkok Metropolis or in a province prescribed by the Minister by a publication in the Government Gazette.

Section 9. The Foundation shall have the power to carry out various activities within the boundaries of its objectives under section 5 and such powers shall include:

(1) to have ownership, possessory rights and real rights;

(2) to create any rights or enter into any juristic acts or both within and outside the Kingdom;

(3) to seek benefits from properties of the Foundation;

(4) to disseminate and publicise information in order to campaign and raise public awareness of the dangers from the consumption of alcoholic beverages, tobacco or other health-deteriorating substance and of health promotion to the extent of disseminating and providing information on the relevant laws;

(5) to do any other act necessary for or in furtherance of the attainment of the objectives of the Foundation.

Section 10. The Foundation has the status of a State Agency, which is not a Government Agency or State enterprise under the law on budgetary procedure, and the incomes of the Foundation are not to be remitted as national revenues.

Section 11. The Foundation shall have the power to arrange for the collection of Foundation levy from persons under the duty to pay taxes under the law on alcoholic beverages and the law on tobacco at a rate of two percent of the tax collected from alcoholic beverages and tobacco under the law on alcoholic beverages and the law on tobacco.

In calculating the Foundation levy at the rate prescribed in paragraph one, any fraction of one satang shall be disregarded.

Section 12. For the benefit of collecting and remitting Foundation levy:

(1) the Excise Department and Customs Department shall be the bodies carrying out the invoicing of Foundation levy for remission as revenues of the Foundation without having to remit to the Ministry of Finance as national revenues, and this shall be in accordance with the regulations prescribed by the Finance Minister;

(2) the Foundation levy shall be deemed to be a tax, but shall not be included in the calculation as a value of tax.

Section 13. Persons under a duty to pay taxes under the law on alcoholic beverages and law on tobacco shall have the duty to remit Foundation levy at the rate prescribed under section 11 together with the payment of taxes in accordance with the regulations prescribed by the Finance Minister.

Section 14. In the case where a person under the duty to pay taxes under the law on alcoholic beverages and the law on tobacco has received an exemption or a tax refund, there shall also be an exemption from or refund of the Foundation levy in accordance with the regulations prescribed by the Finance Minister.

Section 15. In the case where a person under the duty to remit Foundation levy fails to remit the Foundation levy or remits after

the prescribed time period, or remits the Foundation levy at an amount insufficient of that required, not only will there be an offence under this Act, but there shall also be an additional payment at the rate of two percent per month on the amount of money unremitted or remitted after the prescribed time period or the amount that remains to be remitted, as the case may be, calculated from the date due for remission to the date of remission of the Foundation levy, but the additional money calculated shall not exceed the amount of the Foundation levy and this additional sum of money shall also be deemed to be a Foundation levy.

In calculating the time period under paragraph one, a fraction of one month shall be counted as if it were one month.

Section 16. The Foundation shall have the power to expend money from the Foundation in accordance with the rules and procedures prescribed by the Committee as the following expenditures:

(1) expenditures in the operation of the Foundation;

(2) expenditures in the conduct of activities under section 5 and section 9;

(3) other expenditures in accordance with the rules prescribed by the Committee.

CHAPTER II
Management of the Foundation's Affairs

Section 17. There shall be a Committee called the "Committee of the Health Promotion Foundation," consisting of:

(1) the Prime Minister as Chairman;

(2) the Public Health Minister as the First Vice-Chairman;

(3) a qualified person appointed by the Council of Ministers from persons with qualifications under (5) as the Second Vice-Chairman;

(4) members *ex officio*, viz, a representative of the Office of the National Economic and Social Development Board, representative of the Office of the Permanent Secretary to the Prime Minister's Office, representative of the Ministry of Finance, representative of the Ministry of Transport and Communication, representative of the Ministry of the Interior, representative of the Ministry of Labour and Social Welfare, representative of the Ministry of Education, representative of the Ministry of Public Health and representative of the Ministry of University Affairs;

(5) eight qualified members appointed by the Council of Ministers from persons selected from those with knowledge, ability and experiences in the fields of health promotion, community development, mass communication, education, sports, art and culture, law or administration, provided that of this number, at least half of whom from persons in the private sector.

The Manager shall be a member and secretary, and the Manager shall appoint an official of the Foundation as assistant secretary.

The selection of qualified members shall be in accordance with the rules, procedures and conditions prescribed by the Committee.

Section 18. Qualified members must have the qualifications and must not have the prohibited qualities as follows:

(1) being of Thai nationality;

(2) being of more than seventy years of age;

(3) not being a bankrupt, an incompetent or quasi-incompetent person;

(4) not having been sentenced to imprisonment by a final judgement except for an offence committed through negligence or a petty offence;

(5) not being a holder of a political position, a member of a local assembly, a local administrator, an executive member or holder of a position with responsibility in the administration of a political party, a counsellor of a political party or an official of a political party;

(6) not being a person with behaviour in conflict or inconsistent with the objectives of the Foundation under section 5;

(7) not being a person having an interest in the activities conducted with the Foundation, or in activities in conflict or inconsistent with the objectives of the Foundation, regardless of whether it was direct or indirect, with the exception of persons who carry out activities for the benefit of the public and do not seek for profit.

Section 19. The qualified members shall hold office for a term of three years.

In the case where a qualified member vacates office before the expiration of the term, there shall be an appointment of another qualified member to fill the vacancy, except where there are less than ninety days remaining in the term of office, and the person appointed to fill the vacancy shall be in office for the remaining term of the qualified members already appointed.

At the expiration of the term under paragraph one, if the new qualified members have not yet been appointed, the qualified members having vacated office at the expiration of the term shall remain in office for continuing the performance of work until the newly appointed qualified members take office.

The out-going qualified members may be re-appointed.

Section 20. In addition to the vacation of office at the expiration of the term, a qualified member vacates office upon:

(1) death;

(2) resignation;

(3) being removed by the Council of Ministers by reason of neglect of duties, improper behaviour, or lack of proficiency;

(4) being disqualified or being under any of the prohibitions under section 18.

Section 21. The Committee has the powers and duties to control and supervise the operation of the Foundation for the attainment of the objectives prescribed by section 5. Such powers include:

(1) to determine administration policies and approve an action plan for the Foundation;

(2) to approve an annual action plan, an annual financial plan as well as an annual budget for the office;

(3) to prescribe rules and procedures for the appropriation of money to be expended as subsidies to a variety of activities;

(4) to raise funds;

(5) to supervise the performance and administration of general affairs and to issue rules or regulations of the Foundation in the following matters:

(a) the work organisation of the Foundation's office and the scope of duties of each respective section of work;

(b) the qualifications and prohibitions required of the Manager and the rules for the selection of the Manager;

(c) the prescription of positions and the qualifications required for the positions of officials and employees of the Foundation;

(d) the prescription of scale of salaries, wages and other remuneration of officials and employees of the Foundation;

(e) the selection, recruitment, appointment, removal, disciplines and disciplinary penalties, vacation of office, filing of a complaint and making of an appeal against the punishment of officials and employees, including procedures and conditions for the employment of employees;

(f) the administration and management of finance, procurement and property of the Foundation, including the accounting and deletion of property from an account;

(g) the provision of welfare and other fringe benefits to officials and employees;

(h) the scope of powers and duties, and rules relating to the performance of duties, of an internal auditor.

Section 22. At a meeting of the Committee, the presence of at least one-half of the total number of members is required to constitute a quorum.

At a meeting of the Committee, if the Chairman is not present or is unable to perform duties, the First Vice-Chairman shall preside over the meeting. If the First Vice-Chairman is not present or is unable to perform duties, the Second Vice-Chairman shall preside over the meeting. If the Second Vice-Chairman is not present or is unable to perform duties, the members present shall elect one amongst themselves to preside over the meeting.

In the performance of duties, if any member is directly or indirectly interested in the matter to be considered by the Committee, that member shall disclose it at the meeting, and the meeting shall consider whether that member should be present at the meeting and have a vote in the matter, in accordance with the rules prescribed by the Committee.

The decision of the meeting shall be by a majority of votes. In casting votes, each member shall have one vote. In the case of an equality of votes, the presiding Chairman shall have an additional vote as a casting vote.

Section 23. The Committee has the power to appoint qualified persons with a specialisation as advisors to the Committee and has the power to appoint a sub-committee for considering or performing any particular act as entrusted by the Committee.

At a meeting of the sub-committee, section 22 shall apply *mutatis mutandis*.

Section 24. The Chairman, members, advisor to the Committee and members of a sub-committee shall receive a meeting

allowance or other remuneration in accordance with the rules prescribed by the Council of Ministers.

Section 25. The Foundation shall have one General Manager appointed by the Committee.

The Manager must be a person able to work for the Foundation on a full-time basis, and must have the qualifications and must not be under the prohibitions as follows:

(1) being of Thai nationality;

(2) being of not more than sixty years of age on the date of appointment;

(3) being a person with knowledge, ability and experiences suitable to the affairs of the Foundation;

(4) not being under any of the prohibitions under section 18(3), (4), (5), (6) or (7).

Section 26. The Manager shall hold office for a term of four years, and may be re-appointed, but must also have the qualifications and must not be under the prohibitions under section 25 on the date of re-appointment, but may not serve for more than two consecutive terms.

Section 27. In addition to the vacation of office at the expiration of the term, the Manager vacates office upon:

(1) death;

(2) resignation;

(3) occurrence of an event stipulated in an agreement between the Committee and the Manager;

(4) being removed by the Committee by reason of neglect of duties, improper behaviour, or lack of proficiency;

(5) being disqualified or having any of the prohibition under section 25.

The resolution of the Committee for the removal of the Manager from office under (4) shall be passed with the supporting votes of not less than two-thirds of the number of existing members, exclusive of the Manager.

Section 28. The Manager shall have the following powers and duties:

(1) to administer the affairs of the Foundation for compliance with the law and the objectives of the Foundation;

(2) to study, analyse and appraise the Foundation's performance, including the submission of targets, action plans, projects, the annual action plan of the Foundation, and the financial plan and annual budget to the Committee;

(3) to prepare a report and accounting matters of the Foundation, and to submit an annual performance report;

(4) to supervise the work performed by officials and employees of the Foundation for compliance with the regulations;

(5) to perform any other duties as entrusted by the Committee.

Section 29. The Manager must be accountable to the Committee for the administration of the affairs of the Foundation.

The Manager shall represent the Foundation in acts *vis-à-vis* third persons. For this purpose, the Manager may delegate his or her power to any person to perform any particular act on the Manager's behalf, in accordance with the regulation prescribed by the Committee.

Section 30. The Committee shall determine the salary-scale or other benefits of the Manager.

Section 31. Officials and employees of the Foundation must have the qualifications and must not be under the prohibitions as follows:

(1) being of Thai nationality;

(2) being of not less than eighteen years of age and not more than sixty years of age;

(3) being able to work for the Foundation on a full-time basis;

(4) having the qualifications or experiences suitable to the objectives as well as the powers and duties of the Foundation;

(5) not being a Government official or an employee of a Government agency, an official or employee of a State enterprise or other State agencies or an official or employee of a local government organisation;

(6) not holding any position in a partnership, company or organisation carrying out a business in conflict or inconsistent with the objectives of the Foundation;

(7) not being under any of the prohibitions under section 18(3), (4), (5), (6) or (7).

Section 32. An official or employee vacates office upon:

(1) death;

(2) resignation;

(3) being disqualified or being under any of the prohibitions under section 31;

(4) being removed by reason of failing a work appraisal;

(5) being removed or dismissed by reason of disciplinary breach.

The cases of (4) and (5) shall be in accordance with the rules and procedure prescribed by the Committee.

Section 33. The accounting of the Foundation shall be conducted by reference to international practice and in accordance with the forms and rules prescribed by the Committee.

Section 34. There shall be an internal audit with respect to the finance, accounting and procurement of the Foundation, with a corresponding audit report for submission to the Committee, at least once a year.

For the purpose of the internal audit, there shall be an official of the Foundation acting as an internal auditor with direct answerability to the Committee, in accordance with the regulations prescribed by the Committee.

Section 35. The Foundation shall prepare a financial statement, which must include at least a balance sheet and an operation account to be submitted to the auditor within one hundred and twenty days as from the end of each accounting year.

At an interval of every year, the Office of the State Audit or an outsider appointed by the Committee with the approval of the Office of the State Audit shall be the auditor and appraise dispositions of money and property of the Foundation. In this instance, opinions shall be analytically presented as to the extent to which such dispositions have corresponded to the objectives, proceeded in an economical fashion and met the targets. An audit report shall subsequently be prepared and submitted to the Committee.

For these purposes, the auditor shall have the powers to inspect all account books of the Foundation, inquire the Manager, internal auditor, officials and employees of the Foundation and instruct such persons to furnish that additional account books, documents, and evidence of the Foundation as is necessary.

Section 36. The Foundation shall prepare an annual report for submission to the Minister, the House of Representatives and the Senate for consideration within one hundred and eighty days as from the end of the accounting year. This report shall state the work of the Foundation in the past year together with the financial statement and auditor's report.

CHAPTER III
Performance Appraisal of the Foundation

Section 37. There shall be seven members of the Performance Appraisal Committee for the Foundation, consisting of a Chairman and six qualified members appointed by the Council of Ministers by the advice of the Finance Minister from those with knowledge, ability and experiences in the fields of finance, health promotion and performance appraisal. Of this number, there shall be at least two persons who specialise in performance appraisal.

The Performance Appraisal Committee shall appoint a person, as it deems suitable, to act as a secretary.

Section 18, section 19, section 20, section 22 and section 24 shall apply to the Performance Appraisal Committee and the conduct of Performance Appraisal Committee meetings *mutatis mutandis.*

Section 38. The Performance Appraisal Committee has the powers and duties as follows:

(1) to appraise the Foundation's policies and activities;

(2) to monitor, inspect and appraise the performance of the Foundation;

(3) to report the performance, with its suggestions, to the Committee in an interval of every year.

The Performance Appraisal Committee shall have the power to require any person to furnish documents or evidence related to the Foundation, or summon any person to make a statement of facts to form part of its consideration in the appraisal.

Section 39. In the performance of duties under this Act, the Performance Appraisal Committee may appoint a sub-committee to consider and submit opinions in any subject, or delegate the performance of any matter as it deems suitable.

CHAPTER IV
Penalties

Section 40. Any person under the duty to remit Foundation levy who does not remit the Foundation levy or remits an insufficient amount of that required shall be liable to imprisonment of not exceeding one year or a fine of five times to twenty times the amount of Foundation levy that has to be remitted, or both.

Section 41. In the case where an offender liable to a penalty under this Act is a juristic person, the managing director, manager or any person responsible for the operation of that juristic person shall also be liable to the penalty provided for that offence, except where it can be proven that the act was committed without his or her knowledge or consent.

Section 42. Of the various offences under this Act, the Director-General of the Excise Department or a person delegated by the Director-General of the Excise Department shall have the power to make a settlement. The provisions in relation to the settlement of cases under

the law on alcoholic beverages and law on tobacco shall apply to the settlement of cases under this Act *mutatis mutandis.*

Transitory Provisions

Section 43. Upon the establishment of the Foundation under this Act, the operations under the objectives of the Health Promotion Foundation pursuant to the Royal Decree Establishing the Health Promotion Foundation shall be deemed to have been terminated, and the Minister in charge and control of that Royal Decree shall proceed under section 44(2) of the Public Organisation Act, B.E. 2542 (1999) in announcing the cessation of the Health Promotion Foundation's operations in the Government Gazette.

The businesses, properties, rights, debts, budget, incomes, revenue and work performers of the Health Promotion Foundation established pursuant to the Royal Decree Establishing the Health Promotion Foundation, B.E. 2543 (2000) shall be assigned to the Health Promotion Foundation under this Act.

Section 44. The Manager of the Health Promotion Foundation under the Royal Decree Establishing the Health Promotion Foundation, B.E. 2543 (2000) who holds office at the date which this Act comes into force shall provisionally perform duties as a Manager under this Act until the appointment of a Manager under this Act, provided that this does not exceed one hundred and twenty days from the date at which this Act comes into force.

Section 45. In the initial period, the Committee shall consist of members under sections 17(1), (2) and (4) and the person performing the duties of a Manager under section 44 shall be a member and secretary, to perform the duties of the Committee under this Act

until the appointment of qualified members under sections 17(3) and (5), provided that this does not exceed ninety days from the date at which this Act comes into force.

In conducting the appointment of qualified members under paragraph one, the members under sections 17(1), (2) and (4) shall prescribed the rules, procedures and conditions in the selection of qualified members to be nominated to the Council of Ministers for further appointment.

Countersigned by:
Pol. Lt. Col. Thaksin Shinawatra
Prime Minister

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COMH-53

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 12.8

A57/11
8 April 2004

Health promotion and healthy lifestyles

Report by the Secretariat

1. This document is submitted in response to the decision by the Executive Board at its 111th session to defer consideration of the agenda item on health promotion.[1]

2. In 1989, resolution WHA42.44 on health promotion, public information and education for health urgently called upon Member States to develop, in the spirit of the Declaration of Alma-Ata and the First and Second International Conferences on Health Promotion, strategies for health promotion and health education as essential elements of primary health care and the Director-General to provide support to Member States in strengthening national capabilities in all aspects of health promotion. In 1998, resolution WHA51.12 on health promotion urged Member States to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies, and requested the Director-General to give health promotion top priority in WHO.

3. Since 1986, the five international conferences on health promotion, cosponsored and organized by WHO,[2] have been instrumental in guiding the development, direction and global practice of health promotion. Strategies, models and methods in health promotion are limited to neither a specific health issue nor a specific set of behaviours, but apply to a variety of population groups of all ages, risk factors, diseases and settings. Efforts put into improving education, community development, policy, legislation and regulations are as valid for the prevention of communicable diseases as they are for tackling the major risks for noncommunicable diseases (unhealthy diet, tobacco use, sedentary lifestyle and alcohol abuse) and for preventing injury, violence and mental illness. The adoption of the WHO Framework Convention on Tobacco Control, the work towards a global strategy on diet, physical activity and health, and the Move for health initiative are major global steps to reducing these common risks.

4. Mental health promotion constitutes an important component of overall health promotion. In view of the stress and conflicts that individuals and communities face, greater efforts are needed to promote mental health. WHO is reviewing the evidence of effectiveness of activities that promote mental health, especially those with relevance to low- and middle-income countries, and will use the findings to define best practices for countries with different resource levels and diverse cultures.

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[1] Decision EB111(1).

[2] First International Conference on Health Promotion: the move towards a new public health (Ottawa, 1986); Second International Conference on Health Promotion: healthy public policy (Adelaide, Australia, 1988); Third International Conference on Health Promotion: supportive environments for health (Sundsvall, Sweden, 1991); Fourth International Conference on Health Promotion: new partners for a new era – leading health promotion into the 21st century (Jakarta, 1997); Fifth Global Conference on Health Promotion: health promotion – bridging the equity gap (Mexico City, 2000).

5. Health promotion is important for attaining the health-related United Nations Millennium Development Goals, contributing to the reduction in child mortality; improvement of maternal health; prevention and control of HIV/AIDS, tuberculosis and malaria; and access to better sanitation and clean drinking-water. Achieving these Goals will need greater recognition of the inextricable links between health, development and poverty reduction and improved access to major health services; health promotion will be crucial for mobilizing society in this task through advocacy and suitable strategies.

6. Insufficient evidence on the effectiveness of health promotion contributes to limited allocation of resources, and consequently underfunded interventions and less effective health promotion. Special efforts are therefore needed to collect sound evidence, particularly in developing countries.

PROGRESS

7. Member States in all regions have strengthened national capabilities for health promotion, but progress has been uneven. Most countries do not have the policies, human or financial resources, or institutional capacity for sustainable, effective health promotion to counter risks and their underlying determinants. Major tasks lie ahead, including building national capacity, strengthening evidence-based approaches, innovating strategies and means of financing, and preparing guidelines for implementation and evaluation.

8. The Regional Committee for Africa adopted a strategy on health promotion for the African Region (resolution AFR/RC51/R4) in 2001, and has developed guidelines for its implementation. The Regional Office for the Americas has had follow-up meetings and established three groupings of countries to strengthen and advocate health promotion with particular emphasis on settings and healthy municipalities. The Regional Office for Europe has set up a centre for investment for health and development in Venice (Italy) and has an active intercountry network. The Regional Office for the Eastern Mediterranean works actively on health promotion, healthy lifestyles and health education, prevention and control of noncommunicable diseases, and the basic development needs approach. The Regional Office for South-East Asia, too, emphasizes capacity building; it held an interregional workshop to identify the prerequisites for and to prepare guidance on strengthening capacity for health promotion at local and national levels in Bangkok in February 2003. It also surveyed country capacity for health promotion and health education, and networked countries with a focus on standards for health promotion and health education. The Regional Office for the Western Pacific created its Regional Framework for Health Promotion 2002-2005, with extensive support materials, including a catalogue of teaching and learning materials and financing opportunities in the Region. Several countries, such as South Africa and Sudan, are formulating national health promotion policies and strategies.

9. Progress in reviewing and building evidence of the effectiveness of health promotion, and in translating evidence into policy and practice, with due regard to cultural and regional diversities, is being made through the Global Programme on Health Promotion Effectiveness, a multi-partner project coordinated by the International Union for Health Promotion and Education in collaboration with WHO. Partners include many national public health institutions, such as the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America), the Netherlands Institute for Health Promotion and Disease Prevention and the African Medical and Research Foundation; the Swiss Agency for Development and Cooperation provides strong support. WHO is working on some 30 projects from more than 15 Member States in all regions to document successes and to plan, implement, and evaluate interventions with methodological rigour.

10. In addition to a report for the European Commission on the evidence of the effectiveness of health promotion[1] and information accumulated over the past 25 years in the developed countries in North America, Australia and Europe, more evidence of effectiveness in other Member States is becoming available and will be documented by the Global Programme (see paragraph 9). Examples include reduction in the prevalence of smoking in the Republic of Korea; increased participation in sports activities in Singapore; reduction of salt intake in Japan; in Thailand, a fall in new HIV infections from 143 000 in 1991 to 23 676 in 2002 – successes in the prevention and control of HIV infections have also been recorded in Brazil and Uganda; and, in one part of Bangladesh, about 70% of residents switched their source of water from contaminated wells to safe wells. Other examples will be presented in the reports of the technical meeting on the Global Programme on Health Promotion Effectiveness (Hong Kong Special Administrative Region, China, 22-25 October 2003) and of the WHO component of the Programme.

11. The Global School Health Initiative takes an integrated approach that combines school health policy, skills-based health education, a safe and health-supportive school environment and school-based health and nutrition services to tackle major risk factors. School health programmes with these elements are cited as viable public health interventions in every region. WHO, UNESCO, UNICEF, the World Bank and Education International are promoting these components in a joint initiative to focus resources on effective school health. The Initiative serves as an interagency model for working towards both the health and sector-specific goals of each agency. WHO is also working with Education International and two WHO collaborating centres (Centers for Disease Control and Prevention, Atlanta, Georgia, and Education Development Center, Boston, Massachusetts, United States of America) to train thousands of teachers to use modern, interactive methods to educate adults and students about preventing HIV infection and related discrimination in countries with high rates of infection. WHO recently launched a global school-based health surveillance system, a survey element of which generates internationally comparable data for monitoring the prevalence of important health factors among 13-15 year-old students.

12. WHO developed a policy framework on active ageing, which takes a health promotion approach. The document, which was WHO's contribution to the United Nations Second World Assembly on Ageing (Madrid 2002), is based on the fact that health is of paramount importance if older people are to remain a resource for their families, communities and economies.[2]

13. In order to find innovative ways of financing health promotion, the International Network of Health Promotion Foundations held two meetings (Bangkok, March 2002 and Budapest, April 2003). As a result, several countries have decided to establish such foundations, for example through imposing a dedicated tax on tobacco and alcohol, most recently Malaysia and Thailand.

14. International collaboration has been facilitated by establishing networks, including six regional networks for integrated prevention and control of noncommunicable diseases, the WHO Mega Country Health Promotion Network (linking the 11 most populous countries) and the International Network of Health Promotion Foundations. These networks offer forums for exchanging ideas and experience, advocating in-country policy support for health promotion and prevention of noncommunicable diseases, debating current topics in health promotion, and influencing the global health agenda.

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[1] *The evidence of health promotion effectiveness: shaping public health in a new Europe*, Parts 1 and 2, Vanves, France, International Union for Health Promotion and Education, 2000, 2nd edition.

[2] Document WHO/NMH/NPH/02.8.

15. Alcohol consumption raises complex issues. Some evidence attests to beneficial effects of moderate consumption of alcohol, but, overwhelmingly, data show its high contribution to the global burden of disease through its damaging effects across all sectors of society as the direct or underlying cause of many illnesses and accidents, violence and impaired health. Young people are particularly likely to abuse alcohol. Special attention needs to be paid to the messages conveyed in information relating to alcohol, including marketing and advertising, in particular on the impact of alcohol on the health and well-being of young people.

16. In line with WHO priorities, actions are under way to integrate health promotion into health systems. It is intended that, at a preparatory interregional workshop, to be held in November 2003, an outline plan on integrating health promotion into health systems will be prepared for the financial period 2004-2005.

FUTURE ACTION

17. WHO will support Member States in raising awareness of determinants of health, fostering health-inducing environments and strengthening capacity at national and local levels for planning and implementing comprehensive health promotion that is sensitive to gender, culture and age, particularly in developing countries and for poor and marginalized groups. Special attention will be given to the organization of health promotion within health services and systems. Training in health promotion will be strengthened including training of health personnel and, where necessary, curricula will be revised to incorporate the new expanded concept of health promotion. Particular attention will continue to be paid to young people in and out of school, and to major risks including unhealthy diet, physical inactivity and behaviours that encourage transmission of infectious diseases, and their broader social, economic and other determinants.

18. Work will continue on mobilizing and informing public opinion in order to influence policy- and decision-makers towards health-supportive policies and legislation and the promotion of healthy lifestyles. Continued attention will be given to health promotion in specific settings, such as the workplace, schools and the community – the Healthy Cities project exemplifies this setting-based approach.

19. Working with Member States and the international community, WHO will continue to provide technical support and guidance for the design, implementation and evaluation of evidence-based projects worldwide, and to disseminate the successes and lessons so learned through publication of guidelines and articles in peer-reviewed journals. Special attention will be paid to promotion of mental health, an area where evidence is particularly lacking. With an expanded evidence-base, WHO will examine the cost and effectiveness of health promotion interventions.

20. WHO will collaborate with all concerned parties, using the International Network of Health Promotion Foundations, to develop sustainable means of financing health. For example, insurance provisions by the public and private sectors need to be examined as a potential funding source of health promotion; indeed, all new options will need to be identified and scrutinized.

21. The potential contribution of social security in preventing major risks and promoting healthy lifestyles will be explored in a joint workshop to be held with ILO, the International Social Security Association and other key partners, for which a critical review paper has been written.

22. Within the framework of the health-related Millennium Development Goals, WHO is preparing a consultation on health promotion in development, with a focus on poverty reduction, in order to deepen understanding of the design, delivery and assessment of activities, particularly for disadvantaged populations. WHO will also promote intersectoral collaboration and coordination, including not only health and other ministries but nongovernmental organizations, civil society, and academic, research and professional institutions.

23. Attention will be paid to: strengthening national and regional networks to respond to threats to health at national, regional and global levels; exchange of information, by traditional and modern means of communication; and building concerted health actions through mechanisms such as the WHO Framework Convention on Tobacco Control, the global strategy on diet, physical activity and health and the Move for health initiative. WHO will promote collaboration and coordination through the designation of WHO collaborating centres, particularly in developing countries, and through a rigorous and coordinated partnership with those centres.

24. Interaction with the private sector, increasingly a key player in health issues, will be furthered. Health can be more readily improved by making healthy choices easier and more available and affordable. There is a strong need for the private sector to contribute increasingly to the aims of health promotion and healthier choices.

25. In order to respond to the many global changes and trends that directly or indirectly affect health and well-being, to assert WHO's leadership in health promotion, and to make health promotion more relevant to the demands of the new century, the Sixth Global Conference on Health Promotion will be convened in 2005. This conference of policy-makers and invited experts will build on the developments, experience and evidence accumulated since the first such conference in Ottawa in 1986, and is intended to provide a blueprint to meet the health promotion needs of today's society, both nationally and globally. It will also be a major forum for disseminating results and lessons learned from previous studies of the effectiveness of health promotion.

26. At its 113th session the Board, noting the importance of continued efforts to strengthen national capacity for health promotion, and the benefits of promoting equity and healthy lifestyles, unanimously adopted a resolution on health promotion and healthy lifestyles.

