

# COMPREHENSIVE SCHOOL HEALTH EDUCATION:

## SUGGESTED GUIDELINES FOR ACTION

*Education for health is a fundamental right of every child. Health is inextricably linked to educational achievement, quality of life, and economic productivity. By acquiring health-related knowledge, values, skills, and practices, children can be empowered to pursue a healthy life and to work as agents of change for the health of their communities. This goal can be achieved if we have the will.*

### I. INTRODUCTION

The health and well-being of children and youth must be a fundamental value for all countries. Recently, in addition to longstanding health and nutritional issues, urgent worldwide health and social problems, including HIV/AIDS and increasing substance and alcohol abuse, have underscored the need for collaboration among young people, families, schools, agencies, communities, and governments in taking a comprehensive approach to school-based health education.

Yet, too few children have access to such programmes and their implementation remains a major challenge throughout the world. In response to that challenge, WHO, in collaboration with UNICEF and UNESCO convened an expert consultation with participants from 16 countries, as well as other experts in the field in November 1991, to (1) gain a common understanding of comprehensive school health education (CSHE) and (2) outline actions that countries can consider to strengthen implementation of such programmes.

This consultation was based on four decades of effort by UN agencies in advancing comprehensive school health education. In 1986, WHO and UNICEF published "Helping a Billion Children Learn About Health". It described the findings of an international consultation on (1) the complexity of health learning among school-

age children both in and out of school, (2) assessing the current state of health education for this population, and (3) proposing strategies and guidelines for strengthening health education. More recently, WHO organized a number of working group sessions in conjunction with UNESCO and UNFPA on comprehensive school health education at the International Conferences on AIDS (Florence, June 1991) and on Health Education (Helsinki, June 1991). The present consultation was the latest in a series of recent activities to promote comprehensive school health education which recognizes the multitude of factors at work in the critical years when children and youth are maturing.

## THE CASE FOR SCHOOL HEALTH EDUCATION

There are important practical grounds on which to make the school health education of children and youth a high priority. These are based upon the size and accessibility of this population, the impact that health education can make on both health and education, and the existence of a rich tradition of success and innovation in school health education.

The population of school-age children and youth has grown enormously in recent decades. Children are receptive to learning. And, because many attend school, they may be reached readily and cost-effectively. By reaching these school-age children, health education can provide benefits to all levels of society: the individual, the family, the school, the community, and the nation. Over time, these benefits accrue

- because of the documented linkages between the health status of children and their educational achievement; as the nutritional