ACTION BY THE HEALTH ASSEMBLY

27. The Health Assembly is invited to note the report, and to consider the draft resolution contained in resolution EB113.R2.

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COM H-53A.

The 6th Global Conference on Health Promotion

7-11 August 2005

United Nations Conference Centre

Bangkok, Thailand

World Health Organization

Ministry of Public Health, Thailand

1. Health promoting school

Participants will observe a food safety programme in which student volunteers carry out surveillance of illegal food additives and contaminants with appropriate technology in order to enhance food safety promotion in school and nearby community.

4. Healthy Day Care Centre (for pre-school children)

This day care centre for pre-school children is a training and demonstration centre for health personnel responsible for child development. Wide range of activities are programmed for ensuring proper child development in all important aspects including physical, mental, social and spiritual aspects.

7. Health Promoting Hospital

Please come and have a look at one of Thailand's success stories on health promoting hospital located at the renown ancient capital of Ayutha not too far from Bangkok, Wang Noi Hospital. After a long and serious endeavors in applying the healthy hospital concept, Wang Noi Hospital has both explicit and tacit knowledge to share.

10. Healthy Municipality

San Sook Municipality is well known for along time as an efficient local government that spent a lot effort to ward sustainable development of this infamous resort area.

Depart from UNCC at 13.00 hrs. For reservation at registration counter until 8 August 2005 at 12.00 hrs.

2. Healthy community

Bangkok Metropolitan Administration (BMA) is the first local government that joined healthy cities initiatives and making continuously progress towards the goals.

5. Thai Traditional Medicine and Health Care

The Institute of Thai Traditional Medicine was founded in order to revive and developed the body of knowledge of Thai traditional medicine, folk medicine as well as herbs for the purpose of application, promotion, research and quality control.

8. Health care for AIDS patients

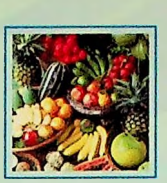
Wat Phrabat Namphu is a good example of private organization responsibility in coping with AIDS in Thailand. It is operated by a strong team-work consisted of Buddhist monks, physicians, nurses, Thai and international organization volunteers.

11. Healthy Hospital / Healthy Community

The people at Ubonrat District of Khonkaen province have set an example of a community that stand out for their cultural and social integrity and their world view that nurture peaceful and sustainable livelihood.

13. Civil network and Health Promotion

The Restaurant Association of Samut Songkram Province plays a proactive role in catalyzing and linking all stakeholders of safety food chain. This network has expanded its work to collaborate with young students in other areas including conscience and awareness raising campaign for local environment and natural resources preservation and ecological tourism support.



3. Healthy Market Place

Tropical fruits, vegetables, flowers, and wide varieties of foods found in oriental market places are attractive to many people. Participants will find out more about the country-wide "Clean Food Good Taste" Programme.

6. Health Promotion /Treatment / Rehabilitation of Narcotic Addicts

Thanyarak Institute is responsible for treatment and rehabilitation of drugs dependent persons including those who are HIV positive.

9. Mental Health Promotion in Community

In this Muslim community at Chawai community of Angthong province, a mental health promotion based on Islamic concept, community affection, unity, assistance, and participating toward comprehensive community development is developed.

12. Health Promoting School / Child Development Center

Wat Sanaeha School is a model for health promoting school and an outstanding school with environmental conservation programme. Another attraction is Wat Houi Jorakae Child Development Centre, a model child care center and an outstanding child development center of the region.

HEALTH EDUCATION FEVER

Fever is not a disease. It is only a symptom – a response to a problem somewhere in the body. It indicates the body's ability to fight a problem. It can eliminate many disease-causing micro-organisms by itself. We need to support the body and this ability.

Fever can be an indicator of the type of disease – e.g., the step ladder pattern in Typhoid, the chills, rigors and regularity of fever in Malaria, the low grade evening temperatures in TB, etc.

Fever weakens the body, apart from that due to disease. Fever may cause Fits, Delirium, and Dehydration especially in infants. This has to be treated actively.

Body temperature rises in summer due to high environmental temperatures, leading to heat-exhaustion and heat strokes. This can damage vital organs of the body.
Onion is the simplest remedy. Eat onion, carry an onion with you, sniff onion to reduce the effects of summer heat. Also, drink a lot of water or buttermilk, or any fresh fruit juices with a pinch of salt in it.

SUPPLEMENTARY MEASURES

Water in an earthen pot cools because it diffuses through the pores in the pot to the surface and evaporates. The heat needed for its evaporation is taken from the water inside, which therefore becomes cool. Water in the pot cools better when it is full of water, in an airy, ventilated place, and in the shade.

Our body is similar. Sweat comes on to the surface from water inside the body, and cools it by evaporation.

1. Drink plenty of water. Have a normal bath.
2. Wear very light clothing. Cover only when chills are present.
3. Take adequate rest.
4. Sit at door, window, under shade of tree/roof, where there is adequate flow of air.
5. Eat well. Take easily digestible foods, like Ganji, Fruits, Soups, etc. (Fever consumes energy.)

HERBAL REMEDIES - FEVER **- REMEDIES (A)**

FOR ADULTS :

BOIL IN ONE GLASS WATER - REDUCE TO HALF. THIS IS A KASHAYAM (DECOCTION). ADD JAGGERY AND MILK TO TASTE –they give energy too.

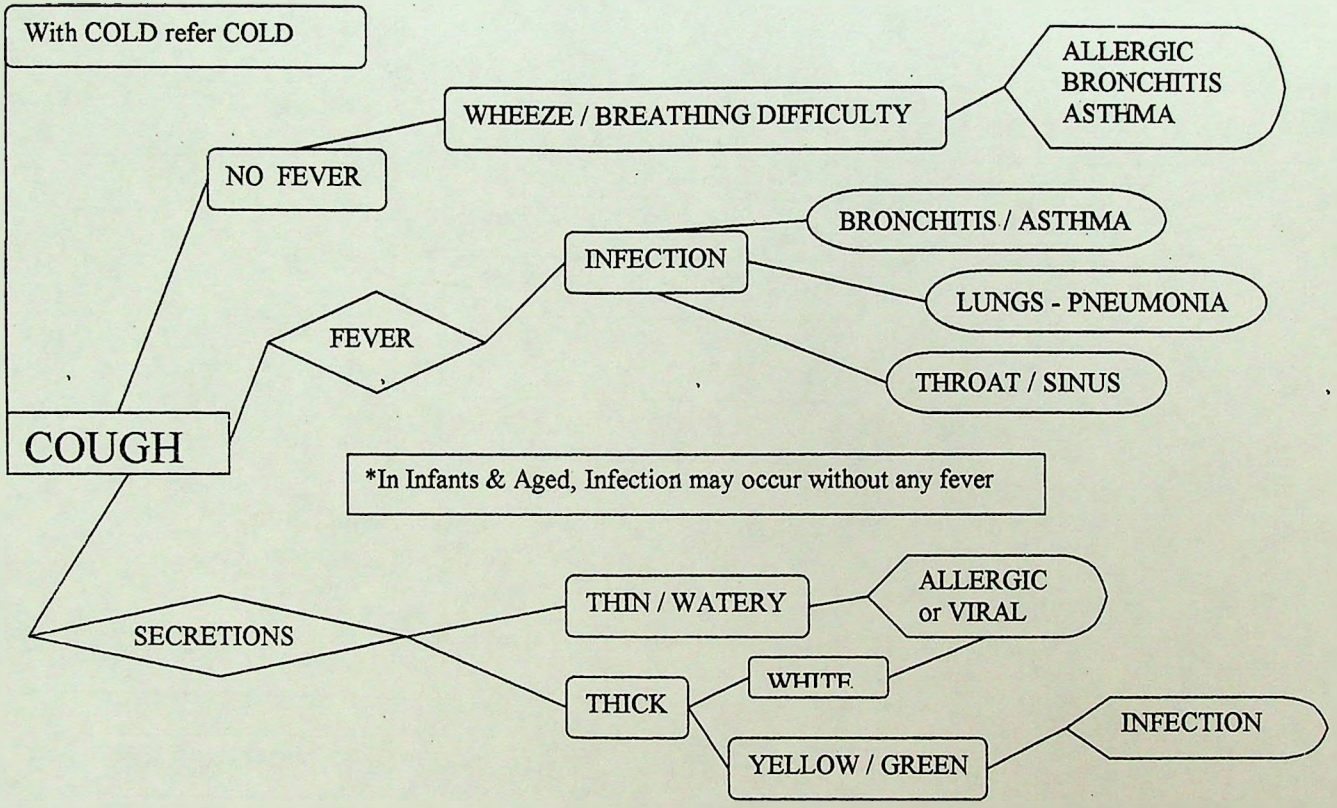
1. Cumin seeds (Jeera) 1 teaspoonful + Pepper 4-5 seeds
2. Dhub grass (Darbe hullu) one handful + Cumin seeds 1 teaspoonful
3. Neem (Baevu chekke) bark one rupee size + Cumin seeds 1 tsf

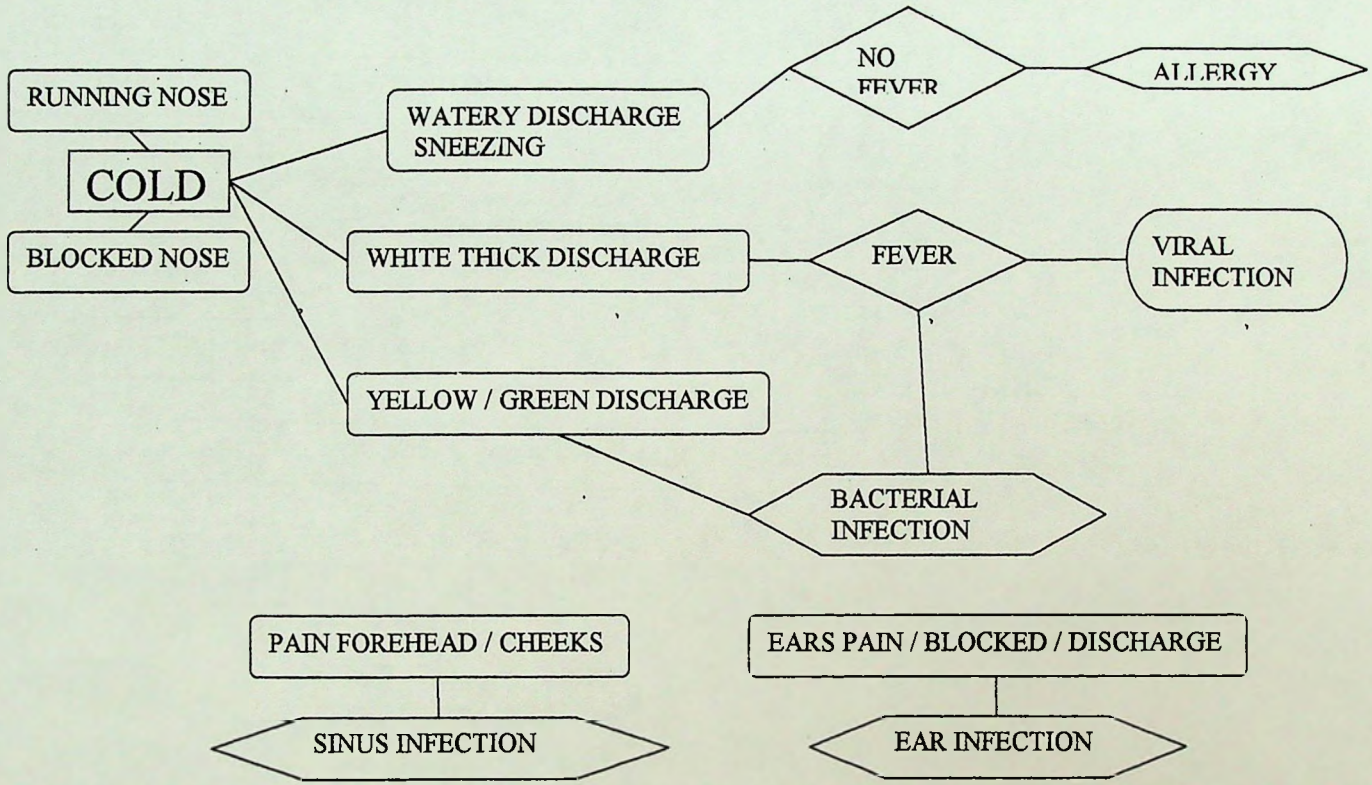
FOR CHILDREN : MAKE AS ABOVE.

4. Tulsi seeds 1 tsf
5. Ajwain seeds ½ tsf
6. 1 tsf of Ajwain leaf juice, can be given directly, or with honey.

EACH IS ONE DOSE. TO BE TAKEN BEFORE FOOD – ON EMPTY STOMACH.

THREE TO FOUR DOSES PER DAY CAN BE TAKEN


With COLD refer COLD
COUGH
NO FEVER
WHEEZE / BREATHING DIFFICULTY
ALLERGIC
BRONCHITIS
ASTHMA
FEVER
INFECTION
BRONCHITIS / ASTHMA
LUNGS - PNEUMONIA
THROAT / SINUS
*In Infants & Aged, Infection may occur without any fever
SECRETIONS
THIN / WATERY
ALLERGIC
or VIRAL
THICK
WHITE
YELLOW / GREEN
INFECTION


RUNNING NOSE
COLD
BLOCKED NOSE
WATERY DISCHARGE
SNEEZING
NO
FEVER
ALLERGY
WHITE THICK DISCHARGE
FEVER
VIRAL
INFECTION
YELLOW / GREEN DISCHARGE
BACTERIAL
INFECTION
PAIN FOREHEAD / CHEEKS
SINUS INFECTION
EARS PAIN / BLOCKED / DISCHARGE
EAR INFECTION

COLDS AND COUGHS

SUPPLEMENTARY MEASURES

1. Drink plenty of water. The body is trying to throw out the infective agent, or allergen through its secretions. Help this process.
2. Steam inhalation half an hour after food directly hydrates the respiratory tract and removes phlegm (Kapha), while eliminating the micro-organisms by its heat. A few crushed leaves of Eucalyptus (Niligiri) or a few drops of its oil put into this water has additional anti-septic effect.
3. Respiratory infections are spread through AIR. So, cover your mouth while coughing to prevent spread to others.
4. Remove phlegm (Kapha) to help yourself and dispose it off safely to prevent spread to to others.
5. Eat easily digestible foods. Eat well. Avoid iced/cold foods and those that do not agree with you.

In chronic cough conditions like Asthma, Bronchitis and Allergies, the precipitating triggers also need to be identified and the person helped to prevent attacks by avoiding them.

The respiratory tract also needs to be strengthened with Pranayama and other breathing exercises.

COUGHS AND COLDS - REMEDIES (B)

Kashayam (Decoction) of any of the following :

1. Jeera + Pepper + Dry ginger + pinch of Turmeric.
2. Methi (Fenugreek) 4 parts + Dry ginger 1 part.
3. Adhatoda leaf dry powder, 1 teaspoonful

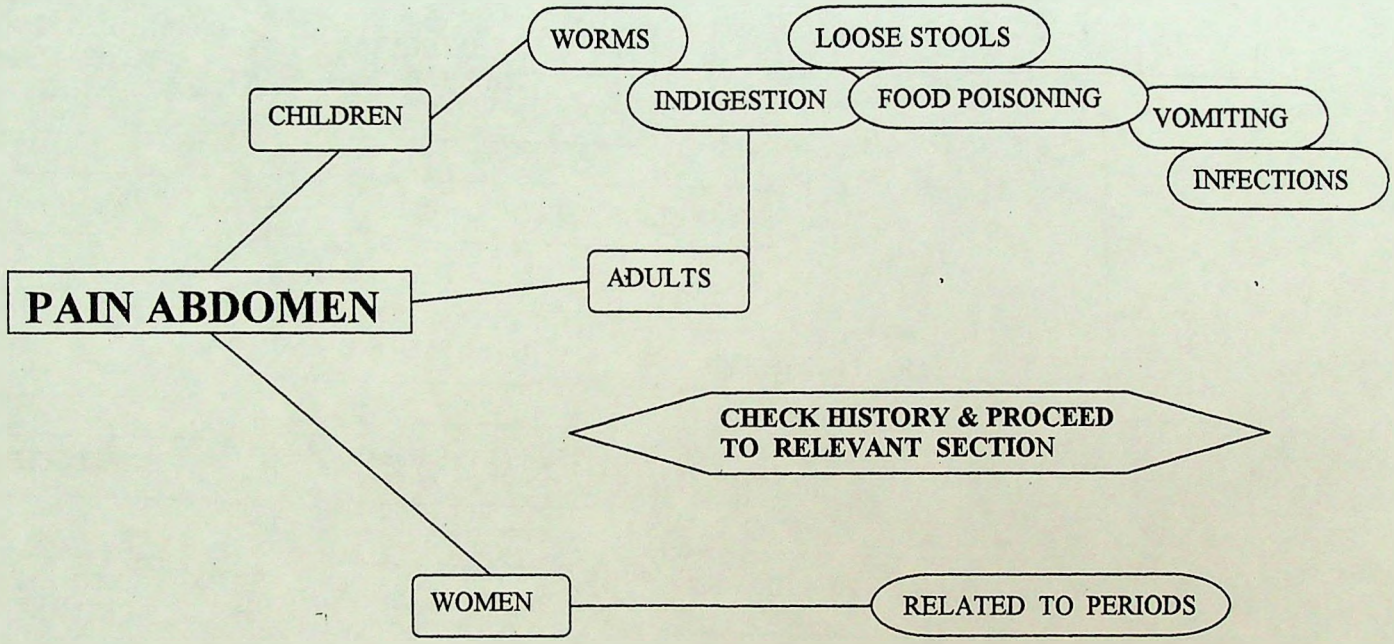
OR
To be taken directly,

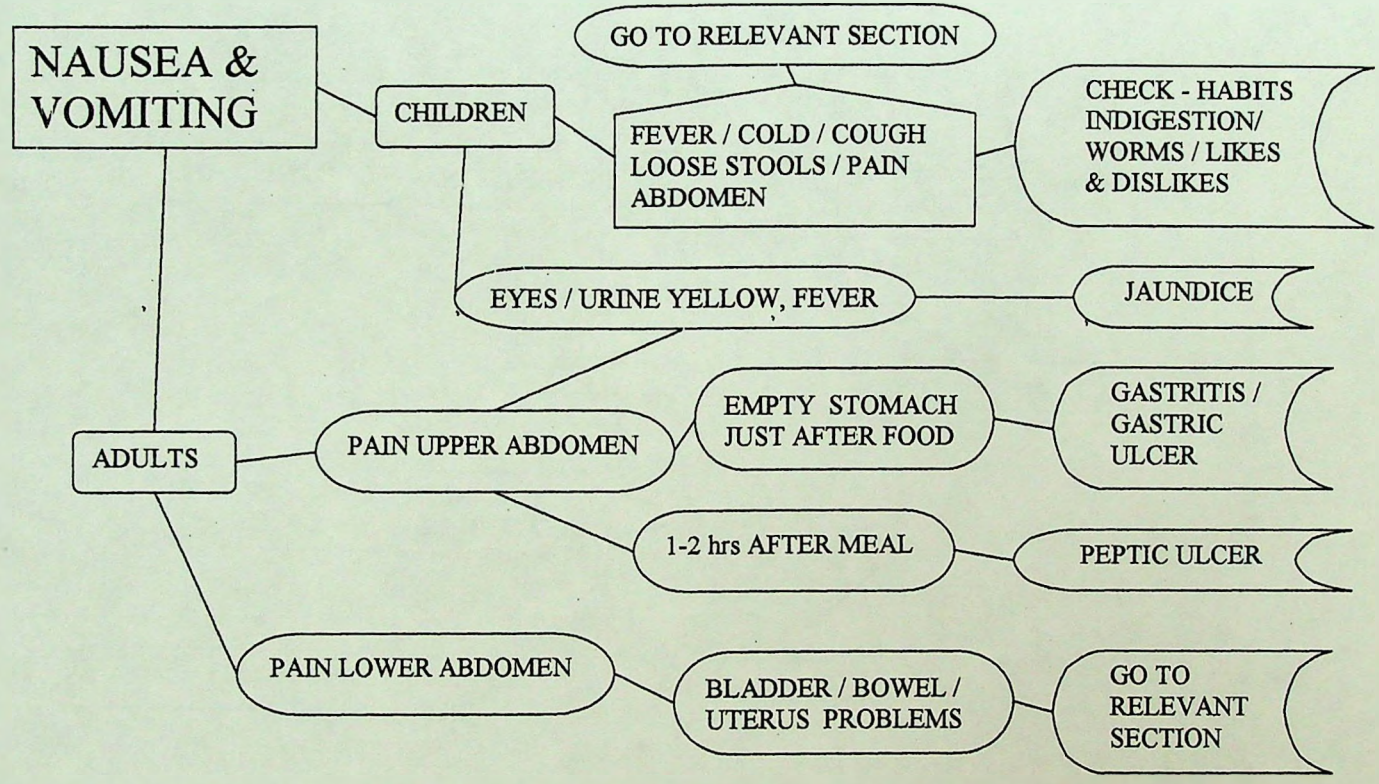
4. Tulsi leaf juice + Honey in equal parts
5. Pomegranate , dry flower powder half spoon in Honey
6. Ginger powder + Pepper powder in Honey.
7. Adhatoda dry leaf powder + Honey.

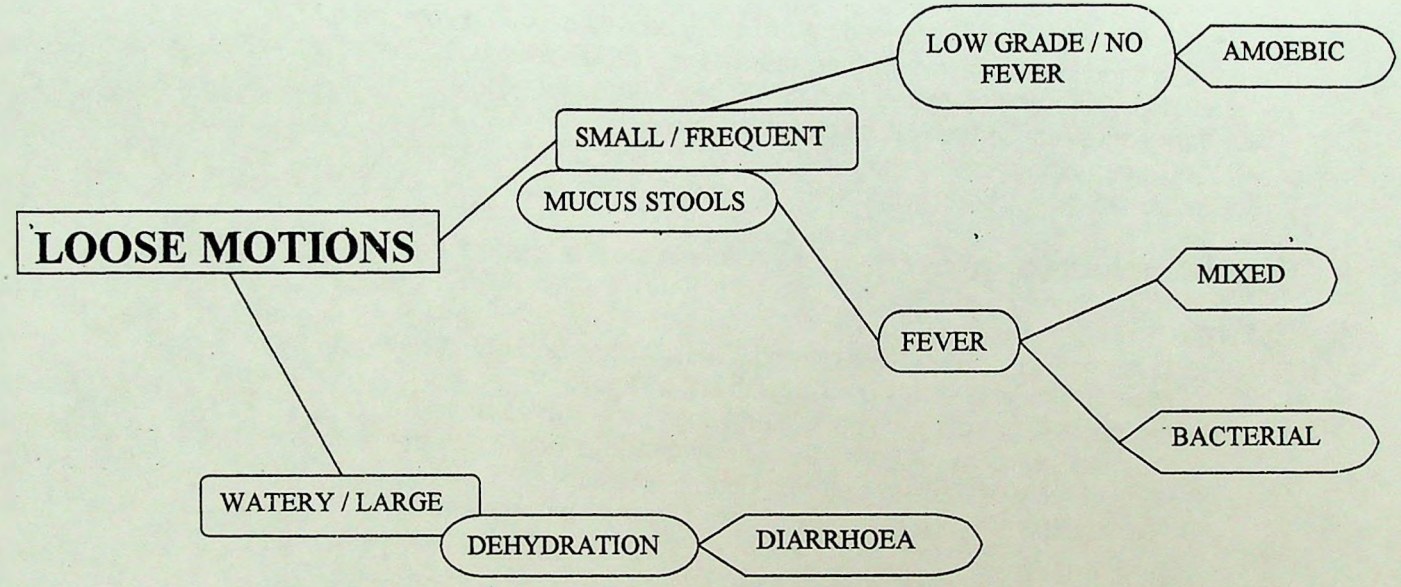
OR
Prepare as Indicated:

8. Steam 3 to 4 leaves of Adhatoda (like IDLI), extract juice and drink.
9. Put handful of Tulsi leaves in boiling water taken off the stove, cover with lid and allow to cool. Squeeze leaves, strain and drink.
10. Half centimeter size Turmeric root dipped in coconut oil or ghee to be burnt and inhaled.
11. Gum or one rupee coin sized bark of Drum-stick tree to be crushed and made into omelette with egg. Eat without salt.

EACH IS ONE DOSE. THREE TO FOUR DOSES ARE REQUIRED PER DAY, TO BE TAKEN BEFORE FOOD.


PAIN ABDOMEN
CHILDREN
WORMS
ADULTS
INDIGESTION
LOOSE STOOLS
FOOD POISONING
VOMITING
INFECTIONS
CHECK HISTORY & PROCEED
TO RELEVANT SECTION
WOMEN
RELATED TO PERIODS


NAUSEA & VOMITING
CHILDREN
GO TO RELEVANT SECTION
FEVER / COLD / COUGH LOOSE STOOLS / PAIN ABDOMEN
CHECK - HABITS INDIGESTION/ WORMS / LIKES & DISLIKES
EYES / URINE YELLOW, FEVER
JAUNDICE
ADULTS
PAIN UPPER ABDOMEN
EMPTY STOMACH JUST AFTER FOOD
GASTRITIS / GASTRIC ULCER
1-2 hrs AFTER MEAL
PEPTIC ULCER
PAIN LOWER ABDOMEN
BLADDER / BOWEL / UTERUS PROBLEMS
GO TO RELEVANT SECTION


LOOSE MOTIONS
SMALL / FREQUENT
LOW GRADE / NO FEVER
AMOEBIC
MUCUS STOOLS
FEVER
MIXED
BACTERIAL
WATERY / LARGE
DEHYDRATION
DIARRHOEA

DIGESTIVE SYSTEM
HEALTH EDUCATION

Diarrhoea and Dysentery indicate bad food and water hygiene. It is very contagious and spreads easily.

1. Eat only fresh and hygienic food. Avoid stale, uncooked and unprotected food.
2. Prepare food in a hygienic manner. Wash all vegetables, foodstuffs, containers, knives, ladles etc., used for cooking. Store well protected from flies, insects, dust, and vermin.
3. Wash hands, eating utensils, serving utensils etc.
4. Keep surroundings clean, and avoid open defecation, urination.
5. Ensure sanitary disposal of Kitchen, and other food wastes.

Healthy eating habits, and plenty of water and fibre in the diet is preventive.

VOMITING **-REMEDIES (C)**

1. Cardamom (Ilaichi) plain or roasted. Chew directly, or paste in water.
2. Mentha (Pudina) leaves crushed with sugar candy.
3. Lemon seed powder – one pinch, or, lemon juice with sugar.
4. Tulsi leaf powder with Coriander (Dhaniya) seed powder 1:1 with honey, is especially useful in children.
5. Juice of stem of plantain tree with Honey – one cup.
6. For vomiting of Bile (Pittha) 1:1 of clear ginger juice and honey.

DIARRHOEA (Neeru Bedhi) **-REMEDIES (D)**

Diarrhoea is the passing of frequent, large, watery stools.Replacement of the water, salts and energy lost is the mainstay of treatment.

1. O.R.S., Buttermilk with salt, Rice ganji with salt, etc
2. Guava (Seebe kayi) decoction. A handful of tender leaves, or, one small unripe crushed fruit in 6 glasses of water reduced to 3 glasses. One glass thrice a day.
   A teaspoonful of leaf/fruit paste – drink water with it.
3. Sapota (Chikku) decoction or paste. Same as above.
4. Pomegranate (Dalimbe) decoction. Same as above.
5. Mango seed kernel powder – one tablespoonful in curds, buttermilk or water, with a teaspoonful of honey. Tender mango leaf dried powder is equally effective.
6. Dried raw banana powder 1 teaspoonful in sour curds.
   Juice of Plantain stem is also effective.

DYSENTERY (Amashanke Bedhi)

Is a condition where small frequent stools are passed with blood and/or mucus. There is pain and frequent urge to pass stools. It is caused by infection of the intestines and their inflammation due to Bacteria, Amoeba, Viruses, etc.

_REMEDIES (E)

ALL THE REMEDIES LISTED IN "DIARRHOEA" ARE USEFUL. ALSO,

1. Fenugreek/Methi seeds (Menthya) one teaspoonful in sour curds.
2. Aloe vera (Lole sara) one tablespoonful with Menthya.
3. A handful of tender leaves of Gooseberry (Amla) in a glass of buttermilk.
4. Periwinkle (Nitya pushpin) leaves, 5 to 6 made into a decoction.

INDIGESTION (Ajeerna), STOMACH PAIN AND FLATULENCE **- REMEDIES (F)**

This occurs due to excess, improper or untimely eating.

1. A tablespoon of Ajwain (Omum) boiled in a litre of water with a pinch of Black/rock salt (Saindra lavana/ Kala Namak). Half to one glassful.
2. Ginger, Pepper, Jeera, Hing (Asafoetida) and Black/rock salt made into a decoction in proportions used for Rasam (Saaru).
3. Saunf and Ajwain powder in ratio 1 : 2 mixed with equal quantity of Jaggery powder, one to two teaspoonfuls after food.
4. Rice, Ragi, Ravva burnt during cooking and stuck to the bottom of the cooking vessel. One to two tablespoonfuls after food.

GASTRITIS AND ULCERS (Hotte Hunnu) **- REMEDIES (G)**

This is injury caused to the stomach when it produces too much acid, because of Spicy, Irregular food, and Stress, Worry, Alcohol, Tobacco and drugs.

1. Methi, one teaspoonful soaked overnight in a glass of water and taken on empty stomach in the morning.
2. Banana stem juice half glass with equal quantity of water taken as above.
3. One tablespoonful of Aloe pulp washed in water with equal quantity of water, taken as above.
4. Marble sized pills made of Turmeric powder and Honey, as above.

CONSTIPATION and PILES (Mala Baddhate, Moolavyadhi) **-REMEDIES (H)**

This is very hard stools not passed daily/regularly, caused by inadequate fibre and water in the diet. Also, missing of meals, inadequate food/water intake and disordered action of the bowel muscle due to illness.

1. Methi, one teaspoonful soaked in a glass of water overnight and taken on empty stomach in the morning.
2. One tablespoonful of Triphala Churna in hot milk or water at night.
3. One tablespoonful of Isabgol powder in water at night.

Piles is a result of severe constipation, when the blood vessels at the anal end swell up, create pain, and bleed.

1. A handful of tender Tamarind leaves chewed and followed by plenty of water at night. A decoction of the same may also be taken.
2. Remedies for constipation are also helpful.
3. Local application of Neem and Turmeric paste helps in healing.
4. Aloe pulp with Castor oil and Turmeric applied locally also heals.
5. A tsf of Methi soaked overnight in a glass water and taken on empty stomach early in the morning.

INTESTINAL WORMS (Hotte Hula/ Krimi)

These are due to eggs entering the intestines through uncooked food or cooked unhygienically. Hook worm larve enter through the skin of the feet. They are parasites in the intestines and affect the nutrition, apart from causing other disease.

There are many types. The common ones are, Round worm (Jantu Hula), Hook worm (Kokke Hula), Tapeworm (Ladi Hula) and Thread/pin worms (Krimi).

- REMEDIES (I)

1. Papaya seeds dried in shade, 1 to 3 teaspoonfuls of the powder taken with food upto thrice daily (3 to 5 days).
2. Neem root-bark powder half teaspoonful or Decoction for one week in the morning, on empty stomach.
3. Neem leaves paste, marble sized, with a pinch of Turmeric and Salt, taken as above.
4. Pumpkin seeds (100gms) in Ghee, as above.
5. Brinjal leaf paste, as in Neem leaf paste above.
6. Betel=nut (Supari) powder. half tsf for children, one for adults.

JAUNDICE (Kaamale)

There are many varieties, some very dangerous. There is fever, yellow eyes and urine, with vomiting, loss of appetite and lack of energy.

This is a viral disease of the liver, affecting food ingestion, digestion and absorption. The commonest variety is Hepatitis A that is water-borne and occurs seasonally as epidemics. The treatment for this variety is,

- REMEDIES (J)

1. Phylllanthus neruri (Bhoovi Amla / Kiru Nelli/ Nelada Nellikai) whole plant washed and crushed to size of marble, taken on empty stomach.
2. 1 cup of juice of tender leaves of Castor plant (Avadala yele) – white variety with plenty of sugar.
3. One tablespoonful of tender Mehandi leaf juice and Jeera with plenty of sugar/ glucose water.

HEALTH EDUCATION

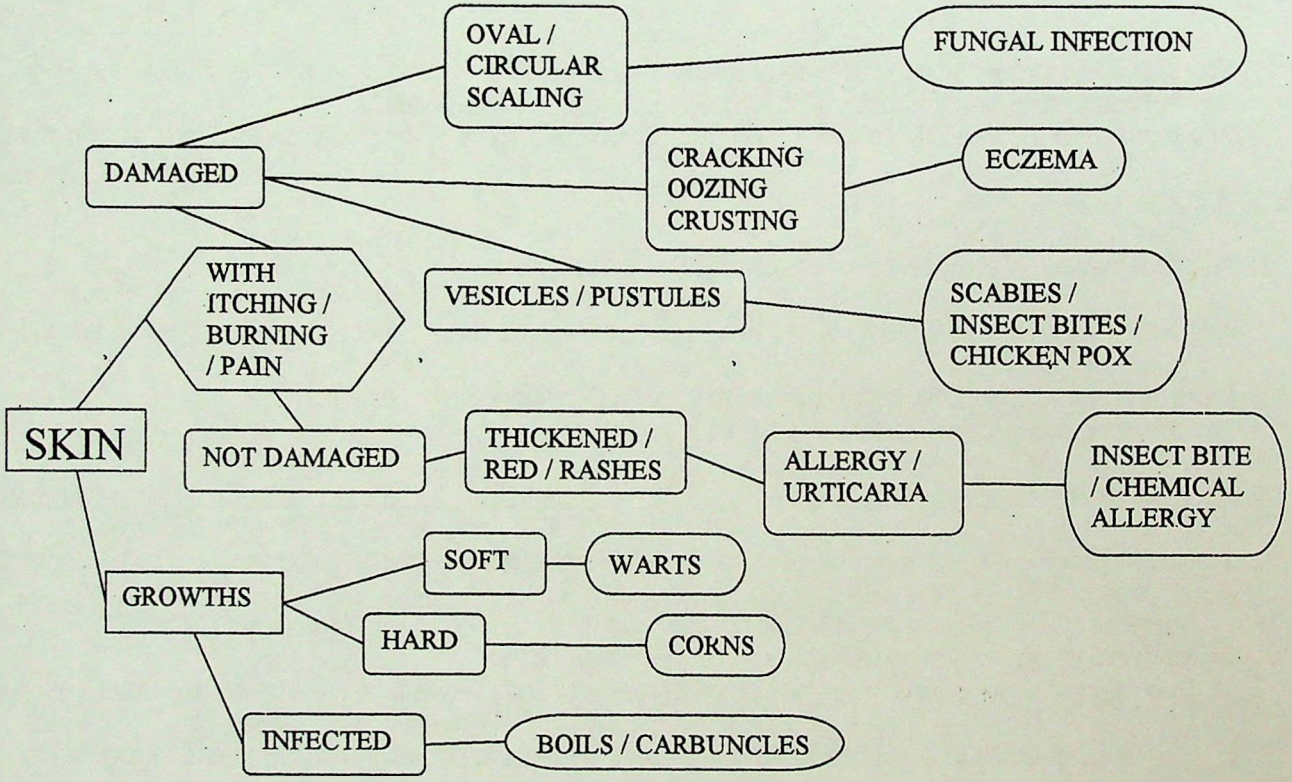
Since the disease is contagious, take precautions in food and water.
The Liver is not functioning well. So, food is not digested or absorbed. Give large quantities of water, Glucose. Sugar, and fruit juices. Mooli (moolangi) in curds with sugar helps rejuvenation of liver function, given thrice daily..
The treatment has to continue for a week or two.

Getting blood tested to ensure it is not of a dangerous variety is important.
Liver stimulants like Chiretta (Bhuvi nimb / Nelada Baevu), Kiru Nelli, Kalmegh etc., and a regulated diet with very little fat need to be continued for a month.

TOOTH, GUM PROBLEMS and MOUTH ULCERS (Bayi Hunnu)

These occur due to food particles rotting overnight in the teeth. They cause and are also the result of digestive problems. Brush teeth and wash the mouth after each meal and especially before going to bed at night.

1. Use Neem, Mango, Karanj (Honge) or Babul ltwigs to brush teeth. **- REMEDIES (K)**
2. Rinse mouth with decoction of Neem, Pipal, Banyan and Babul powdered bark.
3. The powder of the above with salt and Clove (Lavanga) makes a good tooth powder.
4. Clove oil or chewing clove reduces dental pain.
5. Applying Honey heals mouth ulcers faster.


SKIN
DAMAGED
OVAL / CIRCULAR SCALING
FUNGAL INFECTION
CRACKING OOZING CRUSTING
ECZEMA
WITH ITCHING / BURNING / PAIN
VESICLES / PUSTULES
SCABIES / INSECT BITES / CHICKEN POX
NOT DAMAGED
THICKENED / RED / RASHES
ALLERGY / URTICARIA
INSECT BITE / CHEMICAL ALLERGY
GROWTHS
SOFT
WARTS
HARD
CORNS
INFECTED
BOILS / CARBUNCLES

SKIN

The skin is the largest organ of the body. It covers and protects internal organs while maintaining body temperature through sweating and other skin structures like hair and oil glands.

Any damage to the skin affects these functions. Internal disorders of the body can also manifest on the skin.

HEALTH EDUCATION

1. Personal hygiene is essential to skin health. (Wash, Bathe, keep clean)
2. Adequate care of the skin and its structures (Hair and Nails) prevents infections. (Cut, Trim, Clean regularly)
3. Protection with clothing, footwear, gloves, etc., prevents damage from the Environment and work situations.

GENERAL TREATMENT **-REMEDIES (L)**

1. Neem (Baevu) leaves, bark and seed oil are all effective both internally and externally.Paste, Decoction, Infusion or Powder can be used.
   Turmeric (Haldi) adds to its anti-septic properties, while a pinch of salt enhances its effect.
2. Pongemia oil and leaves are effective for external application.
3. Decoction of Dhub grass (Darbe hullu) and Infusion of Tulsi leaves taken internally are used to remove internal toxins.
   Pastes of both Dhub grass and Tulsi are useful external applications.Turmeric adds to their antiseptic effect.
4. Any edible oil could form the base to preserve the properties of these preparations for long periods of time. Bees wax can be added to make ointments of the same.
5. Sandal paste with Turmeric is useful to prevent scarring.

SPECIFIC TREATMENT

INJURIES – CUTS AND ABRASIONS **- REMEDIES (M)**

Clean with soap and water / Neem leaf decoction.
Crush washed leaves of Tridax procumbens (Attike soppu) and apply locally. It acts like a tincture Iodine dressing.
Turmeric can be added to the paste.
Neem paste can be also applied.
Turmeric and Lime powder (Chuna) paste stops bleeding in wounds if one can stand the temporary burning sensation it creates.

ITCHING **- REMEDIES (N)**

Itching could be due to external or internal contact with allergens (substances that do not agree with the body and treated as ' foreign').

Use Dhub Grass / Neem decoction internally. Tulsi infusion helps.
Ajwain. Ginger. Jeera and digestive decoctions reduce allergic itching.
Use oil prepared from Neem leaves externally. (Neem leaves fried in edible oil, crushed and decanted. The neem leaf decant is also useful).

SCABIES (kajji) **- REMEDIES (O)**

Scabies is caused by the itch-mite which burrows into the skin. It is common in children when hygiene is bad, and spreads to all family members through contact, clothing and other personal items.

Take bath in water in which Neem or Guava leaves are boiled.
Apply Neem and Turmeric paste all over the body after bath on three consecutive days.
Wash all clothes, bed clothes and towels etc in hot water and ensure complete drying in the hot sun. Hot-ironing also helps.

Decoctions for itching can also be taken.

BOILS, ABSCESS, WOUNDS and BEDSORE (Kura, Keevu hunnu, Gaaya)

These are caused by bacteria, which destroy the skin and underlying tissue.
Sometimes, Fungi can also cause the problem.

Clean with Neem infusion. **- REMEDIES(P)**

Use any of the General remedies listed above.

In delayed healing and non-healing. Use any of the following:

Grated raw Papaya applied directly to the wound removes all dead material (slough) and promotes faster healing.

Juice of the touch-me-not plant promotes quick healing.

The General remedies can than be used.

Additional oral intake of Neem, Tulsi, Vacha (Baje) in Honey and nutritious food having a high protein content (sprouted grains) hastens healing.

Bedsores can be avoided by meticulous care of skin in bed ridden persons. Massage of skin with spirit(used for injections) strengthens the skin.

ECZEMA (Isubu) **- REMEDIES (Q)**

This is an inflammation of the skin due to internal or external allergy. The eczema may be wet (watery or pus discharging) or dry (crusting and peeling).These take a long time to heal and recur seasonally or on exposure to the allergen.

Pongemia (Honge/Karanji) oil application is the simplest remedy.

Also, equal parts of Neem and Mehndi (Goranti) leaves are boiled in little water till no water remains and made into a paste with Karanji oil for application.

Protection against and avoiding allergen if known is preventive.

RINGWORM (Hulakaddi) **- REMEDIES (R)**

This is cause by fungus. Locally apply -

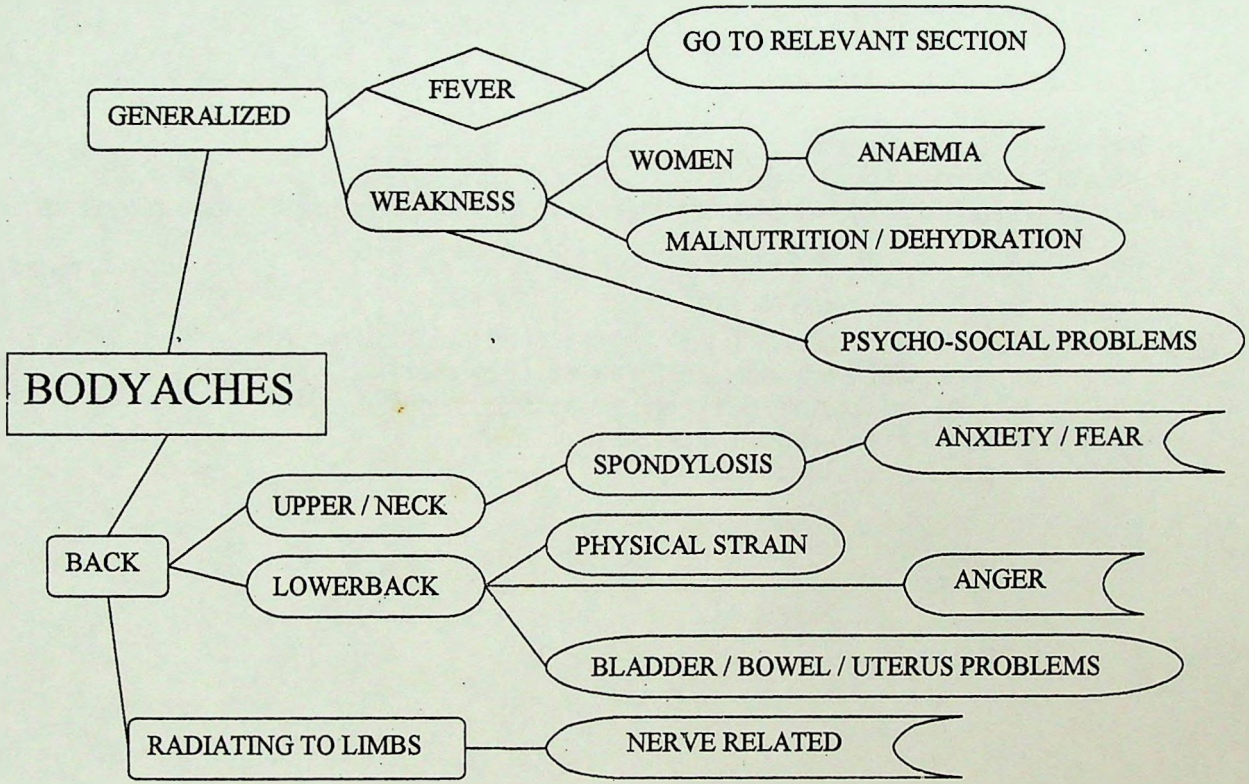
Neem leaf paste or in oil.
Mehandi leaf juice in curds.
Juice of touch-me-not plant.

Hygiene of the skin and clothing is important for cure. Avoiding dampness and wet clothing prevents it.

WARTS AND CORNS **- REMEDIES (S)**

These are caused by viruses or injury with skin thickening and take 2 to 3 weeks to heal.

Rub the corn/wart with raw ginger daily for a week or two.
Mix Lime (Chuna) and Cooking Soda in equal proportions and apply.
Apply the milky juice of Euphorbia hirta (Dudhi ghas).
Apply Aloe vera (Lole sara) juice daily.


BODYACHES
GENERALIZED
FEVER
GO TO RELEVANT SECTION
WEAKNESS
WOMEN
ANAEMIA
MALNUTRITION / DEHYDRATION
PSYCHO-SOCIAL PROBLEMS
BACK
UPPER / NECK
SPONDYLOSIS
ANXIETY / FEAR
LOWERBACK
PHYSICAL STRAIN
ANGER
BLADDER / BOWEL / UTERUS PROBLEMS
RADIATING TO LIMBS
NERVE RELATED

URINARY DISORDERS **- REMEDIES (T)**

Pain, Burning and frequency are the common problems. Rarely, stones in the Urinary tract cause problems. These are due to inadequate intake of water and excess acid being sent out.

1. Dhaniya kashayam – 1 teaspoonful in a glass water, boiled to half.
2. Jeera kashayam similarly made.
3. Banana stem juice, especially for stones.
4. One teaspoonful each of onion juice and honey.

WOMENS' DISEASES **- REMEDIES (U)**

These are related to menstruation, and the menstrual cycle, affecting the women from menarche to menopause. The major causes are Anaemia (Rakta Heenate), Malnutrition and Hygiene.

GENERAL REMEDIES

1. The bark of ASHOKA tree can be taken in any form, swaras, decoction, or arishtam.

2. Shoe flower (Dasavala) arishtam - good for all menstrual problems.
   Take sufficient number of flowers. There should be no water. Place these petals and jaggery in alternate layers in the ratio 3:2. Close container and preserve for 21 days. Strain out the juice.
   Dose : Two teaspoonfuls twice a day during periods.

3. Iron tonic – for anaemia.
   Heat half a kilo of Jaggery till it becomes a stringy liquid (Paakam).
   Into this, put one glassful of Drumstick leaf juice, and one tablespoonful each of Jeera, Saunf, and Cardamom powder. Heat till it becomes thick and is free of water.
   Dose : One teaspoonful twice daily before food.

4. Mix equal quantities of fine bark powder of Babul, Pipal and Fig tree.
   1 tsf twice daily in milk for 21 days. This regulates the cycle.

5. Remove the inner seeds, etc from Fig or Pipal fruit and take it filled with jaggery, early morning, empty stomach.

6. Take Aloe pulp with equal quantity of Jaggery, early morning on empty stomach.

HEALTH EDUCATION

The Menstrual cycle is a normal process in the life of any woman.

It can cause problems due to physical problems cited above, or, even stress of overwork, wrong postures during work and inadequate exercise and rest.

It is easily disturbed by emotional stress too.

Irregular or ineffective menstruation is mainly due to anaemia and stress. The remedies are, 1,2,3 above.

For painful menstruation and white discharge along with it, even before and after, use remedies 4,5,and 6.

For White discharge, which is mainly due to anaemia and infection, use remedies 1 to 3 above, and any of the remedies listed for Dysentery.

Local cleaning and Hygiene in case of infections can be done using Kashayam made of remedy no. 4.

In addition, those used for cleaning cuts and wounds, i.e., Neem, Turmeric etc are effective.

Education in Human Sexuality

* At this age boys and girls need to know what is biologically different about their bodies and why. Body and sexual hygiene have to be taught.

Adolescence

Adolescence is simply a transition stage from childhood to adulthood. It is a stage which all young people go through to become biologically and sexually mature. In girls it may start as early as 9 or 10 years and in boys it begins around 12 or 13 years. Adolescence is a time of rapid change in the body, emotions, attitudes, values, intellect and relationships.

Adolescent changes are triggered by hormones of the pituitary gland and the gonads. The hormones bring about the development and maintenance of the secondary sex characteristics. (See Chapter VII for changes in the male and Chapter VIII for changes in the female).

Adolescents are passionate people and are apt to be carried away by impulse. They can experience irrepressible joy or inconsolable sadness, gregariousness or loneliness, altruism or self-centredness, insatiable curiosity or boredom, confidence or self-doubt. During growing up the maximum change occurs in adolescence.

An adolescent is expected to

— become independent of his/her parents;
— establish a new social and working relationship with peers of both sexes as well as with adults;
— adjust to sexual maturity and changing roles;
— decide on future goals;
— prepare for responsible citizenship;
— develop a philosophy of life with moral beliefs and standards;
— develop his/her own sense of identity.

According to Eric Erikson, 'Before the adolescent can successfully abandon the security of childhood, and dependence on others, he must have some idea of who he is, where he is going and what the possibilities are of getting there'.

The transition can be stormy or calm. A great deal depends on the groundwork laid in preparation for this change. During the early developmental years the child is guided mostly by parents and teachers. The rapport that they build up during these years will help the relationship during adolescence. The adolescent stage spans over almost ten years, so it is divided into two sub-stages: Early and Late Adolescence.

D. Early Adolescence (9 – 14 Years of Age)

General Traits

* This is a period of rapid physical growth for females with development of the primary and secondary sex characteristics along with maturation of reproductive functioning. The physical growth of boys begins a couple of years later.

* Dramatic physiological changes occur like the menarche in females and nocturnal emissions in males.

* Adolescent growth spurt occurs. If nutrition and health care are adequate, they attain adult height and sexual maturity earlier than in previous generations.

* Wide variations in height and development are typical of this stage within individuals of the

same sex. The rate of growth varies — for some it is rapid and for others slow.

* The levels of maturity of females and males vary greatly.

* Both girls and boys develop strong affections ('crushes') for a person

  a. of the same sex,
  b. who is an achiever or a leader in their eyes,
  c. who may be of their age or older.

* Rapid body changes affect the self-concept and the personality of the young adolescent.

* At times, body growth is uneven leading to awkwardness. During this period youngsters either learn to accept their bodies or to dislike them and this has implications on their sexual adjustment in later life.

Behaviour Patterns

The behaviour of boys and girls varies greatly. It also varies among individuals of the same sex. This is due to the wide variations in physical development of adolescents in this age group.

* Both boys and girls feel awkward and self-conscious.

* Girls are anxious about menstruation, pimples, breast size and general appearance.

* Boys are anxious about their height, beard, pimples, voice break, penis size and nocturnal emissions.

* Both boys and girls spend a lot of time looking in the mirror, dressing up, and trying to make themselves attractive to the opposite sex.

* Since girls develop earlier than boys, they seek the attention of older boys and form more social relationships than boys of the same age.

* Both boys and girls question authority, become more assertive and yet are very dependent on adults.

* Adolescents can detect what will irritate their parents and teachers and so deliberately adopt that behaviour. This could include

  a messy room,
  sloppy dressing,
  rude behaviour,
  profane language,
  loud music,
  incessant talking on phones,
  avoiding homework and housework.

How Adults Can Cope With Adolescents

Adults must understand that teenagers have tremendous tasks to cope with within a short time. Too many things are happening at once. There are growth spurts, new feelings and needs, social awkwardness and painful self-consciousness. Teenagers require a lot of space or else their clumsiness may result in spilling drinks, knocking over stools, or bumping into people. They are self-conscious about pimples, teeth, body shape, their hair, etc. Even if they do not acknowledge it, teenagers need the help of adults i.e parents and teachers.

This is a difficult time for adolescents and a very trying one for adults. It is, however, a natural phase which all adolescents pass through, and it can be made less stressful and confusing if the adults are clear about what they should do and how they should go about it. In dealing with adolescents, parents and teachers should :

— Understand and accept this phase.
— Accept the restlessness and discontent of adolescence.
— Allow the adolescent to be independent.
— Allow the adolescent to make his/her own decisions and overlook his/her mistakes if any.
— Support the adolescent by placing trust and confidence in him/her and by recognising that he/she can make sound judgments.
— Avoid scolding and labelling the adolescent in front of friends; provide positive suggestions and praise.
— Avoid correcting the adolescent all the time.
— Avoid needless criticism as adolescents are not sure of themselves and need adult understanding; criticise the specific act under question and

not the person.
— Avoid preaching and saying: 'I told you so', or 'It serves you right.'
— Clearly express their own values to the adolescent.
— Avoid invading the adolescent's privacy.
— Avoid giving conflicting messages; state clearly 'Yes' or 'No' or 'It is your choice' and give justification for the answer.
— Clarify rules and expectations regarding homework, chores, responsibilities, hours to come home, etc.
— Develop good relations with adolescents by being flexible and rethinking on some issues that may need change.
— Keep all communication doors open.
— Shower continuous love and affection on the adolescent.

Value Building

Values that are to be built up are common to both the early and late adolescent stage and are hence taken up together in the age group 14 to 19 years.

Education in Human Sexuality

* The anatomy, physiology and functions of the reproductive organs in the male and in the female should be dealt with in detail.
* Boys and girls should be prepared for the onset of puberty.
* Hygiene of the genitals, body odour, pimples, nutrition and exercise should be dealt with.
* Myths and misconceptions should be clarified.

E. Late Adolescence (14 – 19 Years of Age)

General Traits

* This is a period of rapid physical growth for boys with development of the primary and secondary sex characteristics along with maturation of reproductive functioning.
* Girls at the beginning of this stage are taller than boys. However, the boys outstrip the girls by the end of this stage.
* The needs and urges of an adolescent are sexually oriented.
* Emotional changes are dramatic and are characterised by mood swings.
* The need to be independent and assertive on the one hand and to build up relationships and establish themselves socially on the other intensifies.
* They are preoccupied with themselves and they have the notion that other people's thoughts are focused on them.
* They want to identify with a peer group, and peers exert a strong influence on each other.
* They are anxious about their educational and vocational goals.

Behaviour Patterns

* Teenagers are establishing their own personal identities. They have to free themselves from childhood ties with parents and find their own personalities.
* Their emotions are strong and fluctuating.
* They can be angry, aggressive and rebellious. They question authority and break rules.
* Boys tend to be boisterous and show off their muscle power or use foul language.
* Little things about their appearance, work or relationships with the opposite sex can make adolescents very happy or very sad. If they do not have much support at home or at school, their sadness can result in depression. Chronic

depression may lead to suicidal behaviour.

* Boys are awkward and clumsy. They are concerned about their body image. They are anxious about their height, muscles, body hair, voice change, size of genitals, erection and ejaculation.

* Delinquent behaviour is quite common at this stage and can lead to antisocial or criminal activities. These may include destroying school or public property, thieving more for excitement than a need for the item robbed, driving rashly and causing accidents, or forming gangs and challenging each other. Boys feel a strong need to prove their masculinity.

* Sex-related behaviour can also take extreme forms. Shy individuals may avoid any form of boy-girl relationships. Others may indulge in eve-teasing and flirting.

* Sexual urges may result in masturbation, viewing of pornographic material (magazines, blue films etc.) or visiting commercial sex workers.

* Teenagers, especially boys, are active in sports and they play aggressively.

* Experimentation is common at this stage. Peers encourage and sometimes force their friends to try out smoking, drinking alcohol, using drugs, and having sex.

* Adolescents display different behaviour with adults and with their peers. When with adults on a one-to-one basis, they are more reasonable, understanding, and willing to cooperate. But when they are in peer groups they are entirely different and are quite the opposite.

* Those brought up in families with strong ties, firm values and a good support system may not always exhibit strong negative behaviour patterns. But adolescents from broken homes, with parents who are disturbed, or who are addicted to alcohol or drugs, or who give their children plenty of money but no time, may be more likely to exhibit strong negative behaviour patterns.

* Ragging is something that can start off as teasing, having fun, friendly leg-pulling, but can lead to extremes if it does not stop there. An individual or a group can make a victim's life miserable by persistent ragging or extreme physical and mental torture. Many victims have not been able to cope with the embarrassment, humiliation and torture to which they are subjected. To escape this cruelty some have even been known to commit suicide. Sometimes the ragging itself can lead to death. It is unfortunate that many members of the group may realise that ragging has gone beyond limits and may feel sorry for the victim but do not have the courage to stop the ragging or to appeal to those involved.

How Adolescents Cope

Adults who want to help adolescents to cope with their changing emotions or situations leading to negative emotions and to help build up their self-confidence, should understand the difficulties of adolescents and guide them through their growing years.

1. Coping with emotions or situations leading to negative emotions

(a) *Anger*: Anger can come on suddenly or can be built up because each incident that added to the anger was not resolved at the time. If anger flares up suddenly it is worthwhile to control it and take stock of

* personal feelings;

* what needs to be done to diffuse the anger and not spoil relationships;

* ways of avoiding the situation that caused the anger.

It is not wrong to feel angry but the expression of anger should not hurt anyone. Therefore, while ventilating anger:

* Do not use abusive language which will insult or demean a person or his/her background.

* Do not attack the person physically or verbally; instead address the issue that has brought on the anger.

* Deal with the situation and forget it. Do not carry over anger or bear a grudge. This is not good for relationships.

* Take deep, slow breaths.

* Withdraw from the situation temporarily if possible and take time to cool down.

* Talk about the situation to a non-involved, objective person, or write down your feelings in a diary.

* Look at the situation from the viewpoint of the person who brought on the anger.

* Send a letter to the person explaining how you feel.

(b) *Rejection* : Rejection from a peer group is not easy to handle and may leave the adolescent feeling very low and depressed. The adolescent can cope with rejection by:

* introspecting and rationalising;

* not compromising on values;

* talking to friends, elders or the person who is rejecting him/her;

* looking for people or areas where one is accepted and appreciated.

(c) *Failure* : To achieve, to succeed, and to be admired by members of the peer group is a desire of all adolescents. Some feel hopeless or even depressed when they fail or reach any place other than the first. Some highly motivated achievers are poor losers.

Failure can occur in :

* athletics, sports, any competitive event;

* academics or careers;

* relationships with friends, parents, loved ones;

* falling in one's self-expectations.

To cope with failures one has to :

* Analyse the reasons for failure.

* Accept failure as a natural part of life and not personalise it.

* Set realistic goals.

* Achieve these goals by setting a motivation plan by oneself or with the help of people that matter.

(d) *Ridicule or 'Put-downs'*: 'Put-downs' are words or body language used to hurt, embarrass, belittle, tease, or rag someone and make him/her feel bad. Calling names that are racist, casteist or sexist are often used as 'put-downs'. 'Put-downs' are used by peers to exert negative pressure on individuals. They are also used on a weaker or a quieter member of the group to derive pleasure and power.

Adolescents can respond to ridicule in a positive or a negative way. Sometimes a negative response can work. Figure 6.1 gives these responses.

(e) *Conflicts* : Conflict simply means fight, struggle or hostility. Conflicts occur when:

* People view things differently regarding expectations, goals, male/female roles, etc.

* Priorities of values differ;

* Self-esteem or status is threatened.

* Personalities clash.

Common areas of conflict between adolescents and adults, especially parents, are:

— keeping in tune with current fashion
— sexuality behaviour
— personal expenses
— religion
— interpersonal relationships
— choice of a career

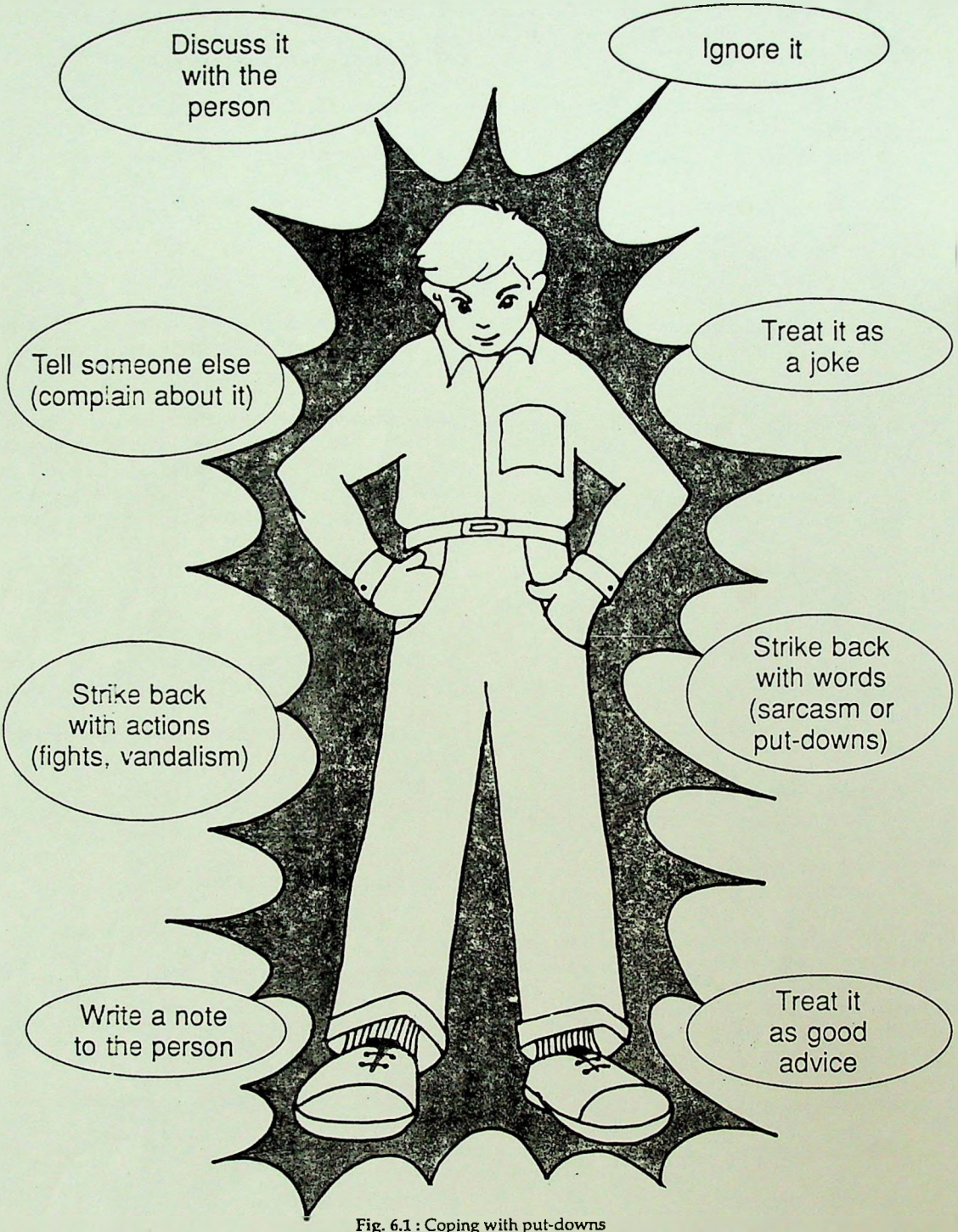


Fig. 6.1 : Coping with put-downs

— general freedom.

Conflicts have to be resolved or they can ruin relationships. They may be resolved by talking, rationalising, compromising, rearranging priorities, or accepting the situation.

(f) *Stress and anxiety* : Stress and anxiety are inevitable when people are faced with the demands of living. A certain amount of stress is necessary for an individual to function adequately. But when the stress exceeds a person's coping capacity it has adverse effects.

Adolescents face much stress because of the inescapable physical and psychological changes they are undergoing.

Coping with stress would need

* Maintaining good physical and mental health.
* Developing a good sense of humour and having fun.
* Developing a positive outlook on life.

(g) *Depression and suicide* : Depression is a state of extreme dejection, a mood of hopelessness, a feeling of inadequacy often accompanied by lack of vitality, vigour or spirit. It leads to lack of interest in normal activities such as eating, sex, work, friends, hobbies, or entertainment. There may be loss of weight, insomnia, an agitated or retarded state of mind, decreased sex drive, fatigue, feelings of self-reproach, and inability to think or concentrate.

Continued depression can lead to thoughts of death and suicide.

Depression is caused by a combination of factors i.e. inability to cope with anger, rejection, failure, stress, anxiety along with low self-esteem and a lack of social support.

People who are contemplating suicide can STOP and help themselves by:

* Stopping self-pity—there are others far worse off than themselves.
* Talking to friends or to The Samaritans Hot Line in Mumbai—a 24-hour service is available at Telephone Nos. (022) 309 20 68 and (022) 307 34 51.
* Thinking positive — taking stock of all the good things that happened in their lives or that life has to offer them.
* Not being alone — having people around them.

Reasons for not expressing emotions : While it is natural for people and especially adolescents to express their emotions, socially their upbringing may prevent them from doing so.

(a) *Social rules* : In our society the unwritten rules of communication discourages the direct expression of most emotions.

'Don't get angry'

'There's nothing to worry about'

'Control yourself, don't get excited'

'For heaven's sake, don't cry'

(b) *Social roles* : The expression of emotions is initiated by the requirements of social roles.

* *Salespersons* must smile no matter how obnoxious the customer.
* *Mothers* have to love their child.
* *Teachers* are paragons of rationality.
* *Sex-role stereotypes* discourage people from freely expressing certain emotions —

Men don't cry, are rational, are aggressive.

Women are prone to tears, are irrational, intuitive, and submissive.

(c) *Inability to recognise emotions* : The capacity to recognise and act on certain emotions decreases

without practice. If one has suppressed anger, love, or other emotions, then expressing and responding to these emotions becomes difficult.

(d) *Fear of self-disclosure* : The expression of feelings makes emotional self-disclosure risky. There is always a chance that emotional honesty could be used against one either out of cruelty or thoughtlessness.

2. Building up self-confidence

Building up confidence in one's own abilities can help adolescents to cope with their changing experiences. Confidence can be built up by :

* Developing self-esteem;
* Developing decision-making skills;
* Resisting negative peer pressure.

(a) *Developing self-esteem* : Self-esteem is how one feels about oneself.

High self-esteem means:

* Believing in oneself
* Accepting one's weaknesses and strengths
* Respecting and liking oneself and others
* Trusting oneself
* Making one's decisions based on what one feels is right for oneself.

Low self-esteem means:

* Lacking self-confidence
* Being unable to accept oneself
* Not respecting or liking oneself and others
* Distrusting oneself
* Letting others make one's decisions as one feels that what others think is more important.

To boost one's self-esteem :

* It is good to *examine one's values*. The values one believes in and which one acts upon should not be different. Hence, self-respect and honesty are very important.
* It is essential to *make time* for reflecting on one's thoughts and feelings. Pursuing enjoyable activities and interests help.
* It is necessary to *set realistic goals* for oneself. Goals should neither be too high nor too low. Planning goals from today to the next month, to the future helps in achieving them. Putting down these goals on paper with a reasonable time frame, circling them or scoring them off as they are achieved, and displaying this sheet in a prominent place will remind one of what one hopes to do.
* It is an asset to develop one's abilities to the fullest and thereby *take pride in oneself* and in one's work.

(b) *Decision-making* : Everyday living requires the making of decisions. The quality and appropriateness of such decisions can affect an individual's well being.

Examples of decisions requiring a great deal of thought:

— Should I smoke?
— What career should I pursue?
— Should I take drugs?
— Should I have sex?

Examples of decisions that do not require a great deal of thought :

— Can I skip breakfast?
— Should I go to a movie?
— Should I have a haircut today?
— Do I take a train or a bus?

Factors that influence decision-making are :

* *Values*
  — What is right for me?
  — Which is more important of the two?

* *Goals*
  — Where do I want to go?
  — Will the consequences fit into my plan?

* *Needs/Wants*
  — Do my wants conflict with my needs?

* *Standards/Expectations*
  — Will it fit into my culture?
  — Will it meet the expectations of people I care about?
  — How will it affect the people among whom I live?
  — Do I want to live up to these expectations?

* *Resources*
  — Do I have enough money, time, physical, mental or psychological capabilities?

* *Lifestyle*
  — Will it fit into my lifestyle?
  — Will it change my lifestyle?
  — Do I want to change my lifestyle?
  — Can I change it?

* *Life stage*
  — Does it fit my stage in life?
  — Am I too young, too old?
  — Does my economic situation support it?

Steps in decision-making :

* Identify the problem.

* Gather information about the situation.

* Weigh the alternatives.

* Think about the possible consequences.

* Review one's values.

* Make a decision i.e. choose the best alternative.

* Announce the decision made and the justification for making it clearly to those involved including the person(s) who may be responsible for creating the problem. Do this boldly and confidently.

* Stick to the decision with conviction.

(c) *Resisting negative peer pressure* : Peer pressure occurs when one's peers, i.e. people of about the same age, try to influence how one thinks or acts. Peer pressures can be good or bad. Either of these can influence one's judgment and actions.

Positive peer pressures cause one to :

— participate in school activities (sports, plays).
— achieve goals (good grades, a good job).
— keep the body healthy.

Negative peer pressures cause one to :

— use alcohol or other drugs.
— skip school or classes.
— vandalise property.
— have sex.
— disobey parents.
— pick on people for ragging, eve teasing, or other antisocial acts.

Negative peer pressures can be very damaging both emotionally and physically. The need to belong to a peer group is so strong in adolescents that they succumb to the influences and pressures of their peers.

Some commonly used techniques for exerting negative peer pressures are:

— using coercion
— using deception
— giving wrong or partial information
— using bribes
— taking bets and challenges
— gross lying
— personal rejection
— using faulty logic
— stressing positive aspects of a particular act and glossing over the negative
— using put-downs
— criticising, 'you are old fashioned', 'you are a sissy'.

How to handle peer pressure:

* Adolescents should know themselves and should be clear about their values.
* Adolescents should know how to make their

own decisions.

* Adolescents should learn to say 'NO' to peer pressure.

When one says 'NO' to peer pressure regarding harmful behaviour, one usually :

— feels good about oneself; one's self-confidence and self-esteem increase;
— gains the respect of others;
— stays out of trouble.

At this stage of their lives, adolescents start forming their opinions about themselves, their peers, and their own parents and comparing them. If they find that their parents are lacking in certain qualities or have double standards, they may either be bold enough to criticise their parents and turn to their peers; or they may suppress their own opinions. This can cause conflict in their minds.

3. Boy – girl relationships

Studies show that adolescents want and seek guidance on how to develop a friendship with a member of the opposite sex. Many young people hesitate to develop a friendship with a member of the opposite sex for fear of being misunderstood or rejected.

Why does developing a friendship with a member of the opposite sex become difficult? This is due to :

— lack of the necessary interpersonal skills;
— ignorance about different facets of sexual attraction;
— social taboo on fearless and free mixing;
— a misconception that friendship necessarily implies a desire for cohabitation.

In a boy-girl relationship, as in any other relationship, it is important to :

* Communicate honestly and clearly to the partner.

* Be positive in outlook.

* Take interest in the partner's activities, lifestyle and background.

* Take responsibility for one's decisions and actions.

* Keep a sense of humour.

* Listen carefully to what the partner is saying.

* Refuse to compromise on one's values regarding sex, experimentation, family or self.

A boy–girl relationship is most often accompanied by *sexual attraction*. The sex drive can be at a

— mental level (thought, fantasies, dreams)
— physical level (sexual urges).

Individuals who get sexually attracted send *signals through non-verbal behaviour* such as :

— touching
— facial expression
— tone of voice (not words)
— distance
— posture
— rate of speech
— number of errors (due to embarrassment or anxiety).

The sex drive can lead to *physical contact*. This may involve mild body contacts (touching, brushing, holding hands, kissing on cheek or forehead); or heavy body contacts (petting, fondling, stimulating genital areas, or intercourse).

Boy–girl relationships may experience momentary sexual attractions. The danger is of premature sexual involvement which culminates in sexual intercourse leading to a possible unwanted pregnancy.

Another issue young people should be aware of is peer pressure and insistence in sexual matters. Some boys and girls have been egged on by their friends to experiment with sex. Such pressures should not be succumbed to when they conflict with one's own values.

A mature boy–girl relationship is possible if the youngsters

* develop healthy attitudes to sex;
* develop respect and healthy attitudes towards members of the opposite sex;
* realise that love is partnership and not ownership;
* know that it is wrong to treat persons as sex objects.

Some principles and restrictions on sexual behaviour : Sexual behaviour must *not* include coercion or deception.

No coercion such as :

* Using one's authority to compel the subordinate in an institution or work situation.
* Taking advantage of a person's poverty, helplessness, weakness.
* Blackmailing.
* Asking for sexual favours in exchange for 'friendship' or assistance.

No deception such as :

* Enticing a person into sex through false promises, marriage, for example.
* Pretending to be pregnant in order to entrap a boy into marriage.

Free Sex : Premarital sex is on the increase in urban colleges.

Arguments in favour of free sex are :

* There is love.
* There is no coercion or deception.
* There is mutual consent.
* There is an understanding about breaking up at will.
* There is a will to take responsibility for the consequences.

Disadvantages of free sex :

* Sex is a physical and an emotional involvement. Both are important in a satisfying relationship. If one person cares more than the other, then the separation will cause a great deal of pain and hurt feelings.
* One can get involved with a married person, leading to secrecy, deceit, conflicts, demands and tensions.
* Pregnancy can lead to motherhood at an immature age.
* Abortions can lead to health risks and psychological strain (See Chapter XIII on Abortion).
* STD and HIV/AIDS infection can be health risks (See Chapter XVI on Sexually Transmitted Diseases and Chapter XVII on HIV/AIDS).
* It may have an effect later on in marriage owing to
  — lack of virginity
  — unfulfilled expectations.

Ingredients of a relationship :

A *mature relationship* can be characterised by caring, sharing, mutual respect, accepting highs and lows, accepting strengths and weaknesses, communicating without reservation, understanding, taking responsibility.

An *immature relationship* is emotional, demanding and is characterised by more taking than giving, smiling when pleased, tantrums when things do not go as desired, holding back communication, complaining, lying, scheming.

4. Hurdles in development

Adolescents are surrounded by influences and temptations detrimental to their physical and emo-

tional well being. They get attracted to or get coerced into smoking, drinking alcohol, and drug abuse. The media and negative peer pressures adversely affect adolescents who become vulnerable to these habits.

(a) Smoking

Smoking is considered as a status symbol and a sign of virility. It is a habit that can develop easily and is hard to break. Smoking is injurious to health; it affects the respiratory tract, causes throat irritation, and eventually cancer of the lungs/throat and heart attacks.

Adolescents must learn to say 'NO' to peer pressures that encourage smoking. It is better not to start the habit. More and more adults are giving up smoking. Public and private offices, public transport systems, etc. have 'No' Smoking signs. Public awareness regarding smoking is now spreading.

If smoking has become a habit then a few substitutes may help break it. Habitual smokers can substitute a cigarette by chewing gum or a sweet. A pencil held between two fingers in place of a cigarette may help.

The following suggestions may help a heavy smoker to cut down the number of cigarettes he smokes daily.

* Do not buy a pack of cigarettes.
* Do not light a cigarette from another person's lit cigarette.
* Do not carry a lighter or a match box.
* Have a puff or two of a cigarette and throw away the rest.
* Cut a cigarette into half and smoke that. This way two cigarettes smoked will seem like four.

Effects of heavy smoking on sexual and reproductive health :

* There is a strong indication that heavy smoking reduces the sperm count in males. This can lead to infertility.
* In some cases men show a reduced sex drive.
* Nicotine causes the blood vessels to constrict in both men and women thereby interfering with the sex response.
* Women who smoke heavily during pregnancy are liable to give birth to babies with lighter weight than normal.

(b) Alcohol

Why do teenagers drink?

* It represents for them
  — a symbol of adulthood
  — a defiance of authority
  — a declaration of virility
  — a sign of being one with the group.
* It is readily available.
* It is relatively inexpensive as compared to drugs.
* It is seemingly safe.
* It starts as social drinking and becomes a compulsion.
* It helps escape from problems.

Prevention : The personality and character of young people needs strengthening by developing self-esteem and decision-making skills. It is necessary to teach the young to resist negative peer pressures.

All effects of habitual or excessive drinking should be discussed in detail with them.

An ancient Hebrew legend tells the difference between moderate and irresponsible drinking. When Noah planted grape vines, Satan revealed to him the possible effects of alcohol. He slaughtered a lamb, a lion, an ape, and a pig. He explained: 'The first cup of wine will make you mild like a lamb; the second will make you feel brave like a

lion; the third will make you act like an ape; and the fourth will make you wallow in the mud like a pig.' (Ginott, 1969, p.190)

Adolescents who decide to drink must learn to handle themselves.

* They should know when they have had enough, that is they should know their limit.

* They should sip the drink slowly and not gulp it down. One glass of drink should last as long as possible. They should discourage refills. They should not get into competitive drinking.

* They should not drive when intoxicated. Many teenagers have been responsible for accidents due to drunken driving.

* They should not make fools of themselves. If they are high and are losing control of their body balance and senses, they should retire quietly.

Effects of alcohol on sexual and reproductive health and family life : The effect of alcohol consumption will vary from individual to individual. Each individual will have to find out for herself/himself what amount of alcohol will be a small dose and what amount will be excess.

* Small amounts of alcohol help one to
  — relax;
  — overcome fear or anxiety;
  — reduce inhibitions.

* Excess alcohol acts as a depressant on the central nervous system
  — concentration and judgment are impaired;
  — caution and inhibitions are reduced;
  — self-control is lessened;
  — senses are dulled;
  — sensitivity to pain is reduced when alcohol is consumed in large quantities.

* Large doses of alcohol leading to addiction

  — causes inability to have an erection. Unfortunately with the first problem of sexual failure, the man's virility is questioned; this causes great anxiety to the man.
  — causes sex crimes including rape and incest.
  — results in unwanted pregnancies and STD due to impaired judgment and not using contraceptives.

* Alcoholics suffer a disruption of normal sex life. Constant heavy drinking will cause the liver to overproduce an enzyme that destroys the male hormone testosterone. This may lead to impotence and infertility. In women, it causes premature menopause. It may also cause excessive menstrual and inter-menstrual bleeding.

* Domestic disharmony is often the result of excessive drinking by one of the partners. The children of such parents are affected due to constant exposure to quarrelling at home by the parents. Children are physically abused and many of them find it difficult to grow into healthy adults.

Can a person addicted to alcohol get help?

Yes, provided the person is willing and determined to give up the habit.

Medical assistance and psychological counselling are available at the centres mentioned in Appendix 4. Alcoholics Anonymous gives help through group therapy.

(c) Drug abuse

Drug abuse is a serious problem with adolescents. Drug awareness is very essential.

The drugs prescribed by doctors are of medical necessity. The use of drugs that are not medically required is considered as drug abuse.

The drugs considered here include marijuana (grass, pot, ganja), sedatives (barbiturates, valium), stimulants (amphetamines, cocaine), opiates (opium, pethidine, morphine, heroin, fortwin). A common characteristic shared by these drugs is the potential for habituation and addiction.

Adolescence is a phase where a great deal of ex-

perimenting takes place. Adolescents have a responsibility to decide whether or not to take drugs.

To exercise this responsibility they should be able to evaluate all the facts related to the use of drugs and explore some of the myths connected with drugs.

Some Facts :

* All the abovementioned drugs have a potential for addiction.
* All of them will seriously affect one's physical and mental health.
* The chances are that one will progress from drug to drug usually to more potent and hazardous ones.
* Their use, even occasional, is likely to get one into trouble at home, with authorities, and with society at large.
* When under the influence of drugs there is a possibility that one may indulge in hazardous activities which one would normally have avoided e.g. driving dangerously, visiting prostitutes etc.
* Most of these drugs are expensive and often beyond the means of a teenager.
* Continued abuse of these drugs can lead to all sorts of problems in school or college and in relationships with friends, teachers, and relatives.
* Continuing to use drugs requires a steady stream of money. It is well known that users often end up indulging in other antisocial behaviour such as stealing, prostitution, or even murder in order to procure money for buying drugs.

Young people should know that the following statements ARE NOT TRUE :

* Only those with significant personal or family problems can get addicted.
* Drugs give one courage to face unpleasant situations and improve mental and physical performance.
* Experimental and occasional use does not lead to addiction.

On the contrary, some drugs can be so dangerous that even one exposure may lead to addiction or even mental derangement or physical illness.

Table VI-A presents some of the commonly used drugs and the effects they have on individuals.

It is important for one to be able to recognise a drug user, as well as a drug pusher. This is necessary to avoid being 'accidentally' introduced to the habit without one's knowledge.

Some users are dull and drowsy for no apparent reason, they do poorly at work and frequently have a poor social reputation. Others may put up a facade of bravado thereby giving the impression of being 'grown up'.

Pushers are those who sell these drugs and, as one can surmise, they have a lot to gain economically by inducting a new user. They have been known to use all kinds of means, fair and foul, to go to places where young people collect and to sell their drugs. Adolescents should report such pushers to their authorities so that these criminal and socially destructive activities are curbed.

Effects of drugs on sexual and reproductive health: Different drugs have different effects on individuals depending upon the amount taken, how it is taken, and how often it is taken. The effects of some of these drugs on the sexual and reproductive health of individuals are mentioned here.

Amphetamines : High doses of amphetamines taken by intravenous injection, lead to sexual problems. Men have difficulty in achieving and maintaining an erection and in achieving an orgasm. Women often have no orgasm.

Barbiturates : Large doses of barbiturates depress the nervous system whereby the sexual ability is

reduced and sexual activity is sharply diminished.

Heroin : Heroin addicts prefer isolation, their sexual desire or drive is low. Their sensory stimulation is also low. In women addicts, it causes cessation of menstruation, cessation of ovulation and sterility. If women do get pregnant, their babies are born addicted and require medical treatment.

LSD (Lysergic Acid Diethylamide) : LSD is a hallucinogen : the addicts have distortions of reality and report a wide range of sexual activity whilst crouched in a corner or lying immobile. LSD taken during pregnancy enters the placenta and can harm the developing baby.

Marijuana : Marijuana causes damage to the reproductive system. Women addicted to marijuana have been known to show menstrual irregularities. Infertility, and perhaps sterility, can also occur.

Spanish fly : This is not an aphrodisiac as is commonly believed. In fact it is poisonous. It produces urogenital irritation which indirectly causes an erection in males and vaginal lubrication in females. Spanish fly does not produce erotic or sexual interest. Large doses lead to stomach pain, disturbances in urinating, damage to kidneys or bladder and in extreme cases even death.

Can a person hooked on drugs get help? Yes, it is possible to get off the habit. It is difficult with some of the drugs but with persistence and determination it is possible.

* Admit that you have a problem.
* Talk to your parents, teachers or other adults whom you trust and ask for their help.
* Medical and psychological help is available at local drug addiction centres. Locate such a centre for help
* Persevere with the course of treatment advocated.

The best way to stop the problem is not to start on drugs but to know the facts and learn to say 'NO'.

(d) Media fantasies

Fantasies to some extent are normal and all adolescents indulge in them.

For some adolescents Indian heroes and heroines from the cinema become role models. These film characters are stereotypical and are far removed from reality. Adolescents who try to emulate them or who long for a relationship with a person that fits these roles are in for disappointment. Many young married people have been disillusioned when their partner has not matched up to their 'filmi' ideal.

Many films depict the macho image in their heroes making them aggressive and taking advantage of females. Females are shown to appreciate their roles. In real life situations, boys emulate the 'filmi' heroes often leading to threatening situations for the girls.

5. Dangers associated with sex

Sexual abuse, STD and HIV/AIDS are dealt with in detail in Chapters XV, XVI and XVII respectively. Unplanned and unintended pregnancies are taken up in Chapter XIII on Abortion.

How Adults Can Cope with Adolescents

Guidance from caring adults is essential. Such guidance helps youngsters to maintain order in their lives during this period of rapid change. No matter how adults feel — anxious, ashamed, afraid — about adolescents, they have a duty to provide them with knowledge, protection and support.

The help given to the adolescent must be subtle and diplomatic.

* Give helpful criticism — address the event; do not attack the person.
* Have a problem-solving approach. Weigh the pros and cons of the problem/situation with adolescents and help them solve their problems.

Table VI-A : COMMON DRUGS—SYMPTOMS OF ABUSE

Type of drug	*Drug name*	*Street names*	*Methods of use*	*Symptoms of use*	*Hazards of use*
Marijuana **Hashish**		Pot, Grass, Reefer, Weed, Colombian hash, Hash oil, Sinsemilla, Joint, Chiba, Herb, Spliff	Most often smoked, can also be swallowed in solid form	Sweet, burnt odour Neglect of appearance Loss of interest, motivation Possible weight change	Impaired memory perception Interference with psychological maturation Possible damage to lungs, heart, reproduction, and immune systems Psychological dependence
Cocaine		Coke, Snow, Toot, White lady, Blow, Rock CRACK	Most often smoked or inhaled; also injected or swallowed in powder, pill or rock form	Restlessness, anxiety Intense, short-term high followed by depression	Intense psychological dependence Sleeplessness, anxiety Nasal passage damage Lung damage Death from overdose
Stimulants Drugs that stimulate the central nervous system *Includes look-alike drugs that contain caffeine, phenylpropanolamine (PBA) & ephedrine	Amphetamines* Dextroamphetamine Methamphetamine	Speed, Uppers, Pep pills, Bennies, Dexies, Moth, Crystal, Black beauties	Swallowed in pill or capsule form, or injected into veins	Excess activity Irritability, nervousness Mood swings Needle marks	Loss of appetite Hallucinations, paranoia Convulsions, coma Brain damage Death from overdose
	Nicotine	Coffin nail, Butt, Smoke	Found in cigarettes, cigars, pipe and chewing tobacco	Smell of tobacco High carbon monoxide levels Stained teeth Yellow fingers	Cancers of the lung, throat, mouth, oesophagus Heart disease, emphysema
Depressants Drugs that slow down the central nervous system	Barbiturates Pentobarbital Secobarbital Amobarbital	Barbs, Downers, Yellow jackets, Red devils, Blue devils	Swallowed in pill form or injected into veins	Drowsiness Confusion Impaired judgment Slurred speech Needle marks Constricted pupils	Infection Addiction with severe withdrawal symptoms Loss of appetite Death from overdose Nausea
	Quaalude Sopor	Ludes Soapers	Swallowed in pill form	Impaired judgment and performance Drowsiness Slurred speech	Death from overdose Injury or death from car accidents : severe interaction with alcohol

Narcotics Natural or synthetic drugs that contain or resemble opium	Dilaudid Percodan Demerol Methadone		Swallowed in pill or liquid form, injected	Drowsiness Lethargy	Addiction with severe withdrawal symptoms Loss of appetite Death from overdose
	Codeine	School boy	Swallowed in pill or liquid form		
	Morphine Heroin		Injected into veins, smoked	Needle marks	
Hallucinogens Drugs that alter perceptions of reality	PCP (Phencyclidine)	Angel dust, Killer hog weed, Supergrass, PeaCee Pill	Most often smoked can also be inhaled, (snorted), injected or swallowed in tablets	Slurred speech blurred vision, incoordination Confusion, agitation Aggression	Anxiety depression Impaired memory perception Death from accidents Death from overdose
	LSD	Acid, Cubes, Purple haze	Usually swallowed	Dilated pupils Illusions, hallucinations Mood swings	Breaks from reality Emotional breakdown Flashback
	Mescaline Psilocybin	Mesc cactus Magic mushrooms	Usually swallowed in their natural form		
Alcohol		Booze, Hooch, Juice, Brew	Swallowed in liquid form	Impaired muscle coordination, judgment	Heart & liver damage Death from overdose and accidents Addiction
Inhalants Substances abused by sniffing	Gasoline Airplane glue Paint thinner Dry cleaner fluid		Inhaled or sniffed, often with use of paper or plastic bag or rag	Poor motor coordination Impaired vision, memory and thought	High risk of sudden death Drastic weight loss Brain, liver, and bone marrow damage
	Nitrous oxide	Laughing gas, Whippets	Inhaled or sniffed by mask or balloons	Abusive, violent behaviour Lightheadedness	Death by anoxia Neuropathy, muscle weakness
	Amyl nitrite Butyl nitrite	Poppers, Snappers, Rush, Locker room	Inhaled or sniffed from gauze or ampoules	Slowed thought Headache	Anaemia, death by anoxia

Source : Healthwatch. The Afternoon Despatch & Courier, 20 February 1995, p. 17

* Avoid back and forth arguments. The situation only deteriorates and makes matters worse.

* Adolescents should learn from adults to distinguish between events that are merely unpleasant or annoying and those that are serious or tragic.

Adults need to be clear about the extent of *freedom* they want to give, and the *limits* they wish to set for adolescents.

The limits should never be arbitrary or whimsical. They should be anchored in values and aimed at character building. The limits should be discussed with the adolescent in the hope of arriving at a consensus, though this may not be achieved. Such discussions should result in clear and explicit ground rules on :

— time limit and frequency of parties or outings with friends;
— dress code;
— pocket money and personal expenses;
— home chores and responsibilities;
— academic achievements.

Maturity cannot come to adolescents by blindly obeying adults. They must learn to make their own decisions, build up their own values, and live their own lives.

Stereotype Adult Messages Sent to Adolescents

Parents and other adults consciously or otherwise often convey messages which can influence the attitudes of adolescents. For example:

* Boys can enjoy sexual liberties, while girls need to be sheltered and protected.

* Boys may be carefree while girls need to shoulder household responsibilities.

* Boys may have a career, while girls should stay at home.

* Boys who are not attracted towards girls are not manly enough.

* Girls need to show their femininity by being coy, dependent, and sensitive.

* Boys may not show their feelings.

* Girls who may have been sexually abused should suffer in silence rather than bring shame upon their families.

* Girls should be married as soon as possible.

These messages can lead to negative attitudes and effects on adolescents. They can :

— curb the development of the personality;
— create double standards in society;
— create gender bias, (i.e. discrimination against females;
— cause pain and heartburn to the affected party.

Some Common Questions Asked by Boys and Girls During Late Childhood and Adolescence

The fifty questions given below were commonly asked by girls and boys during their discussions on human sexuality. This list is by no means exhaustive. The answers to all the fifty questions occur in the text of this book. For easy reference, the chapter number that has the answer to the question is given in brackets at the end of each question. For example : What exactly is menstruation? (VIII) This means that the answer to the question 'What exactly is menstruation?' will be found in Chapter VIII.

1. What exactly is menstruation? (VIII)
2. What care should be taken at the time of menstruation? (VIII)
3. What should one do when the periods are not regular? (VIII)

4. Are there special diets/exercises/customs etc to be followed during menstruation? (VIII)
5. From where does the woman bleed? (VIII)
6. Why do different girls get menstruation at different ages? (VIII)
7. What is the normal duration of menstrual periods? (VIII)
8. Why do some girls have pain during their menstruation? (VIII)
9. Why do boys not get periods as girls do? (VII, VIII, IX)
10. What is white discharge? Is it normal to have it? (VIII)
11. What is menopause? (VIII)
12. What is intercourse? (IX)
13. How frequently can a couple indulge in sexual intercourse? (IX)
14. Can one have intercourse during menstruation and pregnancy? (VIII, IX)
15. Does a pregnant woman get her menstrual periods ? (IX)
16. What is meant by orgasm and coitus? (IX)
17. Do girls become pregnant by kissing a boy? (IX)
18. How do sperms get into the vagina?(IX)
19. What is family planning? (XII)
20. Is the withdrawal method a safe one? (XII)
21. What are the different methods of family planning? (XII)
22. What is abortion? What is miscarriage? What is curetting? (XIII)
23. If a girl does not get her periods, does that mean she cannot have a baby? (VIII)
24. Why is there a feeling of nausea during pregnancy? (IX)
25. How does the baby come out of the mother's body? (IX)
26. What are twins? (IX)
27. What are Siamese twins? (IX)
28. Why are some babies born dead? (IX)
29. What is a Caesarean operation? (IX)
30. Why are some babies born in the seventh or eighth month? (IX)
31. Why are some children born defective? (IX)
32. How do unmarried girls get children? (IX)
33. What is homosexuality? (XIV)
34. What is circumcision? (VII)
35. What is the Rh Factor? (IX)
36. What are wet dreams? (VII)
37. What is rape? (XV)
38. What happens to a girl who is raped? (XV)
39. What happens to a boy who rapes a girl? (XV)
40. Who are prostitutes? (XV)
41. What is meant by VD? (XVI)
42. Who are eunuchs? (VII)
43. How does one become a eunuch? (VII)
44. Does the size of a boy's penis have anything to do with his masculinity? (VII)
45. Why do some mothers get all daughters only or all sons only? (IX)
46. Why can't some women get babies? (IX)
47. Who is a lesbian ? (XIV)
48. Who is a transvestite? (XIV)
49. What is masturbation? (XIV)
50. What is AIDS? (XVII)

Education in Human Sexuality

* Adolescents need help in building up their self-esteem.

* They need to develop skills in

  — decision-making
  — resisting negative peer pressure
  — handling negative emotions
  — protecting themselves from eve-teasing, rape, and sexual harassment (for girls and boys)
  — building up and maintaining healthy and satisfying relationships.

* Adolescents need to learn about

  — sexual and reproductive health
  — safe sex
  — different forms of sexual behaviour
  — the harmful side of sex.

* Anything and everything adolescents bring up and want to know about should be discussed.

VALUE BUILDING

1. Sexuality is a natural and healthy part of living.
2. All persons are sexual.
3. Sexuality includes physical, ethical, spiritual, social, psychological, and emotional dimensions.
4. Every person has dignity and self-worth.
5. Individuals express their sexuality in varied ways.
6. In a pluralistic society, people should respect and accept the diversity of values and beliefs about sexuality that exist in a community.
7. Sexual relationships should never be coercive or exploitative.
8. Sexual relationships should be based on mutual trust, honesty, commitment and respect.
9. All children should be loved and cared for.
10. All sexual decisions have effects or consequences.
11. All persons have the right and the obligation to make responsible sexual choices.
12. Individuals and society benefit when children are able to discuss sexuality with their parents and/or other trusted adults.
13. Young people explore their sexuality as a natural process of achieving sexual maturity.
14. Premature involvement in sexual behaviour poses risks.
15. Sexual behaviour must be responsible and self-disciplined.
16. Abstaining from sexual intercourse is the most effective method of avoiding pregnancy and preventing STD and HIV / AIDS.
17. Young people who are involved in sexual relationships need access to information about health care services.

F. Youth (19 + Years of Age)

General Traits

This is the period of transition from adolescence to adulthood.

- Youth take on a more responsible role.
- This is the age for making decisions about careers and lifestyles.
- Many show a greater involvement in community activities.
- This is also the time to start thinking about selecting a partner, courting and marriage. Girls may be more likely to discontinue their studies and get married. On the other hand, some young people delay marriage as they are too busy building up their careers and financial security.

Youth and Marriage

One of the most important events in life is marriage. Young people start dreaming about marriage at this stage. There is also pressure from the parents and society to have a partner and settle down in marriage. The practice in some places is to get young people married even before the legal age. As people become educated, they become aware of the drawbacks of early marriages, and the actual age at which young people marry is rising.

With greater opportunities available to girls for education and jobs in the cities, girls are becoming more independent and are making more decisions on their own. They choose to develop interests, pursue careers and postpone marriage. Some of them may marry late in life and there are some who decide not to marry at all. A single man is more readily accepted in society than a single woman. Yet more women than before are living single lives and are coping with the challenges that go with this lifestyle.

In joint families single women or men go relatively unnoticed by society. In nuclear families being single becomes prominent.

Singleness is dealt with in Chapter XI, 'Preparation for Marriage and Singleness'.

Value Building

Youth should build up the same values as Adolescents.

Education in Human Sexuality

The emphasis at this stage is on preparation for marriage, family planning, and family life.

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School Health Service.

Introduction :-

Practically all school going children spend 8 - 12 years in a school. These are formative years whence the health intelligence, health attitude and health practices develop. These important factors determine the future health of the forthcoming citizens.

The school health service becomes the responsibility of every nation because of the following reasons

(1) Children of today are the citizens of tomorrow They are the wealth of the nation and their health is our wealth. Very often, the value of health is not realized till it is lost.

(2) In India the school going population i.e. 5 - 15 years of age make up a big majority, ie 38% of the total population. Naturally the majority claims major attention.

(3) Education is being made compulsory for all children. To learn effectively, child should be healthy.

(4) The school going age is a dynamic situation when lasting and deep impressions are formed. Obviously There is a special need to watch & develop the physical, mental and social health of the children.

(5) School is usually the first experience of group living. Group living poses following problems a) psychological in form of stress, Conflict, withdrawal or aggression ; b) There is added risk of communicable disease as the spread of disease becomes easy c) Accidents may result from play on the road to school. However, the group living because of many individuals being available together offers an excellent opportunity for control of communicable diseases

through immunizations and health education.

6) Children are most receptive to health education. Educating the school children in health matters in turn helps the community also, because, the children are bound to influence their parents about what they learnt at the school.

History :- In India, school health services were first started in 1909 in Baroda. In Karnataka, the school health service is a joint responsibility of Departments of Education and Health. However, the School Health Services in India are fragmentary and has a haphazard approach. There is no follow up or rehabilitation which then amounts to loss of large sums of money, time & energy spent in examination of the school children. The apathy towards school health programme is due to lack of resources, interest, co-ordination & co-operation. Besides, these services reap long term benefits which are not dramatic and therefore not impressive to the authorities to invest adequately. A School Health Committee (1969) made various beneficiary recommendations which most of them are still not implemented.

Objectives of School Health Programme :-

1. To find out the health status of the pupils. Only when we have the baseline information, are we able to identify the needs of school going community and therefore plan for their betterment.
2. To detect early any disorder/disease and to treat it in time. "A stitch in time saves nine".
3. To control the spread of communicable disease.
4. To rehabilitate the handicapped children.
5. Health education.

The above objectives are achieved through a comprehensive school health programme, the components of which are as follows:-

1. Health supervision.
2. Healthful environment
3. Immunizations.
4. Physical Training Programmes.
5. School feeding programmes.
6. Services for handicapped children.
7. Health education.

Health Supervision:-

~~Regular~~ Health supervision at regular intervals is advisable. There should be at least three medical examinations during the school career namely (i) on admission (2) intermediate period - adolescents and (3) before the child leaves the school. One medical officer per 5000 children is required. Ethics demand that prior permission of the parents/guardians should be sought. A record of the findings of medical examination, advise given and follow up action is maintained and kept confidential. The cumulative records are forwarded to the next school authorities in case the child leaves the school.

Unfortunately, as stated before, no follow up action is taken following school examinations. A lot many ailments are detected during these examinations. The ailment commonly detected in children attending school are, malnutrition disorders e.g. Vitamin A, D and B complex deficiencies, anaemia, defective vision, partial deafness, dental - caries, skin conditions, worm infestations, ear infections & respiratory disorders. Most of these diseases are preventable by simple measures and if allowed to persist may lead to devastating results. e.g. Vitamin A deficiency leads to blindness There are 5 million blind people in India ! 2/3rd of

of this blindness was preventable. Vitamin A deficiency causes night blindness, Bitot's spots, dryness of the conjunctiva, and keratomalacia leading to blindness. Eating a correct diet which is neither costly nor unavailable prevents blindness. Very few parents know that Vitamin A is essential for care of the eyes, that Vitamin A deficiency produces blindness, that Vitamin A rich foodstuffs are cheap and easily available; eg. a) yellow vegetables - carrots, sweet potato, yam b) yellow fruits like mango, papaya, jackfruits c) green leafy vegetables like amaranth, drumstick Spinach etc.

The health examinations have an educative value for the child learns to value health. The Spread of communicable diseases is checked, the diseases if detected early can be arrested in time. To learn effectively, child should be healthy.

Healthful environment :-

What surrounds us is our environment. It affects health by bringing the disease & host near each other or by keeping them apart. e.g. healthful building with adequate ventilation, light, furniture checks the communicable disease spread and allevi discomfort. Inadequate ventilation & overcrowding favours Spread of the disease. Inadequate lighting may aggravate visual disorders. Improper furniture may lead to postural defects which in turn affects respiration, circulation and may interfere with proper vision. The ideal desk for a child should be a single desk & a single chair. The seat should be of such a height so that the feet do not hang but touch the floor. The back rest should be curved. The slope of the desk should be 15° for writing & 45° for reading. Though ideal is the single desk with chair, a narrow adjustable desk is acceptable

- X. Types of the desk,

Water supply to schools should be protected. ~~In case of a village, the~~ as most of the diseases are waterborne and many children are likely to be affected by unclean or unhygienic water supply. The proper hygiene regarding watersupply latrine, food hygiene will have an educating experience for the child to later the child emulates what he sees at the school. In villages, the school well should be models for the villagers. For the teacher is one of the most-respected among in the village and what is done at school is looked upon as the best. Ideally, the school well should be sanitary - draw well with adequate covering, slope, drainage and should be disinfected regularly with bleaching powder.

Emotional environment is equally important in the development & health of the child because ~~of~~ unneccessary or unjust punishment brings out violence, hatred and other social problems due to frustration, fear and vengence. To have a good emotional environment it is essential to have cordial relations among everyone. The teacher should be mature and understand He is should be adequately trained and paid. The status of teacher should therefore be ~~allowed~~ elevated. Other benefits like leave, Provident fund etc be ensured.

Immunizations :-

Immunizations help check the spread of the disease because a stronger ~~body~~ resistance is now available against the disease. Following immunizations be carried out ~~as~~ during school period :-

1. Spox revaccination
2. BCG "
3. D.T. vaccine - 5-6 years
4. Typhoid vaccine ~~is~~ needed in our country
5. Boosters ~~of~~ the risk of getting infection is high close of tetanus toxoid - 11-12 years.

Physical Training Programmes

including games and gymnastics improve the health of the child with a sense of team work and fair play among children.

School feeding programmes:-

Mid-day meal programmes are being increasingly adopted by Schools. It is all the more necessary that the children be given midday meal for firstly his diet at home is inadequate and secondly he may have walked a long distance to reach the School. A hungry child can hardly learn effectly. The school lunch should provide at least 1/3rd Daily requirement of nutrient.

~~Daily requirements~~

~~Nutrients~~ ~~Food stuffs~~

The ~~meal~~ programme is also an excellent medium of education wherein the child learns the basic facts about nutrition, good manners and it helps them in a group to get over the poor eating habits in food fads. Very often, the parents of low income trying to economize do stop one of the childs meals at home. The mid day meal programme is a supplementary feeding and not a substitute. This needs to be impressed on the parents' minds.

Applied nutrition programme: launched by Govt. of India helps the intending schools / homes / institutions to grow vegetables / fruits in the school by supplying knowledge, seeds, fertilizers etc free of cost. The idea is the people should grow more to feed themselves. Children when so encouraged feel proud and learn more about food if the products of their labour are utilized towards mid day meal programme

Care of handicapped children:-

There are Special Schools for physically handicapped children e.g. deaf, dumb or blind children. All handicapped children need extra reassurance to instil a sense of confidence in them. Specialist services should be available to these children.

The mentally handicapped children should never be ridiculed. They too need special attention and need be referred to the Child Guidance Clinics.

~~Behaviour problems~~

Health education:-

It is a dynamic process which effects changes in knowledge, attitude & behaviour of the people so that their health practices change to improve their health status.

People participate in changing their way of life. Children are usually being given some health education at home. This effort is supplemented and reinforced at the School. The results are far reaching because the child learns health habits and may influence those at home.

The areas of health education should cover personal hygiene, nutrition, environmental sanitation, immunization, first aid education, physical training, and Sex education. Many teachers feel embarrassed to talk about sex to the children and many children grow up with misconceptions and are not able to adjust well in the society due to their, sexual behaviour. The discipline of mind, the accepted social behaviour, individual responsibility are all required to be instilled in the child's personality right at the home and be continued in the School.

Hed should be linked with everyday experience and needs of the children.

Role of Teachers :-

It is impossible to measure the role of teachers in the society. He is the pivot of social reforms; he is the leader of the community. People look up to him for guidance not only in school matters but in many other social fields.

At the school, the teacher moulds the child, helps develop his personality, guides his health habits and watches over his health. It is the teacher who is the first one to observe the illness of the child. The daily observation of the child is a great contribution of the teacher in checking spread of illnesses.

Daily Observations :-

1. Blinking / watering of eyes.
2. Running of nose.
3. Rashes
4. Cough
5. Defective posture
6. Inability of the child to hear well
7. Lack of concentration to the studies
8. Inability to read from the blackboard

Finally the teacher helps in control of communicable diseases by encouraging communizations and by way of health education. Teacher is key personnel in rendering first aid in event of accident / illness

All personnel who come in contact with the child in school influence the child's health particularly the teacher. Obviously, the teacher should himself have sound health and mind. Regular health examinations of school teachers should also be a concommitant responsibility of the Government.

School health services:

The school health services becomes one of the basic responsibilities of any government because i) the children of today are the citizens of tomorrow who should be healthy and happy ; ii) the school going population i.e from 5-15 years, form a major portion of the total population. e.g. In India, the school going population makes up about 38% of the total population. iii) The government has made education compulsory. Therefore, the concomitant responsibility of child's health lies upon the government. That is because, to learn effectively, the child should be healthy. Besides, iv) this age period is a dynamic situation when many deep and lasting impressions are formed, the impact of which may be felt at a much later date. Therefore, a watchful care of the physical, mental and the emotional development of the child is neccessary. v) The school is generally the first experience of most of the children regarding group living. Hence, a) problems arise in form of stress, strain, conflicts, withdrawal and aggression. b) The added risk is in form of spread of communicable diseases. However, for this very reason, the school forms an ideal place for effective collaboration and control of communicable diseases. c) Accidents may result due to excitement in group play or due to the nature of the play or due to the distance required to be travelled. vi) The children are more receptive to health education. They also help in turn to influence their parents and thereby the community regarding the spread of health education

History: In India, school health services were first started in 1909, in Baroda. Even today, in our country, these services are most unsatisfactory because of lack of interest, lack of resources and the lack of co-operation among the concerned authorities.

(contd)

What happens in India, is a haphazard health supervision, sometimes with detection of a disease or disability with an utter lack of follow up regarding treatment and rehabilitation; with the result that it leads to entire wastage of large sums of money, time and energy. This may be because the cost of school health services is heavy while it is not easy to demostrate its benefits and therefore not impressive.

→ Renuka Roy Committee.

Objectives:-

of school health services are

i) to ascertain the health status of the pupils.
ii) To detect any discomfort, disease or disability among the students and to treat it and rehabilitate the students.
iii) To prevent onset and the spread of communicable diseases.
iv) To rehabilitate the handicapped children.
v) Health education.

Components

School health services, consist of provision of:

I Health supervision
II Healthful environment
III Immunizations.
IV Physical education programmes.
V School feeding programmes.
VI Services for the handicapped children
VII Health education.

Administration of school health services varies greatly and its responsibility may fall in the four general categories.

1) Shared by departments of health and education.
2) Carried out entirely by the Dept. of education.
3) Run by school health committee.
4) Imparted independently by the school.

In Mysore, it is a joint enterprise by the departments of education and health. This has many advantages. e.g.

(Contd)

School health services:

I- Health supervision:

Diseases common among the school children in India are malnutrition, defective vision, partial deafness, tonsilitis, dental caries, skin conditions, worm infestations, respiratory disorders etc. lice infestation, scabies, dermatitis, ringworm

For health supervision, regular examinations at intervals are neccessary. At least, a minimum of three examinations during the entire school carrier should be carried out. e.g. (i) on admission of the pupil, ii) at an intermediate period e.g. of those at the begining of puberty, iii) before the child leaves the school.

Medical examination of a referred child suspected to have some abnormality, is more useful than a routine check up. A medical examination should be comprehensive and painstaking to command respect. It should be sufficiently informative to guide the school personnel, and should be sufficiently personalized to form a desirable educative experience.

The personnel includes (i) a school medical officer, (ii) a school nurse and (iii) a part time dental officer. A school health programme can be no better or worse than the staff which provides the services. Therefore, the importance of selection of staff regarding training and ability to work in a co-operative team should be realized.

One school medical officer is appointed for every 5,000 students. On an average, the medical officer should spend about twenty minutes per pupil, longer in case any abnormality is detected. His duties are 1) Sanitary inspection. Separate

2) Appraisal of the total health status of the pupil.

3) To report ill health or disability discovered on examination and to advise the school authorities and parents regarding the treatment and also to contact the private physician when needed. He is also in contact with specialists.

4) To take neccessary steps to prevent and check the outbreaks of communicable diseases.

5) Health education by guiding the teachers regarding the health programmes.

The importance of the school nurse is second only to the teacher and her duties are;

1. to render first aid;
2. to assist school medical officer during examinations
3. To carry out homevisiting during which time she establishes cordial relations with parents and acts as a freind and counsellor. Thereby, health education is also carried out. She furthers this purpose during the parent nurse conferences.
4. To check communicable diseases. By conducting the teacher nurse conferences, She imparts a clear concept to the teacher regarding the normal development of the child and also utilizes the opportunity to tactfully suggest the circumstances in which minor abnormalities could be missed.
5. She also instills the value of health and makes the children appreciate the physical, mental and social well being.

Examination:-

Ethics demand that prior permission of parents/guardians should be sought before one of examination of a child at school. If, the parents is present during the examination, it is an asset.

Record kept for the purpose consists of:

1. General information.
2. Personal history.
3. General examination.
4. Laboratory test
5. Advise given.
6. Progress.

1) General information: is usually filled up by the school nurse or teacher, furnishing the following details, namely, name, age, sex, address, nationality, class, name of the school, date of inspection and measurements. i.e. height and weight.

2. Personal history:

Present complaints if any are noted. Past history with particular reference to infectious diseases and immunizations already carried out is obtained. Family history is enquired into for hereditary diseases, mental disorders or tuberculosis.

3. General examination:- is carried out right from when the student enters the room till he leaves. The physician observes his gait, hearing, speech, intelligence, personal cleanliness and colour of the skin, particularly for anaemia. He examines the teeth; nose; throat; eyes for disease and visual acuity; ears for discharge and for hearing. Heart, lungs, spleen, liver are also examined to detect abnormalities. The diseases detected may be anaemia, malaria, tuberculosis, rickets, deformities eg. Squint, talipes, hare-lip, stunted growth, or deformed chest.

Screening tests may include i) psychometric examinations; ii) reading readiness test and iii) vision testing.

4. Laboratory tests:- include blood examinations for haemoglobin percentage which is particularly valuable in case of high school girls. (Tuberculin test with chest X-rays may help in control of tuberculosis).

5. Advise:- is given regarding diet, exercise oral prophylaxis, immunizations and also regarding the treatment of the disease or disability.

6. Progress:- of the child is recorded and evaluated regarding development, health status, treatment and rehabilitation.

(contd)

School medical records should be treated as strictly confidential and kept in the custody of the principal. These records should contain no information which is detrimental to the career of the child. They should be made available to the family physician. They should be cumulative and forwarded to the next school authorities in case the child changes the school. It is important to emphasize that the records should not be treated as an end in itself but be a means of implementing both the preventive and curative programmes.

II. Healthful environment:

A. Physical environment.

B. Emotional environment.

A. Physical environment:

1. Site:- The soil should be well-drained and the school should be located away from the noise, dust, fumes and traffic hazards. Usually a clear space of 60 feet is kept from the street. Plenty of open space is provided for play grounds and future construction. {10 acres for secondary school ?, 5 acres " primary school}

2 Design:- Should be attractive besides ensuring adequate lighting and ventilation in each room. Total Area provided should be an acre per thousand pupils, or The floor area in a classroom should be 10 - 16 ft per pupil. The height of the rooms should be 12 ft and above while the corridors should be 6 - 8 ft wide; Each class room should have separate entrance & no class room should be a passage The Staircases should be adequate in number to prevent congestion and also act as fire escapes. The stairways should be 4 feet wide and be provided with handrails. The surfaces should be readily washable.

3 Other facilities:- include recreation room, library, teacher's room, dining room etc.

(contd)

Lighting : is properly acheived by, placing proper of adequate number of windows and ventilators. Glare or sharp shadows on the working site are cut out. For this purpose, the surfaces should be light coloured, furniture be of a light shade while the blackboads should have a dull surface.

Eye strain due to improper lighting causes headache, blinking of and rubbing of eyes, holding of books close to the eyes. Cross ventilation, 1500 - 1800 c.ft of fresh air/hour should also be a rule. Accoustics should be provided for proper hearing.

Water supply :- Drinking water is supplied in form of fountains to obviate the need for cups. 1-2 fountains per 100 children are usually adequate. In rural areas, water is obtained from a well which is properly constructed, protected, well fitted with a pump and periodically examined.

Wash basins :- Should be adequate in number and be placed at proper heights. Plenty of soap and clean towels should be supplied.

Sanitary conviniences :- Separate arrangements should be made for the boys and the girls. 2 water closets / first thirty students and one water closet / additional 30 students upto 300 students and 1 water closet / additional 60 students thereafter is considered to be adequate. In rural areas privies are provided.

Other facilities may include recreation room, dining room, library and teachers' room.

School furniture :-

Single desk and a seat are best. The desk should be 26" in height and have a slope of 15° for writing and 45° for reading purposes. The seat should have a rounded front edge, provided with a suitably curved back rest and have a height such that the feet should touch the floor.

Zero desk : The edge of the writing surface is vertically in line with the edge of the seat.

Plus desk :- There is a gap between the desk and the seat. This provides convinience when the student has to stand up to answer questions.

Minus desk :- The edge of the writing surface overlaps the edge of the seat.

Adjustible desks are however the best.

Posture is very important and each student must be made to realize it. Too much of stooping causes myopia, contracts chest, interferes with respiration, causes defective curvature of the spine and an extra strain on the heart.

School Hostels :-

The floor space provided should be 60 square feet per head. Adequate number of rooms, common room, dining hall, kitchen etc. should be provided. General sanitation is insisted upon along with proper disposal of refuse and excreta. Facilies for water and lighting should be adequate while food sanitation must be the rule.

Emotional environment :-

depends almost entirely upon the degree of physical, mental and social well being of the staff (right from the peon to the principal). The class teacher is however the key person and his relationship with others particularly the principal is important. Teachers should have a good physical health, thorough training in education and should be well adjusted in life to love the children and be loved by them in turn. Unnecessary punishment or illtreatment of a child begets anger, frustration and a desire to get away with antisocial activities.

The staff should therefore be emotionally mature, understanding and properly trained responsible persons. The salary and the status of the teacher should be raised to increase the prestige of the teacher.

Immunizations:-

1. Small pox Revaccination should be carried out and repeated specially when there is an epidemic.
2. Booster doses of diphtheria and tetanus should be given when the child enters school and at the age of 11-12 years (5-6 yrs School entry) 4 BCG revaccination should be carried out.
3. Typhoid vaccine (2 doses) against typhoid is needed particularly in our country as the risk of getting infection is high as among school children. Combined TAB vaccine should not be used

Prior permission of parents is essential before carrying out any immunizations.

Adrenaline should be kept handy.

(11-12 yrs Primary school leaving) - 1. Small pox revaccination 2. Booster Tetanus toxoid and 3. Typhoid vaccine.

Physical Education Programme:-

consists of PT, games, gymnastics. It is very important because it instil a sense of team work and fair play among children.

School lunch programme:

is designed to provide a thoroughly nutritious meal at a low cost to all the pupils. It should provide at least 1/3rd the daily requirement of nutrients. This is an excellent medium of education wherein the children learn the basic facts about nutrition, good table manners and also it helps them in overcoming the poor eating habits and food fads.

Applied nutrition programme:-

The children actively participate in the programme by growing vegetables & fruits in gardens at school. The product is utilized towards providing them a nutritious meal at midday.

Schools for handicapped :-

Special schools with trained staff and special media & equipment are required for the education of the blind, deaf and dumb.

For the mentally retarded one, help of child guidance clinic should be sought.

Specialist services must be available in form of orthopaedic, physiotherapy, paediatrics, E.N.T, dental and eye clinic Specialists. Benefits will be seen through out the life.

Health education :-

Children are most receptive to health education. Besides it is a controlled group which can be reached easily. The far reaching effects are seen because the education of the School child has influence on the family at home and therefore on the community as a whole.

The School health nurse and the teacher help in health education of the children. Therefore, this subject should be covered up during the teacher's training programme.

First aid :-

becomes necessary very often among school children who get hurt due to accidents or during play. Usually an expert care is provided by the School health nurse but in her absence the teacher should be well conversant with the first aid measures. In such Emergency it is advisible to know where to contact the parents and also the nearest hospital of, Choice.

family physicians &

Control of communicable diseases among School children:-

1. Daily observation
2. Immunizations, as an
3. Closure of schools in extreme event at the advise of School medical officer.

Daily observation:-

School teacher and school nurse play an important part by making daily observations and sending home children who appear to have communicable diseases.

Immunizations:

are a measure of specific protection against communicable diseases.

Closure of schools:-

Should be only an extreme measure at the advise of the school medical officer in cooperation of the public health officer for the district. This may disturb the curriculum.

Diphtheria:-

a) Infected children are isolated until the local lesion heal with no discharge and till the three consecutive daily swabs prove negative i.e. 4-6 weeks.

b) Suspected cases are also excluded from school.

c) Susceptible persons are detected by Schick test i.e. Schick +ve cases are isolated for 14 days and immediately actively immunized.

d) Swabs are taken to detect carriers.

e) Daily medical examinations of the contacts is essential for at least 7 days.

Pulmonary Tuberculosis:-

a) Mantoux test
b) Mass X-ray

Influenza:

Danger exists in case of overcrowding and in ill ventilated places.

Whooping cough:

a) Infected cases are isolated for 6 weeks after the onset of coughing
b) Contacts are excluded for 3 weeks

Mumps:

a) Infected cases are isolated till one week after the swelling subsides i.e. 14 days.
b) Contacts are excluded for 7 days.

Small pox:

a) Isolation should be enforced till all the scabs have separated including those on the soles of feet i.e. 3-4 weeks.
b) Contacts - vaccination is done within a week.

Chicken pox :-

Isolation for a period till the skin becomes clear. The contacts are kept under surviellance for 21 days.

Measles :-

Isolation of infected cases for a period of 3 weeks i.e. till the cessation of discharges. No new admissions allowed during an epidemic. The contacts and the sucertible persons should be isolated for 14 days.

Scarlet fever :-

Isolation of the infected for 4 weeks i.e. till the cessation of discharges and the contacts for 2 weeks is essential.

General measures :-

1) Adequate ventilation
2) Spacing of beds in hostels
3) Washing facilities
4) Adequate meal services.

All the levels of prevention can be practiced at the school during with efficient School health services.

I Primary prevention :-

A. Health promotion : through

1) Adequate nutrition by school lunch programme
2) Proper physical activities including school schedule optimal to physical growth.
i.e. Good posture and physical exercise help in training of the musculature.
3) Health Supervision of students and the staff.
4) Health education.

B. Specific Protection is through

1) Personal hygiene
2) Safe and potable water supply
3) Sanitary disposal of wastes
4) Proper building + adequate
i) attractive, approaches.
ii) dimensions
iii) play grounds.
5) Immunizations.

II Secondary prevention :-

C. Early diagnosis detection and treatment-

1) Appraisal of health status and treatment of deviations from health

III Tertiary prevention

D. Limitation of disability : Continued towards follow up and physiotherapy helps the objective.

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DOCUMENT

PREVENTING HIV/AIDS/STD AND RELATED DISCRIMINATION: AN IMPORTANT RESPONSIBILITY OF HEALTH-PROMOTING SCHOOLS

World Health Organization

UNAIDS

UNESCO

Geneva, 1998

WHO Information Series on School Health

PREVENTING HIV/AIDS/STD AND RELATED DISCRIMINATION: AN IMPORTANT RESPONSIBILITY OF HEALTH-PROMOTING SCHOOLS

The development of this document is a joint effort of the Department of Health Promotion, Social Change and Mental Health Cluster and the Office of HIV/AIDS and Sexually Transmitted Diseases.

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CONTENTS

FOREWORD

Investments in schools are intended to yield benefits to communities, nations and individuals. Such benefits include improved social and economic development, increased productivity and enhanced quality of life. In many parts of the world, such investments are not achieving their full potential, despite increased enrolments and hard work by committed teachers and administrators. This document describes how educational investments can be enhanced, by increasing the capacity of schools to promote health *as they do learning.*

For better or worse, health influences education. Healthy children learn well. If children are healthy, they can take full advantage of every opportunity to learn. But, children who cannot attend school because of poor health or unhealthy conditions cannot seize the opportunities that schools provide. Similarly, schools cannot achieve their full potential if children who attend school are not capable of learning well. Poor health and unhealthy conditions jeopardize the value of school attendance.

This document is part of the WHO Information Series on school health promotion prepared for WHO's Global School Health Intiative. Its purpose is to strengthen efforts to help young people learn how to prevent HIV infection, AIDS and Sexual Transmitted Disease (STD). Approximately 60% of today's new HIV infections are occurring among persons under 25 years of age. Young people learn about sexuality, HIV, AIDS and STD, in school *in informal* as well as formal ways. Therefore, we must ensure that our formal sources of learning provide accurate information that can reduce undue fear and prejudice and enable young people to protect themselves, both now and in the future. The HIV pandemic continues into the 21st century because of ignorance and our inability to help each other take better control over the circumstances that can lead to infection. Schools can help overcome both of these barriers.

WHO's Global School Health Initiative is a concerted effort by international organizations to help schools improve the health of students, staff, parents and community members. Education and health agencies are encouraged to use this document to prevent HIV infection, AIDS, STDs and related discrimination and to take important steps that can help their schools become "Health-Promoting Schools".

Although definitions will vary, depending on need and circumstance, a "Health-Promoting School□ can be characterized as *a school constantly strengthening its capacity as a healthy setting for living, learning and working* (see box after the foreword).

The extent to which each nation's schools become Health-Promoting Schools will play a significant role in determining whether the next generation is educated and healthy. Education and health support and enhance each other. Neither is possible alone.

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HEALTH-PROMOTING SCHOOL

A Health-Promoting School:

- fosters health and learning with all the measures at its disposal
- engages health and education officials, teachers, students, parents, and community leaders in efforts to promote health
- strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion
- implements policies, practices and other measures that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements
- strives to improve the health of school personnel, families and community members as well as students; and works with community leaders to help them understand how the community contributes to health and education

1. INTRODUCTION

This document, part of the WHO Information Series on School Health, is intended to help people use health promotion strategies to improve health and prevent HIV/AIDS/STD and related discrimination. Based on the recommendations of the Ottawa Charter for Health Promotion (Annex 2), it will help individuals and groups move toward a new approach to public health, one that creates on-going conditions conducive to health and healthy lifestyles, as well as reducing prevailing health problems.

While the concepts and strategies introduced in this document apply to all countries, some of the examples may be more relevant to certain countries than others. Cultural variations are closely linked to HIV/STD risks and planners need to consider them carefully in designing interventions.

1.1 *Why did WHO prepare this document?*

The World Health Organization (WHO) has prepared this document to help people care for themselves and others, acquire the ability to make healthy decisions and have control over their lives, and ensure that society creates conditions that allow all its members to attain health. **(1)**

It provides information that will assist individuals and groups to:

- make a strong case for increased efforts to prevent HIV/AIDS/STD through schools
- understand the nature of a Health-Promoting School
- plan and implement HIV/AIDS/STD prevention and health promotion as part of developing a Health-Promoting School

1.2 *Who should read this document?*

This document is directed towards:

- Governmental policy-makers and decision-makers, programme planners and coordinators at local, district, provincial and national levels, especially those from the ministries of health and education
- Members of nongovernmental institutions and of other organizations and agencies responsible for planning and implementing health and HIV/AIDS/STD interventions, especially programme staff and consultants of national and international health, education and development programmes interested in promoting health through schools
- Members of the school community , including teachers and their representative organizations, students, staff, parents, volunteers and school-based service workers
- Community leaders, local residents, health care providers, social workers, development assistants, media representatives and members of organized groups (e.g. youth groups and women's groups interested in improving health, education and well-being in the school and the community)

1.3 *What are HIV, AIDS and STD?*

The term "HIV" stands for the Human Immunodeficiency Virus. This virus destroys the body's immune system so severely that it cannot fight certain diseases. While an HIV-infected person can live for many years without major health problems, the virus' destructive effects will eventually result in Acquired Immune Deficiency Syndrome, or "AIDS".

People with AIDS become increasingly vulnerable to diseases and ultimately die from diseases that their immune systems and medicines cannot fight. Research is showing that early treatment with a combination of medicines can delay the development of AIDS in people infected with HIV.

Sexually Transmitted Diseases, or "STDs" is a general term for infectious diseases that are spread through sexual contact. HIV/AIDS can be regarded as an STD. Other major STDs are syphilis, gonorrhea and chlamydia. The highest rates of STDs are usually found in the 20-24 age group, followed by the 15-19 age group. (2)

1.4 Why prevent HIV/STD infections and related discrimination?

Today, HIV infection is one of the major causes of disease and death among persons aged 25-44. It has already taken millions of lives and caused enormous personal, social and economic losses throughout the world. Education about HIV can help to prevent new HIV infections and reduce suffering and economic loss

Furthermore, ignorance and lack of information about HIV/AIDS fuels a great deal of prejudice, causing individuals to fear contact with people who may be infected with HIV or who have AIDS. Since health is a fundamental human right, society is obliged to help dispel biased attitudes and prejudices that affect society's overall well-being.

1.5 *Why focus efforts on schools?*

The school is a priority setting because it offers substantial opportunities to prevent infection and discrimination:

- Schools provide an efficient and effective way to reach large numbers of the population, including young people, school personnel, families and community members.
- Schools can provide interventions that help reduce infections and related discrimination.
- Students can be reached at influential stages in their lives when lifelong behaviours are formed.
- Schools can provide a channel to the community to introduce HIV/AIDS prevention information and technology and advocate policies that reduce discrimination.

1.6 *How will this document help people promote health?*

This document is based on the latest scientific research and experience related to HIV/AIDS prevention, but it is more than a technical document. It is designed to help people address the broad range of factors that must be changed to prevent and reduce risk behaviours and conditions that lead to HIV infection, and help

schools become Health-Promoting. This document will help individuals and groups to carry out five major tasks.

Create Healthy Public Policy

This document provides information that can be used to argue for increased local, district and national support for tobacco use prevention interventions in schools. It also provides a basis for justifying decisions to increase such support.

Develop Supportive Environments

This document describes physical, psychological and social enhancements to the school and community environment that can help reduce the spread of HIV infection and related discrimination. It also describes how parents, teachers, community leaders and others concerned about HIV/AIDS/STD interventions in schools can support these changes in schools.

Reorient Health Services

This document describes how existing health services can be enhanced and made more accessible to to complement school health promotion efforts.

Develop Personal Skills

This document identifies information and skills that young people must acquire in order to reduce the risk of infection and avoid conditions that can lead to HIV infection. It also identifies the skills that others need to create conditions conducive to preventing HIV/AIDS/STD and developing Health-Promotion Schools.

Mobilize Community Action

This document identifies essential actions that the school, in collaboration with the community, must take to promote health and prevent the spread of HIV/STD infection, mobilize community support and strengthen school health programmes. It also provides arguments and facts that can be communicated through the mass media to call attention to the problem of HIV/AIDS/STD and to the important role schools can play in prevention.

1.7 *How should this document be used?*

Information in Section 2 and Section 3 can be used to argue for HIV/STD prevention interventions in schools. Section 4 creates a strong basis for local action and for planning interventions relevant to the needs and circumstances of the school and community. Section 5 provides specific details about how to integrate HIV/AIDS/STD interventions into various elements of a Health-Promoting School. Section 6 provides information to use in evaluating and improving efforts to prevent HIV/STD infection and related discrimination.

For specific guidance on planning, implementing and evaluating, this document should be used in conjunction with the WHO document "Local Action: Creating Health-Promoting Schools." Local Action: Creating Health Promoting Schools provides practical guidance, tools and tips from Health-Promoting Schools around the world and can help tailor efforts to the needs of specific communities.

2. CONVINCING OTHERS THAT THE PREVENTION OF HIV/STD INFECTION AND RELATED DISCRIMINATION THROUGH SCHOOLS IS AN URGENT PUBLIC HEALTH ISSUE

The following arguments can be used to convince others of the importance of implementing HIV prevention interventions in schools and the need for increased investment in such efforts.

2.1 Argument: For better or worse, schools already play a significant role in the HIV pandemic

Intentionally or otherwise, schools play a significant role – for better or worse – in contributing to or hindering the prevention of HIV/STD infection and related discrimination. Examples of the roles they play are listed below.

For the better, schools:

- provide access to education about HIV/AIDS/STD to students, staff and community members
- work with communities to determine the most appropriate and effective ways to educate young people about HIV/AIDS/STD
- take part in national and community initiatives to prevent HIV/AIDS/STD
- develop policies about HIV that support the rights of students and staff to learn and work in schools
- develop policies that support the provision of HIV/AIDS/STD education
- provide education to young children to reduce fear about HIV/AIDS
- provide education to pre-adolescents to explain how HIV is and is not spread and how HIV affects families, communities and nations
- provide education to adolescents, before they are faced with sexual decisions, to help them acquire the knowledge, attitudes, values, skills and support needed to avoid HIV/STD infection
- integrate HIV/STD education into education about reproductive health, life skills, alcohol/substance use and other important health issues
- include HIV/STD education in other relevant subject areas such as home economics, family life, science, social studies and other areas as suggested in official school policies
- enhance education about HIV/AIDS/STD through practices that foster caring, respect, self-efficacy, self-esteem, decision-making and through conditions that allow for the healthy development of students, teachers and other staff
- provide training about HIV/AIDS/STD for all teachers and school personnel
- involve young people in HIV/AIDS/STD education in the classroom, through peer education and through a variety of other learning experiences such as theatre, song and poster design
- teach boys and girls to respect themselves and one another
- foster discussion of HIV/AIDS/STD, sexuality and other important health issues in the community and family

For the worse, schools:

- are a source of rumour and misinformation about AIDS
- permit individuals who are not adequately informed to address HIV/AIDS/STD with students and staff
- ask or even require teachers to teach about HIV/AIDS/STD without providing proper training or tools
- develop policies that prohibit the attendance of students and staff who are infected with HIV and consequently generate unwarranted fear

- isolate students, teachers and staff whose families are infected or affected by HIV/AIDS
- prohibit discussions about HIV/AIDS/STD lessons, creating suspicion and curiosity
- prohibit teachers from providing sexual information along with education about HIV/AIDS/STD, thereby restricting clear and accurate information about routes of transmission and differences in sexual orientation
- provide only sporadic, fragmented and inadequate opportunities for students to learn about HIV/STD prevention, resulting in many unanswered questions and concerns among students and staff
- exclude young people from being actively involved in developing and implementing learning experiences that could influence their health for the better, including education about sexuality and HIV/STD prevention
- help sustain gender inequality by not teaching young men and women how to interact with one another respectfully
- help sustain biased attitudes among students, teachers and staff by not acknowledging differences in opinions, values and beliefs about sexuality, gender and equity
- remain isolated from national and community HIV/AIDS/STD initiatives even though the issues are highly relevant to young people

2.2 Argument: HIV infection is in pandemic proportion

During 1997, an estimated 5.8 million people became infected with HIV and 2.3 million persons dies from AIDS.(2) By the end of 1997, the total number of AIDS deaths since the beginning of the epidemic stood at 11.7 million. AIDS and HIV infection are a worldwide pandemic that requires a worldwide response.

2.3 Argument: HIV/AIDS is affecting millions of young people

HIV infection is one of the major problems facing school-age children today. They face fear if they are ignorant, discrimination if they or a family member or friend is infected, and suffering and death if they are not able to protect themselves from this preventable disease. Since 1988, the number of children and adolescents infected by HIV has increased sharply, in both urban and rural areas worldwide. An estimated 30 million people alive today are infected with HIV or have AIDS; at least a third of these are young people aged 10-24. Every day an estimated 7000 young people become infected with HIV.(1) In many countries, 60 percent of all new infections are among 15-24 year olds who will likely develop AIDS in a period ranging from several months to more than 10 years.(2) At present, women and adolescents are the primary groups becoming infected with HIV in Latin America and the Caribbean. In Sub-Saharan Africa, adolescent females are becoming infected in their early teens and peak infection rates occur before age 25. Even the young people, neither infected by HIV nor orphaned because of AIDS are affected by the socio-economic consequences from the epidemic in hard-hit communities and countries. These figures are a cause of great concern to health professionals, educators and concerned community members because HIV infection is preventable.

2.4 Argument: HIV infection is a chronic disease that affects the physical, psychological and social well-being of individuals who are infected, their peers, families and community members

Statistical data about HIV/AIDS does not adequately convey the loss experienced by families, communities and nations. Physically, HIV and AIDS are an ordeal for those with the illness. A common cold can turn to

topics. Yet, parents often lack factual information and/or have difficulty addressing these issues with adults as well as with children.*(11)* Some parents rely on schools to educate their children in ways they themselves cannot.

Opinions and needs vary from school to school and from community to community. It is clear that in any community, however, schools alone cannot make decisions about the most appropriate way to help young people learn about HIV prevention. Community members must be well informed and closely involved in making such decisions. Schools need to educate their community members and create forums for debate and discussion. Only then, together, can they make decisions that will equip young people with the knowledge and skills necessary to prevent HIV/STD infection and related discrimination.

2.7 Argument: Policies and curricula can provide highly visible opportunities to demonstrate a commitment to equity, gender and human rights

Schools, traditionally, are the institutions that model society. Within the context of this "model" society, students learn skills needed to make decisions about complex issues. Schools promote objectivity, inquiry and debate as a part of the learning process, and by their very nature can further discussion of social issues such as equity, gender and human rights. HIV/AIDS challenges equity, gender and human rights. The school can either be a place that practices discrimination, prejudice and undue fear, or it can be a place that demonstrates, in a highly visible manner, society's commitment to three - - - concepts.

EQUITY. Schools can ensure that "every child and every adolescent has the right to education", especially education that is necessary for survival. According to the Convention on the Rights of the Child, the right of children, even those with impairments, to receive education should not be circumvented under any circumstances.*(12)* In response to the challenge of HIV, youth need to receive information about HIV/AIDS/STD and the risk of HIV/STD infection.*(13)* Pupils infected with HIV should have the same educational opportunities as others. Equity also ensures that both boys and girls receive complete information about HIV/STD and their prevention and that both young men and women are taught about risk behavior, respect and care for partners, and communication and other behavioral skills.

GENDER SPECIFICITY. Worldwide, rates of HIV infection are increasing among women, who are more vulnerable – physiologically, socially, economically and psychologically – to the disease.*(13)* In Africa, south of the Sahara, there are already six women with HIV for every five men with HIV. *(14)* Yet in many places, schools are apprehensive about providing sex education or discussions of sexuality because of cultural demands to protect young women from sexual experience.*(2)* Thus, women often lack the skills needed to communicate their concerns with their sexual partners or to practice behaviours that reduce their risk of infection. In addition, women are often subject to systematic interpersonal and institutional inequalities; important methods of HIV/STD prevention, such as condoms, are controlled by men. Gender-specific education can help women address such structural and interpersonal inequalities.

HUMAN RIGHTS. Schools can help ensure that everyone has access to the knowledge and skills that can help avoid HIV/STD infection and related discrimination. Those who are economically, socially or legally deprived have little or no access to HIV/STD prevention programmes. The school may be the only channel for reaching the deprived (especially women) with knowledge and skills for their well-being. Professional educators, regardless of moral or political convictions, are bound to protect and promote the human and civil rights of all people and help people recognise the psychosocial damage caused when human rights are denied, whether for reasons of religion, culture, gender or sexual orientation.

3. CONVINCING OTHERS THAT HIV PREVENTION INTERVENTIONS IN SCHOOLS WILL REALLY WORK

The following arguments can be used to convince others that HIV prevention efforts in schools are worthwhile and help policy-makers and decision-makers justify their decisions to support such efforts.

3.1 Argument: We know how HIV infection is spread

The specific behaviours which spread HIV infection are well defined. Schools have been successful in teaching young people that HIV is spread from an infected to an uninfected person through: unprotected sexual intercourse; shared use of unsterilized drug injecting equipment, and skin piercing, tattooing and shaving equipment; blood transfusions (though only in countries where blood screening is not routine); and from an infected mother to her child during birth or breast-feeding.*(15)*

3.2 Argument: Schools can help prevent and reduce the risk of HIV infection among young people

Schools have been successful in helping young people acquire the knowledge, attitudes and skills needed to avoid infection. Education, when it is appropriately planned and implemented, is one of the most viable and effective means available for stopping the spread of HIV infection.

Evaluation studies of HIV/AIDS education have identified the characteristics of school programmes that are effective in persuading students to adopt safer sexual practices. Effective programmes focus on specific risk-taking behaviour, are based on social learning theory, use active and personalised teaching methods, provide instruction on how to respond to social pressures, reinforce social norms against unprotected sex, and offer opportunities to practice communication and negotiation skills. Also, programmes that promote postponement of sex and protected sex seem to be more successful than programmes that promote abstinence alone.*(16)* Annex 1 describes curricula that have proven effective in reducing risk behaviours related to HIV/STD infection among youth.

3.3 Argument: HIV prevention interventions can have a broad impact on students' health and the classroom environment

HIV/AIDS/STD interventions in schools can teach children behaviours that will empower them to make healthy choices related to sex and other health issues. They can provide children with opportunities to learn and practice life skills, such as decision-making and communication skills, which in turn, can help enhance other important areas of adolescent development. HIV/AIDS interventions that deal with personal beliefs and use participatory techniques can also lead to closer bonds between the teacher and the class*(17)* and demonstrate to the school population and community that the school cares for its students.

3.4 Argument: Sex education will not lead to early sexual activity

Researchers in many different cultural and ethnic settings have studied whether sex education leads young people to engage in sexual intercourse much earlier than they would if they had not received sex education.

A 1997 UNAIDS review of 53 studies, which assessed the effectiveness of programmes to prevent HIV infection and related health problems among young people, concluded that sex education programmes *do not lead to earlier or increased sexual activity among young people.* In fact, the opposite seems to be true. Twenty-seven studies reported that HIV/AIDS and sexual health education neither increased nor decreased

sexual activity and attendant rates of pregnancy and STDs. Twenty-two reported that HIV and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy and STD rates. These findings did not support the contention that sexual health and HIV education promote promiscuity. On the contrary, the review concluded that school-based interventions are an effective way to reduce risk behaviours associated with HIV/AIDS/STD among children and adolescents.*(18)*

3.5 Argument: HIV prevention interventions in schools can benefit the entire community as well as students

In many places, schools are a vital, central component of the community; school decisions and actions directly affect many community members. Families of children in the schools may lack education themselves but hope to learn from their children. This is particularly true of migrant or lower socio-economic populations.

Young people, who are adequately informed can play a positive role in helping prevent HIV/STD. They can spread their knowledge to family members and others in their communities through their daily interactions, school/community projects, drama or print media; they can reach out to the community and foster discussion, debate, reflection and learning.

4. PLANNING THE INTERVENTIONS

Efforts to prevent HIV/AIDS/STD and related discrimination can be an entry point for schools that want to build their capacity to plan and implement a wide range of health promotion efforts. The first step is to recognize HIV/STD prevention as a priority for both health and education. The next step is to plan the interventions: determine which strategies will have the most significant influence on health, education and development and how to integrate interventions with other health promotion efforts for maximum results.

This section describes key steps to consider in planning HIV/AIDS/STD interventions as an essential element of a Health-Promoting School:

- Establishing a School Health Team and a Community Advisory Committee
- Conducting a situation analysis
- Fostering political and cultural acceptability
- Developing school policies, intervention goals and objectives

4.1 School and community involvement in planning

Health-Promoting Schools involve members of the school and the community in planning programmes that respond to local needs and can be maintained with available resources and commitments. Linkages are needed between school administrators, teachers, health care workers, youth workers, pupils and peer leaders. Two important groups to involve in the planning process are: a School Health Team and a Community Advisory Committee.

4.1.1 School Health Team

A School Health Team is a group of people working together to maintain and promote the health of all people who are working and learning at school. Potential members include: teachers, administrators, students, parents and school-based service providers, such as members of the health services. The team should include a balance of students and adults with various responsibilities in the school who are committed to the idea of health and HIV/STD prevention Ideally, the team coordinates and monitors health promotion policies and activities, including those related to HIV/AIDS. Since schools should implement programmes that respond to important and relevant local needs, it is essential to involve students, parents, teachers and school management in the planning process from the beginning.

- Young people, involved in an early stage of planning, can help develop a programme that responds to their specific needs and concerns.
- Parents and teachers can help ensure that programmes are developed in a culturally appropriate manner.
- Teachers and other school staff can help ensure that interventions are developed with consideration of what they know and what they can do to establish HIV/STD prevention as an essential element of a Health-Promoting School.

If a school does not have a School Health Team or group organised to address health promotion, the HIV/STD prevention effort can provide the opportunity to form one. The School Health Team can include a balance of students and adults who have various responsibilities in the school; members should be committed to the idea

of health and HIV/STD prevention. The School Health Team, or selected members, can be responsible for planning, designing and evaluating efforts to prevent and reduce HIV/STD. Active participation builds a sense of ownership and involvement, which underpins community support and enhances the sustainability of the programme.

4.1.2 Community Advisory Committee

A Community Advisory Committee can represent a wide spectrum of local groups and organizations that are somehow linked to the school and provide information, arrange resources, give advice and provide support for HIV/STD prevention. It is important for schools to work with outside groups and individuals who have an impact on students' knowledge, attitudes and behaviours related to HIV/STD prevention.

The Community Advisory Committee should include men and women with a diversity of skills who:

- are influential in the community or district
- are interested in health promotion and HIV/STD prevention
- are able to mobilize support and connections
- represent the community's geographical areas as well as economic, social, ethnic and religious make-up

It may be beneficial to collaborate with existing community groups, such as a healthy city council or local AIDS prevention committee. Potential partners can include: representatives of local government and non-governmental organizations, businesses and vendors, media, religious leaders, community residents, community youth agencies, social service providers, health service providers and sports figures.

To facilitate the efforts of the School Health Team, the Community Advisory Committee can help to:

- determine local needs and resources
- disseminate information about health and HIV/STD prevention
- build community support
- encourage community involvement
- help obtain resources and funding for health and HIV/STD prevention interventions
- reinforce learning experiences provided in school

The Community Advisory Committee and the School Health Team should work together to plan health promotion efforts and coordinate the various components of a Health-Promoting School, such as health education, health services, and community and family involvement so that all aspects of health promotion work together for health and HIV/STD prevention.

Implementing HIV/STD prevention interventions provides an opportunity to form a Community Advisory Committee that can subsequently address other health promotion issues.

4.2 Situation analysis

Policy-makers, decision-makers and interested groups at national, district and local levels should consider a situation analysis to guide the development of Health-Promoting Schools and HIV/STD prevention programmes. The School Health Team and Community Advisory Committee, once established, can start the local planning process by conducting a situation analysis.

4.2.1 Purpose of conducting a situation analysis

A situation analysis will help people better understand the needs, resources and conditions that are relevant to planning interventions. A good situation analysis has several benefits:

- Policy-makers and decision-makers need strong arguments, especially when their actions involve allocating resources.
- Accurate and up-to-date information can provide a basis for discussion, justification for action, setting priorities and identifying groups in special need for interventions, such as children living in geographical areas where HIV/STD infections and substance use are prevalent.
- Data obtained through the situation analysis can help ensure that interventions are tailored to the specific needs, experience, motivation and strengths of students, staff, families and community members. Data also provide a baseline against which to measure trends in HIV infection and related behaviours, such as condom use or shared needle use.

4.2.2 Information needed

Information about potential risk may be very important for convincing policy-makers and the public that HIV/STD interventions are important in schools. Look for HIV and STD infection rates, where they are available: current data about death caused by AIDS or substance use can also be useful. These data are useful in determining the extent to which HIV, AIDS, STD and substance use are health problems in the community or nation. Data on sexual behaviour, unintended pregnancy and (psycho-active) substance use rates can help to determine the extent to which young people are at risk of HIV/STD infection in the community or nation.

Data about knowledge, attitudes and skills are also important for planning effective education programmes.*(19)* These data may already be available from the local health unit or can be obtained by conducting a survey. Many survey questionnaires exist and the local health agency may be able to provide examples. These data are especially useful prior to beginning HIV/STD prevention interventions in schools. The table below outlines the basic questions that might form the basis of a situation analysis and sets out the methods for collecting data.

Basic Questions	Methods for Data Collection
How prevalent are HIV and STD infections, unintended pregnancy and substance use in the community or nation?	Review existing data from a local health authority; or sample survey by self report
How prevalent are HIV, STD infection and unintended pregnancy in school-age children and young people?	Same as above; data for infection rate and burden
How many people are thought to be affected by HIV/AIDS?	Same as above
Are there data on HIV infection rates or AIDS-related deaths among school-age children, young people or adults in your community or nation?	Same as above
What are the important behaviours, behaviour determinants and conditions that place young people and adults at risk for HIV infection in the community?	Local health unit; STD data; substance use data

Do parents, teachers and young people have basic knowledge about AIDS and HIV/STD infection?	Questionnaire; Focus group discussions
What are the common attitudes and beliefs of teachers, parents and youth towards AIDS and HIV/STD infection?	Same as above
What are the common attitudes and beliefs of teachers, parents and youth towards education about AIDS and HIV/STD infection?	Same as above
Does any school HIV policy pertaining to privacy, learning and employment exist, and are school staff, teachers and students informed of its existence?	Interview with school officials
Are other health programmes and interventions being implemented in schools into which education about HIV/STD can be integrated?	Interview with school and community leaders

4.3 Political and cultural acceptability

4.3.1 Political commitment

The success of efforts to implement Health-Promoting Schools and education to prevent HIV/STD infection depends on the will, commitment, support and action of health and education authorities. Endorsement and support from leaders and senior officials are essential. Political and community leaders, as well as concerned citizens, must be involved in supporting HIV/STD prevention interventions in schools.

Evidence of political commitment:

- Public acknowledgement by a wide range of political, social and religious leaders of the importance of HIV/STD prevention and the need for schools to play a significant prevention role
- Clear sanction and support from the Ministries of Education and Health
- Financial support to ensure that schools have sufficient resources to develop and implement policies, curricula and training.
- Demonstration of solidarity towards those infected and affected by HIV/AIDS in communities and nations. *(20)*

4.3.2 Community commitment

Success also depends on the extent to which people in the community are aware of and are willing to support health promotion efforts. From an early stage, schools need to obtain from parents and community members about the design, content, delivery and assessment of the programme. Schools can then respond to their concerns and get their commitment. Community group meetings, parent-teacher associations, formal presentations, open houses, civic clubs and religious centres organised by the Community Advisory Committee are useful vehicles for community involvement. Commitment and support of many parties on various levels is needed to share expertise, facilities and resources. Partnerships with representatives from sectors such as education, health, business, communication, recreation, voluntary service, nongovernmental organisations and religious groups can demonstrate and provide commitment, resources and support for health promotion and HIV/STD prevention.

Communities can show their commitment by:

- Acknowledging, openly, the importance of HIV/STD prevention: local health and education officials, community leaders and other relevant groups can voice their views and lead the way
- Allocating local resources, such as public money for HIV/STD prevention interventions in schools
- Coordinating school interventions and activities with other programmes in the community, such as community-based prevention programmes, substance use prevention programmes, local testing/counselling agencies and hospice services.
- Ongoing efforts to attract community attention to the problem, through HIV- and STD-related peer education, dramas, print material and community forums
- Involving existing councils, school boards and organisations, such as women's groups, youth groups and civic groups to gain a critical mass of support

4.3.3 Supportive school policies

Developing supportive HIV/STD-related school policies is as important as designing HIV/STD education. Supportive school policies guide the planning, implementation and evaluation of efforts to promote health and prevent HIV/STD infection. School policies are brief documents that set out a clear set of school standards on health and HIV/STD prevention. They incorporate the input of all relevant constituents of the school community: students, teachers, parents, staff, administrators, nurses and counsellors. Policies need to:

- meet national and local needs and standards and be adapted to the health concerns, norms and values of different ethnic and cultural groups represented at school.
- support collaboration and coordination between the health and education sectors and between the school and community are essential for success.
- address all components of a Health-Promoting School that will be modified through the programme.

Examples of supportive policies and regulations:

- Policies that require HIV/STD training for all school personnel
- Required coordination between health and education authorities at local and district levels in planning and implementing HIV/STD interventions in schools
- Policies for students and personnel that support privacy, attendance, employment and infection control
- Policies that support HIV/STD prevention and other health interventions for all levels of schooling, starting in the earliest grade and continuing through the last grade.
- Designation of a school-level coordinator with responsibility and authority to deal with issues and concerns

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- Designation of a school-level coordinator with responsibility and authority to deal with issues and concerns

- Policies about the content of curricula, including sensitive issues such as sexual abstinence, safe sex, birth control, family planning, sexual harassment and sexual orientation
- A code of professional ethics that protects students, teachers and staff from sexual harassment and abuse.(21)

4.4 Goals and objectives of HIV/STD prevention interventions in schools

Using information gathered in the situation analysis, the School Health Team, in collaboration with the Community Advisory Committee, can develop goals and objectives for health promotion and HIV/STD prevention interventions.

4.4.1 Goals

Goals should describe in broad terms what the programme is to achieve. In a Health-Promoting School, the overall goal of HIV/STD-related interventions is to prevent HIV/STD infection and reduce HIV-related discrimination. A goal must be broken down into specific objectives so that everyone clearly understands what needs to be done to achieve the goal.

4.4.2 Objectives

Objectives are steps for achieving the overall goal. Objectives may focus on health status, behaviour and/or conditions, as well as measurable changes in knowledge, attitudes, skills and services. The following list provides examples of objectives that could be developed for HIV/STD prevention interventions in middle and/or secondary schools:

By (insert date), the percentage of students who report that they engage in sexual intercourse without a condom will be reduced from ... percent to at least ... percent as evidenced by self reported information collected in anonymous surveys of secondary school students.

By (insert date), the percentage of students that are able to identify at least four ways that HIV is transmitted will increase from ... percent to at least ... percent as evidenced by pre- and post-test results among middle school students.

By (insert date), the percentage of students that participate in at least one school/community project to prevent HIV/STD infection and related discrimination will increase from ... percent to at least ... percent as evidenced by student activity reports.

By (insert date), the percentage of students who report that they are confident they can assert their decision not to engage in sexual intercourse with pressuring partners will increase from ... percent to at least ... percent, as evidenced by pre-post tests of middle school students.

5. INTEGRATING HIV/STD PREVENTION INTERVENTIONS WITHIN VARIOUS COMPONENTS OF A SCHOOL HEALTH PROGRAMME

A Health-Promoting School strives to use the school's full organizational capacity to improve the health of students, school personnel, families and community members. Such a school offers many opportunities to promote HIV/STD prevention as an essential element for the attainment of health. HIV/STD prevention interventions can serve as an entry point for developing or enhancing policies, planning groups and the various components that serve as a framework for a Health-Promoting School. These components include, but are not limited to:

- school health education
- healthy school environment
- school health services / counselling and social support
- school / community projects and outreach
- health promotion for school staff
- physical exercise, recreation and support (Sport ?)

Effectiveness of interventions integrated into each of these components depends on the extent to which they are supported by people, policies and trained staff. Not every school will have the resources to integrate HIV/STD prevention interventions into all of the components at one time. Each school has to establish its own priorities, in collaboration with all parties concerned, to decide how thoroughly the components will be addressed.

A Health-Promoting School enables students, parents, teachers and community members to work together to make such decisions. It is important to start with small changes as soon as possible instead of waiting until resources become available to address all of these components simultaneously.

5.1 School health education

Overall, school health education seeks to help individuals adopt behaviours and create conditions that are conducive to health. Thus, *the clear and precise delineation of behaviours and conditions that are to be influenced is essential for the development of effective school health education efforts.* Examples of behaviours and conditions commonly addressed to prevent HIV/STD and related health problems are listed below.

Common behaviours related to HIV infection

- **Sexual behaviours that increase risk for contracting HIV infection:**
  - vaginal intercourse without a condom with an infected person
  - anal intercourse without a condom with an infected person
  - semen or vaginal fluid taken into the mouth during oral-genital sex
  - any sexual act that involves the contact of blood, semen and/or vaginal fluid between two or more persons *(15)*

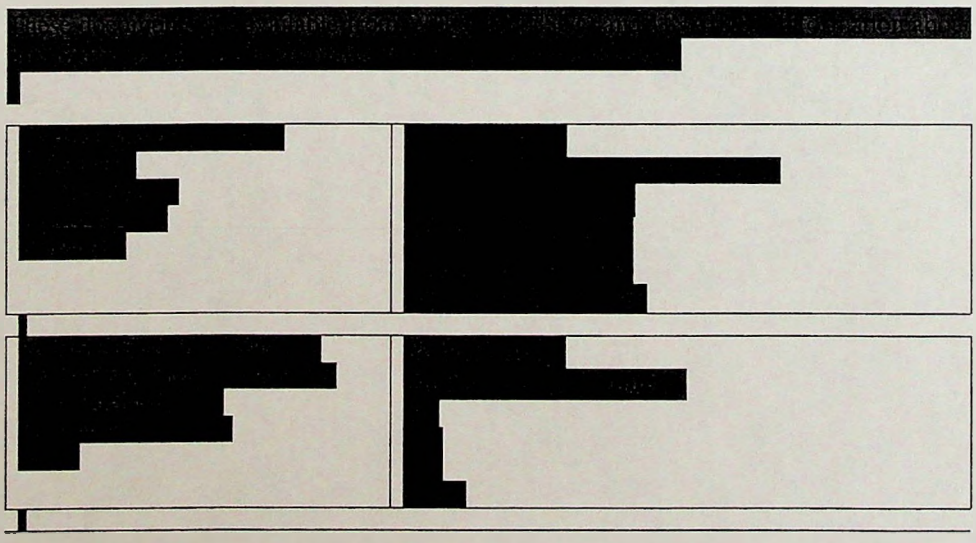
- **Substance use behaviours that increase risk of HIV infection:**
  - sharing needles with HIV-infected persons or persons who do not know their health status
  - using alcohol and other substances that lower inhibitions and increase the chances of engaging in unsafe sexual practices or substance use
  - failure to boil equipment if clean needles are not available
  - failure to clean shared needles (by rinsing them twice with water, twice with bleach, twice with water)

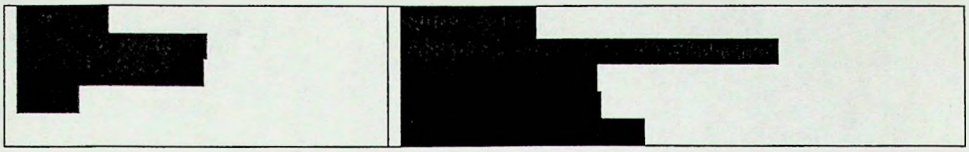
- **Perinatal behaviours that increase risk of infecting the unborn child:**
  - failure to obtain prenatal testing and treatment, when available, to reduce risk of infecting the unborn child
  - failure to assess risk of infection to child via breast-feeding

- **Transfusion or use of blood products/equipment that present risk of infection:**
  - failure to consider the degree of risk before accepting blood in countries that do not conduct routine testing of blood donations
  - receiving donated blood of unknown origin in countries that have not achieved a safe blood supply
  - using needles, syringes or other drug injecting equipment that are not sterilized.

- **Behaviour involving instruments that present risk of infection:**
  - failure to clean instruments that may involve blood, such as tattoo, skin piercing and shaving instruments, dental equipment and medicinal drugs administered through injectors

To help schools develop health education interventions to address such behaviours and conditions, WHO and UNESCO have developed "School Health Education to Prevent AIDS and STD", a resource package containing a Handbook for Curriculum Planners, Student Activities and a Teacher's Guide.





5.1.1 Knowledge, values, beliefs, attitudes, skills and related conditions that influence behaviours associated with HIV/STD infection

In a Health-Promoting School, health education to prevent HIV/STD infection is designed to help students acquire the knowledge, attitudes, beliefs, skills and support needed to make informed decisions, practice healthy behaviours and create conditions conducive to health. The design must consider the developmental level of the students, starting at primary levels and continue into secondary levels, building on and reinforcing previous learning experiences.

Important knowledge, attitudes, values and skills related to the prevention of HIV and related discrimination are described in the boxes below. Items are categorized for different developmental levels (young children, pre-adolescents and adolescents). Close collaboration between education and health officials, as well as with parents, students and community members, is necessary for schools to determine which is the most important and appropriate content to provide to help their young people avoid HIV and STD infection.

Young Children: Knowledge, attitudes, beliefs, values and skills related to HIV transmission that are necessary for **young children** to acquire.

Knowledge: Students will learn that:

- HIV is a virus some people have acquired
- HIV is difficult to contract and cannot be transmitted by casual contact, such as shaking hands, hugging, or even eating with the same utensils
- people can be HIV infected for years without showing symptoms of this infection
- many people are working diligently to find a cure for AIDS and to stop people from contracting HIV infection.

Attitudes/Beliefs/Values: Students will demonstrate:

- acceptance, not fear, of people with HIV and AIDS
- respect for themselves
- respect between adolescent males and females – tolerance of differences in attitude, values and beliefs
- understanding of gender roles and sexual differences
- belief in a positive future
- empathy with others
- understanding of duty with regards to self and others
- willingness to explore attitudes, values and beliefs
- recognition of behaviour that is deemed appropriate within the context of social and cultural norms
- support for equity, human rights and honesty

Skills: Students and others will be able to:

- acquire practical and positive methods for dealing with emotions and stress
- develop fundamental skills needed for healthy interpersonal communication

Pre-adolescents: Knowledge, attitudes, beliefs, values and skills related to HIV transmission that are necessary for **pre-adolescents** to acquire.

Knowledge: Students will learn:

- bodily changes that occur during puberty are natural and healthy events in the lives of young persons, and they should not be considered embarrassing or shameful
- the relevance of social, cultural, and familial values, attitudes and beliefs to health, development and the prevention of HIV infection
- what a virus is
- how viruses are transmitted
- the difference between AIDS and HIV
- how HIV is and is not transmitted

Attitudes/Beliefs/Values: Students will demonstrate:

- commitment to setting ethical, moral and behavioural standards for oneself
- positive self-image as a result of defining positive personal qualities and accepting positively the bodily changes that occur during puberty
- confidence to change unhealthy habits
- willingness to take responsibility for behaviour
- a desire to learn and practice the skills necessary for everyday living
- an understanding of their own values and standards
- an understanding of how their family values support behaviours or beliefs that can prevent HIV infection
- concern for social issues and their relevance to social, cultural, familial and personal ideals
- a sense of care and social support for those in their community or nation who need assistance, including persons infected with and affected by HIV
- honour for the knowledge, attitudes, beliefs and values of their society, culture, family and peers

Skills: Students will be able to:

- communicate messages about HIV prevention to families, peers and members of the community
- actively seek out information and services related to sexuality, health services or substance use that are relevant to their health and well-being
- construct a personal value system independent of peer influence
- communicate about sexuality with peers and adults
- use critical thinking skills to analyse complex situations that require decisions from a variety of alternatives
- use problem-solving skills to successfully master the decisions about issues that are experienced by young persons
- influence others in relation to sexual behaviour and other interpersonal activities in ways that protect one's self-esteem, health and well-being
- communicate clearly and effectively a desire to delay initiation of intercourse (e.g., negotiation, assertiveness)
- appropriately use health products (e.g. condoms)
- show empathy toward persons who may be infected with HIV

Adolescents: Knowledge, attitudes, beliefs, values and skills related to HIV transmission that are necessary for **adolescents** to acquire.

Knowledge: Students will learn:

- how the risk of contracting HIV infection can be virtually eliminated
- which behaviours place individuals at increased risk for contracting HIV infection
- what preventive measures can reduce risk of HIV, STD and unintended pregnancies
- how to obtain testing and counselling to determine HIV status

Attitudes/Beliefs/Values: Students will demonstrate:

- understanding of discrepancies in moral code
- a realistic risk perception
- positive attitude towards alternatives to intercourse
- conviction that condoms are beneficial in protecting against HIV/STD
- willingness to use sterile needles, if using intravenous drugs
- responsibility for personal, family and community health
- support for school and community resources that will convey information about HIV prevention interventions
- encouragement of peers, siblings and family members to take part in HIV prevention activities
- encouragement of others to change unhealthy habits
- a leadership role to support the HIV prevention programme
- willingness to help start similar interventions in the community

Skills. Students will be able to:

- refuse to have sexual intercourse
- assess risk and negotiate for less risky alternatives
- purchase and demonstrate the appropriate use of condoms
- obtain and demonstrate the appropriate way to sterilise needles

5.1.2 Important considerations in planning education about HIV/AIDS/STD

Virtually every school will have students who have in the past or who are at present engaging in risky sexual behaviour, whether by their own choice or forced by others. Students must be taught specific ways to reduce the risk of HIV/STD infection.

Health education to prevent HIV/STD infection and related discrimination should be an important part of a school health curriculum, integrated into various subject areas and included in the school's extracurricular activities. School health education should be provided as a planned, sequential course of instruction from the primary through the secondary levels, addressing the physical, mental, emotional and social dimensions of health. It can be taught as a specific subject, as part of other subjects, or as a combination of both.

Health education to prevent HIV/STD infection and related discrimination *should be combined with education about life skills, reproductive health and alcohol/substance use so that the learning*

experiences will complement and reinforce each other. To link these issues, organize them into a school health education curriculum and/or coordinate the simultaneous or sequential presentations of related topics in different classes. Co-teaching, sharing teaching resources, referring students to related lessons and involving students from different classes in group activities also link health, HIV/STD prevention and other relevant topics.

Scientific terms and biological-technical details may seem important; however, for the purposes of health education, they are less important than practical and basic information that will enable students to avoid infection. It is more important for a student to learn how the virus is spread and how to negotiate safe sex, for example, than to learn about the composition of the virus.

Students need to also learn about the fears that surround HIV/AIDS/STD. Some students may fear risk when abstaining from sexual intercourse or engaging in common sexual activities such as masturbation. Some students may experience fear when engaging in expressions of affection such as hugging, kissing and touching genitals. Some students may fear being near or touching someone who may have acquired HIV infection. Because of misconceptions about how HIV is and is not transmitted, some students may suffer undue anxiety and concern. Students must be taught how the virus is and is not spread. When they overcome fear, their understanding and empathy toward people who have HIV/AIDS can grow.

Interviews, informal discussions or questionnaires can be used to gain Useful information from students and parents about values, beliefs and attitudes that may influence behaviours and conditions associated with HIV infection. Information enhances understanding among teachers, other school personnel and health workers, and allows them to focus interventions on the factors that contribute most to HIV infection in the community. This information is also important in developing complementary educational efforts such as those carried out by mass media, health workers, religious groups and other organizations.

The influence of mass media is important to consider. Young people are frequently exposed to and influenced by the media. While schools are teaching one set of messages, the media may be providing quite different messages. School-based programmes should take into account information provided through the mass media and take steps to refute unhealthy messages.

Three steps may be useful to schools as they tailor HIV/STD education to the specific needs of students and others in the community:

- Secure the collaboration of education and health authorities and involve parents, students and community members as well as local organisations in the information collection process.
- Identify specific behaviours and conditions most relevant to HIV/STD prevention in the community.
- Identify specific factors associated with the behaviours and conditions that are most relevant to the community. Specifically delineate the knowledge, attitudes, beliefs, values and skills that students need to acquire in order to practice healthy behaviours and reduce conditions that increase risk of HIV/STD infection.

Integrating educational efforts to prevent HIV/STD and related discrimination into other school health components, such as physical activity and health promotion for staff, will enhance the overall framework of a Health-Promoting School.

5.1.3 Selecting educational methods and materials for health education

Educational methods such as lectures, discussion, role-plays and audio-visual aids should be selected to address specific factors, such as knowledge, attitudes and values, myths, skills and support related to a particular behaviour. Materials need to correspond with the developmental level of students and be sensitive to the cultural context.

Select an education method on the basis of how well it will influence a particular factor. For example, a lecture is an effective way to increase knowledge, but less effective in influencing beliefs and building skills. Discussions, debates and carefully prepared written materials can be more effective than a lecture in dispelling the logic or foundation of local myths. Practice sessions and role play exercises are more effective in building skills than lectures, discussions, debates or written materials.

5.1.4 Choosing educational options

Education about HIV/STD prevention and sexual behaviour poses a major dilemma for many educators, a dilemma fuelled by public pressures and the different beliefs and values of the state, various religions and diverse parents. Several options are often proposed as schools try to determine the most appropriate foci for HIV/STD education in a community. Each needs to be considered and discussed with teachers, parents, students and members of the Community Advisory Committee; as a strategy to prevent HIV infection, each option has its own strengths and limitations. The options are:

- abstinence from sexual intercourse
- non-penetrative sex
- condom use
- monogamy with an uninfected partner
- abstinence from substance use

If schools choose to help students recognise all the options for prevention, they can teach students to select options that correspond to their own standards, lifestyle, age and personal situation. Some options will only be realistic for older students. If schools choose to promote only one option, they are likely to fail to provide a viable option for a significant proportion of students. Thus, each option should be discussed and careful considered. A combination of options is clearly a more complete and potentially effective approach.

Abstinence from sexual intercourse

From a medical point of view, this practice is the safest, as it reduces the chances of infection with HIV and STDs through sexual behaviour to zero and is in accordance with traditional values about young people and sexuality held in many parts of the world. In practice however, young people in many countries do have sexual relationships, or may be forced to have sex, so a significant number of them may not find the option of abstinence acceptable or realistic. Many young people, who at first intend to abstain from sex, cannot maintain that intention because of peer pressure or other personal or social factors. Programmes that promote abstinence alone have proven largely ineffective in reducing sexual activity or sexual risk taking.

Non-penetrative sex

Sexual behaviours that involve the exchange of semen, vaginal fluids or blood between partners can pass HIV from an infected to a non-infected partner. These behaviours include vaginal and anal intercourse without using a condom, taking semen or vaginal fluids into one's mouth in oral sex and any sex act that involves blood contact. Abstaining from these risky behaviours virtually eliminates the chances of contracting HIV infection but does not eliminate the chance of contracting other STDs. Kissing, hugging, touching/caressing and non-penetrative sexual activities such as masturbation do not carry the risk of HIV infection and are not likely to result in an STD. For many young people, however, and especially for adolescent males, sex means vaginal intercourse, and they may not accept the option of non-penetrative sex.

Condom use

A condom, used appropriately in connection with potentially risky sexual behaviour, reduces the risk of HIV/STD infection considerably. In spite of what parents and other adults tend to think, adolescents tend to be sexually active. In many countries, the average age of first sexual intercourse is about seventeen years,**(22)** and in some countries the average age of initiation is even lower. Although young people usually are monogamous within a given relationship, the relationship itself lasts for a short period of time. Most young people who are sexually active can be called serially monogamous; they do not realize that serial monogamy is identical to having multiple sexual partners. Acceptance of condom use is growing and condoms are increasingly available throughout the world. Moreover, research shows that education about condom use does not lead to increased promiscuity among young people. *(23)*

Monogamy

An exclusive sexual relationship with one person can protect against HIV/STD infection, provided that the sexual partners are not already infected when entering the relationship and do not become infected during the relationship. However, marriage, divorce and remarriage to another partner have become increasingly commonplace in many countries. (24) Extramarital relationships pose a threat to people who rely on monogamy to prevent HIV/STD infection. An overwhelming majority of people disapprove of extramarital sexual relations, but in fact, most have extramarital affairs at some point during their marriages.**24** In

polygynous societies, multiple sex partners are accepted and indicate a man's social and economic status. (24)

Substance and needle use

Drug use influences the spread of HIV directly and indirectly. An important drug use behaviour that puts people at risk for contracting HIV infection in a direct way is needle use. The behavioural objective in this case is to stop people sharing needles or to encouraging them to clean shared needles prior to use. Infection through needles is not restricted to illicit drug use and may also occur with medicinal drugs (administered in some countries through injectors), or with preventive care (such as vitamin injections in some cases), or tattooing or piercing. Modes of transmission vary greatly depending on the cultural context and the adequacy of health care: the content of local interventions need to reflect local culture and realities.

Misuse of alcohol and substance use can also increase risks indirectly by lowering people's inhibitions against engaging in unsafe sexual or drug-using behaviour.

5.1.5 Peer education and involvement

Participation and empowerment are key principles of a Health-Promoting School. Youth should be involved in preparing of school health programmes, in carrying out the activities and evaluating them in a structured way.

It is well known that young people get much of their sexual health knowledge from their peers. Young people are often sensitive to peer pressure and can exert a strong influence on one another. This influence can be negative, with young people encouraging each other to engage in risk behaviours, or channelled to have a positive influence.

Research shows that when peers deliver prevention it enhances the effects of the intervention. (25) Peers can contribute to HIV/STD prevention interventions in formal and informal ways. Education sessions led by peers can help to spread messages about what is safe behaviour and what is not. Young people can be effective educators: they can use language and arguments that are relevant and acceptable to their fellow students. They are capable of presenting information and skills in an informal way and in a safe atmosphere. For these reasons, they are credible and may be able to offer more applicable solutions to prevention problems among their peers.

Peer educators can sometimes reach groups that professionals cannot (e.g. intravenous drug-using youth, youth in prostitution, migrant youth, gay youth and marginalised youth). In some countries, the taboo on sexuality is very evident, and the distance between teachers and students is vast. Peer educators, working with students, can provide an entry point for HIV/STD education.

Peer education is an investment in young people. Peer educators can serve as role models and form the basis for peer support networks. They can serve as counsellors and as opinion leaders in setting the agenda, communicating values, promoting a positive social norm in safe(r) sex and in life-skills training.

The work of peer educators has an impact on the peer educators themselves. It offers opportunities for students to learn to care for others and to take control of their health. It can have a positive influence on their self-esteem, skills and attitudes with regard to sexuality and sexual health.

The role of a peer educator can extend far beyond the classroom. Peer programmes provide an excellent way to link schools to community-based organisations and offer opportunities to educate a vast number of people.**(25)** Students who are trained educators in HIV/STD prevention can address classes in their school and community youth groups, answer telephone hotlines and staff offices where students can drop by to discuss HIV/STD- related concerns and issues. Peer educators are relatively low cost and typically there is an abundant pool of potential volunteers.

In order to function effectively, however, peer educators need to be properly trained and supervised. It is already known that peer educators who have only been trained to transmit knowledge run the risk of being rejected by their peers because they are perceived as "know-it-alls". They need skills in counselling, empathy, decision-making, resistance to group pressure; assertiveness and building self-esteem. Follow-on coaching can support their efforts once they begin to work as peer educators.

5.1.6 Training school personnel to implement health education and other efforts to prevent HIV/STD infection and related discrimination

Teachers, who play a fundamental role in education, play an equally important role in preventive education. Pre-service and in-service training for teachers is crucial if preventive education is to be effective. Teachers and their representative organizations should be involved in every stage of planning, implementing and evaluating HIV/AIDS training. In particular teachers need to be trained to use participatory and interactive methods to ensure that education about HIV/STD is effective, as well as culturally and ethically appropriate for each community.

In all communities, the training of teachers should be of highest priority because, for better or worse, teachers are role models for their students and other members of their community. School personnel can be strong role models if they demonstrate their willingness to learn about HIV/STDs, the capacity to show compassion and empathy towards individuals infected and affected by HIV/AIDS and respect and understanding for others regardless of gender, sexual orientation or life circumstances.(26)

An HIV/STD training programme for teachers and other school personnel should include, besides a rationale for implementing HIV/STD education, guidelines that will support teachers in:

- mobilizing support inside as well as outside the school
- giving financial and professional incentives
- designing training, based on needs of the teachers and the school situation
- establishing pre- and in-service training for teachers of all grade level
- providing sufficient time for on-going training. **(21)**

The training design should begin at a level that is appropriate for the knowledge, attitudes, beliefs, values and skills of the teachers. However, in all cases it should include information on:

- allocation of personnel, time, resources and authority to a staff member who will be responsible for initiating, managing and coordinating the training

- development of a core group of trainers or training teams that will enable all relevant teachers and school personnel to receive training in a timely manner
- regularly scheduled follow-up sessions or other means by which to periodically provide updates on HIV/STD or related health problems
- supervision of coaching by experienced trainers for those teachers who would like to have this kind of support
- evaluation of the impact and effectiveness of the training and revision of the training format as needed (20)

The content for training should specifically include:

- accurate information about HIV/STD prevention
- accurate information about sexual behaviour, beliefs and attitudes of young people
- accurate information about alcohol and substance use in relation to HIV/STD prevention
- opportunities to examine the teachers' own standards and values concerning sexuality, gender roles and substance use
- explanation of a wide variety of teaching methods (especially participatory teaching methods)
- practice that uses various methods to impart knowledge, develop attitudes and build skills related to HIV/STD prevention and responsible sexual behaviour in a way that is inspiring and effective
- conflict management and negotiation skills
- identification and discussion of gender specific issues
- suggestions about ways to deal with cultural and religious traditions that may present barriers to discussions about sexuality
- lessons about how to promote compassion and appropriate guidance and care for persons infected with HIV
- skills necessary for identifying and referring students with sexual health problems to appropriate services
- integrating HIV/STD prevention and related topics into the existing curricula (7)

Curricula for HIV/STD prevention and other health-related issues may be available through governmental and nongovernmental agencies and organisations, universities or teachers' unions. Teachers and students themselves can also generate supplementary materials specific to the local situation. Information about obtaining the WHO/UNESCO resource package "School Health Education to Prevent AIDS and STD" is found in Section 5.1 School health education and in Annex XX.

5.2 A healthy school environment

School environment plays a key role in determining the success of HIV/STD prevention programmes. Creating an environment that fosters understanding, caring and empathy for others contributes greatly to positive values, beliefs and attitudes about HIV/STD prevention among students, teachers, staff and the community. To create an environment that supports education about HIV and other STDs, schools must consider policies and practices, including rules, guidance and referral to services.

5.2.1 Policy for HIV-infected school staff, teachers and students

A Health-Promoting School is a place that promotes a caring and supportive environment for individuals who work and study there. Students and teachers who are infected with HIV should not fear any restrictions based solely on their HIV status. There is no acceptable

reason for denying education to a student infected with HIV, or denying employment to a teacher infected with HIV/AIDS. For students and school personnel infected with HIV, it is necessary to create and/or uphold policies and regulations on attendance, confidentiality, support services and care and referral services.

Policies for HIV-infected students and school personnel may state points such as these:

- Confidentiality and privacy of HIV-infected persons should be guaranteed.
- Full attendance and equitable, safe and humane treatment for students and school personnel with HIV/STDs should be paramount.
- Decisions about educational and working environment, such as use of special aids or necessity to accommodate persons with HIV, must be documented and individualised;
- Special services can be provided to assist those with limited strength or whose illness hampers their educational and/or working performance.
- Policies and procedures on intervention and prevention of harassment should exist to promote an environment that fosters respect and compassion as well as social growth for all students and school personnel.
- HIV-related disability definitions should conform to prevailing laws, where applicable.
- Requirements and procedures established through collective bargaining must be respected.

Policies help ensure the social, emotional, psychological and physical well-being of HIV-infected students and school personnel. By serving all people equitably, the school promotes understanding, respect and compassion among its students, staff and community.

Efforts to develop policy for school personnel infected with HIV should aim to ensure that employers cannot take action against an employee based solely on his or her HIV status. Policy in terms of employment must not be influenced by HIV status. Reasonable accommodations should be made for employees who are able to perform the tasks of their position with reasonable assistance. These might include: job-related aids or services, change in work site, periodic rest periods and flexibility with occasional absences. (7)

5.2.2 Universal infection-control precautions for teachers and students

Universal infection-control precautions are practices that schools, like other organisations, need to follow to prevent a variety of diseases. Precautions should include policies on caring for wounds, cleaning-up blood spills and disposing of medical supplies.(7) While these precautions are valuable in preventing certain diseases, such as flu, chicken pox or ear infections, schools must recognise that HIV is more difficult to transmit. HIV/STD infection is not transmitted by casual contact, such as shaking hands, hugging or using toilet seats or eating utensils. Even kissing and deep kissing does not transmit HIV. Universal precautions are simply policies that schools put into place as safeguards for emergency situations. Schools should inform both personnel and students about the infection-control policy in order to diminish fears and address concerns through open discussion.

5.2.3 Creating an environment that promotes HIV/STD prevention and fosters understanding, caring and empathy for others.

A Health-Promoting School, rather than creating fear and tension among its students, teachers and staff, promotes values of mutual respect, acceptance and offers a safe, trustful environment. Teachers,

administrators, staff and students actively display these values inside and outside the classroom. Teachers demonstrate to students that HIV-positive individuals and people who associate with HIV-positive individuals are not to be feared. For example, a teacher might openly hug an HIV-positive student upon his or her return to the classroom after hospitalisation. Promoting activities in school, like *World AIDS Campaigns* and *AIDS Awareness Day*, are ways to support people who are infected or affected by HIV/AIDS. Such activities create understanding of HIV and its broad implications. As educators, people who are HIV infected or who have AIDS have had a great impact in correcting misunderstandings and in promoting solidarity. In many countries, the high prevalence of HIV and STD among homosexuals and men who have sex with men increases already existing homophobia and discrimination. Promoting gender equity and respect for different beliefs, cultures, religions and sexual orientation helps ensure that all teachers, students and staff feel accepted.

In addition to providing a social climate that promotes understanding and solidarity, a Health-Promoting School provides a physical environment that contributes to HIV/STD prevention. Examples include offering adequate information about HIV/STDs in the school library, mounting posters in the hall and instituting security regulations to ensure safe travel to and from school. The school can provide facilities for storing medication needed by students and staff. Some schools have worked with local health services to make condoms accessible to students who need them.

5.3 School health services

A Health-Promoting School can serve as a point of delivery of a wide variety of support services not available to students, teachers, staff and the community. Not all schools can provide such school health services, yet where resources are available consider the following services.

5.3.1 Caring and support

Health-Promoting Schools can maintain and support the mental health of students and staff in a manner that complements the prevention of HIV/STD infection and promotes physical health. An individual's psychological well-being, including self-esteem and self-confidence, is critical to making healthy decisions and avoiding health risk behaviours. School counselling programmes and support services that help students, school personnel and families cope with HIV/STD-related problems are important components of a Health-Promoting School.

Support services can address a range of health issues and involve a variety of professionals to deliver services. The AIDS epidemic, emphasising the importance of many of these services, has created the need for additional services of this type. Collaboration among teachers, administrators and parents is necessary for optimum provision of support services and to ensure they are available equally to students, staff and teachers.

Support services include:

- referring students to school and community-based support services for physical and mental health
- counselling or social support in areas of adolescent development, sexuality, peer pressure, identity formation, illness and death;
- developing peer networks to promote acceptance of a range of healthy sexual attitudes and behaviours;
- providing factual and up-to-date information on HIV/STDs and its prevention;
- providing places for students in which fear and anxiety about HIV/STDs can be expressed without ridicule or judgement (27)

Ideally, these services are easily accessible, do not have a waiting list and offer contact with the service provider on a regular basis.

5.3.2 Other support

School health services serve a vital role in meeting the diverse needs of the students, teachers and staff. Where available, one of the most effective ways in which a school can serve its students is by providing opportunities for referrals to an appropriate source of care, such as antibody testing or treatment of HIV-related conditions.

Out of school support

Close cooperation between community services, especially those aimed at youth, and school health services is necessary to ensure that referral services are directly available to students and staff. Schools can identify resources by developing and updating a referral list of appropriate organizations and contacting representatives of those organizations. Such a list might include: support groups for people with AIDS, home nursing, HIV-test counselling, drug treatment, emergency day care and other sources of assistance. School can also help to generate support services when community resources are inadequate.

Antibody testing

HIV-antibody testing is another area in which school health services can play an active role. Issues associated with youth and HIV testing are complex and varied. Pre-test and post-test counselling are crucial, and counselling techniques appropriate for adults are sometimes not appropriate for young people. (27) All such efforts should be confidential.

5.3.3 Treatment for HIV-related conditions

The needs of HIV-infected youth differ greatly from the needs of HIV-infected adults. Often, HIV infection will result in severe bacterial infections. Mental and motor deficiencies are found in a large number of children with HIV. Also associated with the progression of HIV infection are: slowing motoric activity, impaired intellectual ability, poor concentration and problem solving, and difficulty in merging visual-motoric abilities. It is important to have procedures for monitoring a student's condition. Where available, school health services may help in:

- administration of medication
- special feeding programmes, as recommended
- neurological assessments
- counselling or social support for peer and family relations

Schools should observe the confidentiality of infected students and school personnel and disclosed information to staff on a need-to-know basis only. The school nurse, in close collaboration with the student's physician, can help develop a care plan for an infected student that identifies the services needed as well as the roles and responsibilities of the school. The plan also identifies staff persons responsible for services and supervision and is revised as appropriate. As resources permit, a staff person can be responsible for coordinating support services as well as reporting changes in the student's physical or mental health status to parents and care providers. This staff person can help ensure that the student's educational needs are met during periods of absence due to hospitalisation or poor health.

5.4 Family, school and community projects and outreach

A Health-Promoting School that addresses health promotion and HIV/STD prevention by engaging students, school personnel, families and community members in collaborative and integrated efforts to improve health, both in the school and through school/community projects and outreach.

The family and community also provide settings where students can understand, practice and share what they learn about health and HIV/STD prevention in the classroom. Offering the potential to support and reinforce HIV/STD prevention interventions and health promotion, parents and community members must work together with school staff in order to create conditions that allow everyone to obtain good health. Students are most likely to adopt healthy sexual behaviour patterns if they receive consistent information and support through multiple channels, such as parents, peers, teachers, community members and the media. A Health-Promoting School needs to strengthen community links and involve parents and the wider community as much as possible. Community members and parents, in turn, should be justified in feeling that their school is open and receptive to their ideas and participation.

Cooperation and coordination between the school health programme and the community are likely to be most successful when dynamic, positive and productive school/community links exist. Schools and communities can benefit from partnerships with local businesses and representatives from agencies and organisations, such as local health departments and youth-serving agencies. The school, for instance, can utilise specialist services in the community to obtain advice and support in preventing HIV/STD infection and promoting health in school. Commercial organisations and businesses can advise on health choices or provide donations in support of HIV/STD prevention. Collaboration is especially important with national and local youth organisations in an effort to gain support for HIV/STD prevention. Partnerships between schools and organisations may include jointly scheduled activities, or coordination of resources and collaboration under a mutually agreed mission.

School/community projects provide a way for students to become actively involved in the learning process. They provide a forum where the community can acquire specific health-related knowledge, a prerequisite for enabling community members to take control of their behaviours and those conditions that prevent HIV/STD infection. Various ways to involve the students in their own learning process are described in Section 5.1.5, Peer education and Involvement.

Drama is a powerful way to reach families and members of the community. Historically a way of conveying information to large groups of people, drama provides an opportunity for audiences to experience abstract concepts visually. It allows for easy-to-understand language and dialects. Drama creates a forum for communication about sensitive issues in a culturally and socially acceptable manner. Able to reach many people in various locations, it is an excellent method to use when conveying information to youth because it allows for creativity as well as participation. When schools involve youth in a drama presentation about HIV/AIDS, and other health issues, they must be very clear about the health message conveyed. Character development provides insight about perceptions that others have about HIV/AIDS or other health issues, and also helps develop respect and appreciation for experiences of people from different backgrounds. (28)

5.5 Health promotion for school staff

In a Health-Promoting School, health promotion is not limited to students. It is also provided for teachers and nonteaching staff. All school personnel need to learn how to avoid HIV/STD infection and encouraged to show solidarity with people living with HIV/AIDS. There are several reasons why school health promotion for staff is important. School personnel can help identify policies and practices that support or undermine their

health and well-being. A school health promotion programme for staff can help develop policies that support their health and find ways to change policies that are not conducive to the health of teachers and other staff. These efforts benefit the school: healthy teachers are better able to fulfill their responsibilities and serve as strong role models.

6. EVALUATION

Evaluation, a powerful tool that can inform and strengthen school health programmes, can be used to plan as well as to document the effects of action. Most evaluations seek to provide information about the extent to which the programme is being implemented as planned and producing the intended effect.

Evaluation helps to:

- provide information to policy-makers, sponsors, planners, administrators and participants about the implementation and effect of the programme
- provide feedback to those involved in project planning to determine which parts of the programme are working well and which are not
- make improvements or adjustments in the process of implementation
- demonstrate the value of the efforts implemented by the school, parents, students and community members
- document experience gained from the project so that it can be shared with others

Responsible officials, members of the school health team or their designees should regularly review the implementation process and assess the effectiveness of school health interventions. All groups affected by the programme should have the opportunity to provide input. Based on the results of information gathered from evaluation, those involved in planning and carrying out the interventions will make decisions about the programme and its various components.

An evaluation is useful and complete only when its results are reported, communicated to those who are involved, and used to improve programme efforts.

6.1 Types of evaluation

Two main types of evaluation are most relevant to school health programmes: process and outcome evaluation.

6.1.1 Process evaluation

Process evaluation assesses how and how well the interventions are being implemented. Process evaluation answers questions such as these:

- To what extent are the interventions being implemented the way they were intended?
- To what extent are the interventions reaching the individuals in the target group?

Evaluation is an important activity that is often limited because of scarce resources: time, personnel or budget. When resources for evaluation are scarce, schools may find it more feasible to conduct a process evaluation rather than an outcome evaluation. Too often, programmes rush to study their impact on youth without fully understanding whether or how well the intervention was implemented. Process evaluation can show that the intended programme is effectively implemented before outcome evaluation is attempted.

6.1.2 Outcome evaluation

Outcome evaluation measures the extent to which the programme achieves specific objectives. It can demonstrate the benefits of school health promotion programmes or illustrate the need for further programmes. Outcome evaluation can demonstrate changes in behaviour, increases in knowledge, changes in attitude or belief, increased confidence to use new skills and improvements in social or environmental conditions that are relevant to the prevention of HIV infection and related discrimination. Brought to the attention of the community, the evaluation results can help reinforce commitment and convince others to support the programme.

6.2 Evaluating the planning and implementation of HIV/STD interventions

6.2.1 Evaluating HIV-related policies

School health HIV-related policies (addressed in Chapters 4 and 5), can be assessed to determine what exists and what the policies cover. Content and process can be assessed by comparing adopted policy with policy guidance that may be available from the local health agency or other relevant organisations. Expert appraisal of the medical content of the policy can ensure that facts and medical research are accurately reflected. Persons for whom the policies are intended can be surveyed for their insights as to the value of the policy.

Here is a checklist that schools can use to evaluate a school's HIV-related policies.

Does a school policy exist that:

- ☐ expresses the goal of preventing the spread of HIV infection and minimizing the negative impact of HIV/AIDS?
- ☐ offers rationale for educating students and school personnel about HIV/STD infection?
- ☐ addresses the placement of HIV/STD in the curriculum?
- ☐ encourages the integration of HIV/STD issues into relevant subject areas?
- ☐ outlines the amount of time that should be devoted to education about HIV/AIDS/STD?
- ☐ requires that HIV/STD lessons are taught sequentially from primary school through secondary school, taking into account the students' ages and developmental stages?
- ☐ establishes a supportive school environment that does not discriminate against students or teachers based on their sexual orientation or gender?
- ☐ ensures that teachers are protected from criticism or censure if they address controversial topics like HIV/AIDS and sexuality in a manner consistent with school policy?

For HIV-positive students and staff, does a policy exist to:

- ☐ protect their privacy and confidentiality?
- ☐ outline appropriate hygienic precautions about exposure to blood?
- ☐ ensure that students' and teachers' rights to education and employment are upheld?
- ☐ guarantee nondiscrimination as it relates to staff, students and family?
- ☐ ban discriminatory comments among students and staff (28)
- ☐ include emergency leave for illness or bereavement of school personnel, students and related family members?

6.2.2 Evaluating HIV/STD curriculum

Proposed curricula should be carefully reviewed. Curriculum review committees are perhaps the best way to evaluate curriculum content. By combining experts with teachers, students and community leaders, the committee can achieve a balance of opinions so that curricular content can be developed with consideration for community values. Here is a checklist that schools might use to assess important aspects of curriculum development.

Does the curriculum:

- ☐ integrate HIV/AIDS education across the core curriculum and within comprehensive school health education?
- ☐ provide all students, at each grade level, with age- and gender-appropriate learning experiences, and consider cultural and religious beliefs?
- ☐ include the prevalence of HIV/STD infection among young people in the nation/area and the extent to which young people practice behaviours that place them at risk of infection?
- ☐ define curriculum objectives that reflect the needs of students, based on local assessments and relevant research?
- ☐ include lessons that provide opportunities to address a range of preventive options, e.g., delaying sexual intercourse, condom use, no use of drugs, use of clean needles?
- ☐ include opportunities to practice skills for avoiding HIV/STD infection, pregnancy and drug and alcohol use?
- ☐ address the use of effective teaching strategies in the design of the curricula?
- ☐ provide opportunities for parents and the community to learn about and reinforce education about HIV/STD?
- ☐ help students recognize their attitudes and feelings about HIV and people living with AIDS?

6.2.3 Evaluating HIV/STD staff development programmes

Whether students will improve their HIV/STD-related knowledge, skills and attitudes depends to a large extent on their teacher's ability to communicate effectively and teach about complex and sometimes taboo topics. Training can be provided in in-service workshops or continuing education programmes. (See 5.1.6)

Survey instruments that can be used to evaluate staff development activities include surveys to assess: educators' needs; general attitudes among educators towards people with HIV or AIDS; confidence in teaching abilities; comfort with sensitive issues; and HIV/AIDS knowledge. These can be administered pre- and post-training. Below is a checklist to assess important aspects of HIV-related training.

Does training for school personnel include:

- ☐ training objectives and content that will meet identified needs of the teachers?
- ☐ allocation of authority, personnel, time and resources to a staff member who will be responsible for initiating, managing and coordinating the training?
- ☐ follow-up sessions or other means by which to periodically provide updates on HIV and other important health problems?
- ☐ consistency with the HIV/STD and substance use education offered in the

curriculum?

- ☐ practices to increase teachers' comfort with discussing sexual behaviour, intravenous drug use and slang terms?
- ☐ ways to deal with cultural and religious traditions that perhaps hinder discussion about sex and sex-related matters in the school?
- ☐ innovative participatory techniques, skill-building exercises, and HIV/AIDS-related topics integrated into the existing curriculum?
- ☐ referral skills and ways to access health and social services?
- ☐ methods to assess the impact and effectiveness of the training, with revisions in the training format made as needed?

6.2.4 Evaluating the school environment

School environment strongly affects the success of classroom interventions. (See 5.2) The following checklist may be helpful in evaluating the degree to which the school is creating an environment that supports principles and interventions related to HIV/STD prevention.

- ☐ Does the physical and psycho-social environment:
- ☐ provide information about HIV/AIDS in the school library?
- ☐ sponsor school assemblies or after-school programmes designed to promote HIV prevention?
- ☐ display posters and relevant materials as part of a public awareness programme?
- ☐ place HIV/STD prevention high on the agenda for meetings of parent/community/school groups?
- ☐ maintain a school/community task force to develop programming to prevent HIV/AIDS/STD and related discrimination?
- ☐ provide resource materials for parents to supplement school programmes? (25)
- ☐ provide opportunities for students and staff to openly address their fears through discussion?
- ☐ promote values of mutual respect, acceptance and trust?
- ☐ host positive activities like the World AIDS Campaign and AIDS Awareness Day events?

6.2.5 Evaluating school health services

Services for those infected or affected by HIV/AIDS can support individuals in need and contribute to a positive school environment. The following checklist may be helpful in evaluating the extent to which health-related services are available.

- ☐ Does the school provide or facilitate access to:

- ☐ school counselling programmes and social support to guide students, staff and families through HIV/STD-related problems?
- ☐ counselling or social support in the areas of adolescent development, sexuality, peer pressure, identity formation?
- ☐ Referrals for students and staff to appropriate nonschool-based physical and mental

health services, where those services are available?

- ☐ confidential or anonymous HIV-antibody testing with pre-and post-test counselling?

Are health services in the school or agencies to which the school refers:

- ☐ offered by providers who are trained in skills to work with young men and women, married and unmarried, in a supportive, nonjudgemental way?
- ☐ organised to overcome barriers that often discourage adolescents, including lack of confidentiality, transportation, inconvenient appointment times and high costs?
- ☐ integrated with other relevant services in the community?

6.3 Evaluating student outcomes

When the school has determined that HIV-related policies, curricula, and/or interventions have been adequately implemented, and resources are available, the School Health Team may be ready to conduct outcome evaluation. This evaluation can determine any changes that have occurred over a specific time period: from before an intervention is implemented (data collected during the needs assessment called baseline data) to after implementation, and demonstrate that the changes occurred as a result of the intervention. Pre- and post-tests can help to compare behaviours, skills, attitudes and knowledge after the intervention. Tests can also be used to compare groups that receive the interventions with those who do not.

Outcomes that are directly tied to the objectives should be measured. It may be most feasible to concentrate on outcomes for which records already exist (e.g., items that have already been collected in the needs assessment should be relatively easy to collect again). The table below, from the ***Handbook for Evaluating HIV Education Programs*** (prepared by the Centers for Disease Control and Prevention/Division of Adolescent and School Health) provides examples of outcome data that can be used to evaluate HIV/STD-prevention interventions. (29) The handbook provides specific guidance on evaluation design and measurement tools. Another reference that offers helpful details about outcome evaluation is ***School Health Education to Prevent AIDS and STD: A Resource Package for Curriculum Planners***, prepared by WHO and UNESCO. (30)

Examples of Outcome Data

Evidence Category	*For Students' HIV Education*	*For Teachers' HIV Staff Development*
Behaviour	Reported activities while in high-risk situations	Appropriate use of recommended classroom procedures
Skills	Ability to display refusal skills in simulated high-risk situations relating to HIV infection	Ability to respond appropriately to students' questions about sensitive topics
Attitudes	Perceptions about one's personal susceptibility to HIV infection	Confidence in being able to modify students' high-risk behaviours

Knowledge	Knowledge about the routes by which HIV is/is not transmitted	Knowledge about the instructional principles relevant to modifying students' attitudes

ANNEX 2

OTTAWA CHARTER FOR HEALTH PROMOTION (1986)

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

PREREQUISITES FOR HEALTH

The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and
- equity.

Improvement in health requires a secure foundation in these basic prerequisites.

ADVOCATE

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable

through **advocacy** for health.

ENABLE

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

MEDIATE

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to **mediate** between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

HEALTH PROMOTION ACTION MEANS:

BUILD HEALTHY PUBLIC POLICY

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

CREATE SUPPORTIVE ENVIRONMENTS

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be

a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment -particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

STRENGTHEN COMMUNITY ACTION

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

DEVELOP PERSONAL SKILLS

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

REORIENT HEALTH SERVICES

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

MOVING INTO THE FUTURE

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

COMMITMENT TO HEALTH PROMOTION

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

CALL FOR INTERNATIONAL ACTION

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION

The move towards a new public health

Annex 3

Integrating HIV/STD prevention in the school setting: a position paper (XX)

1. Rationale

Young people (10 to 24 years) are estimated to account for up to 60% of all new HIV infections worldwide. Many young people can be reached relatively easily through schools; no other institutional system can compete in terms of number of young people served. Prevention and health promotion programmes should extend to the whole school setting, including students, teachers and other school personnel, parents, the community around the school, as well as school systems. Such activities are a key component of national programmes to improve the health and development of children and adolescents.

2. HIV/STD Prevention and Health Promotion

HIV/STD-related programmes provide an opportunity to strengthen and accelerate existing health promotion activities in schools. Education to prevent HIV/STD should be integrated into education about reproductive health, life skills, alcohol/substance use, and other important health issues; included in other subject areas as appropriate and established by official policies; enhanced by school practices that foster self-esteem, caring, respect, decision-making, self-efficacy, and conditions that allow for the healthy development of students and staff. This is done, inter alia, through materials development, teacher training, supervision, and the participation of parents and communities.

3. Policies

Developing and monitoring a range of policies will be essential for effective programmes. This includes policies on: human rights (right to education, to non-discrimination, to confidentiality, to protection of employment, to protection from exploitation and abuse); access to school by students and school workers living with HIV/AIDS; pre- and in-service teacher training; community/parent participation; content of curricula and extra-curricular activities, and link with health services capable of providing diagnosis and treatment of STD for young people as well as the means of protection against unwanted pregnancy and HIV/STD, including contraceptives and condoms. Policies are developed at different levels, according to the degree of centralization of the school system.

4. Learning How to Cope

For young people to develop healthy and responsible behaviour patterns, and avoid infection, it is not sufficient to lean the biomedical aspects of sexual and reproductive health. Equally important is learning now to cope with the increasingly complex demands of relationships, particularly gender relations and conflict resolution; how to develop safe practices, and now to relate with the increasing number of people living with HIV and AIDS.

5. Age

Prevention and health promotion programmes should begin at the earliest possible age, and certainly before the onset of sexual activity. They should reach students before most of them leave or drop out of school, particularly in countries where girls tend to leave at a younger age. This means that age-appropriate programmes should start at primary school level.

6. Life Skills

A life skills approach is important in such programmes. Skills that enable young people to manage situations of risk for HIV/STD infection are also essential for the prevention of many other health problems. Such skills include how to respond adequately to demands for sexual intercourse/offers of drugs; how to take responsible decisions about difficult options; how t apply risk reduction techniques; how to refuse unprotected sex when sexually active, and how to seek appropriate support and care, including health services and counselling.

7. Response of School Systems

Although prevention education through school settings is recognized by almost all countries as necessary, significant institutional, political, religious and cultural barriers to its implementation will need to be resolved. In each country, the school system as a whole must respond to HIV/STD and AIDS, in close collaboration with the Ministries of Education, Health, Youth and other government sectors, teachers' associations and other NGOs and the wider community.

8. UNAIDS Action

UNAIDS will (i) facilitate the strengthening of national capacity to develop, implement, monitor and evaluate programmes that integrate HIV/STD prevention, health promotion and non-discrimination into school policies, curricula as well as extra curricular activities, and training; and (ii) identify effective and innovative policies, strategies and action in this area.

9. Goals By the Year 2000

By the year 2000, UNAIDS will aim to:

- increase significantly the number of countries which have developed detailed policies and implemented programmes for non-discrimination and HIV/STD prevention in the school setting; and

- increase towards full coverage the percentage of young people attending school, who learn how to avoid discrimination and reduce the risk of infection.

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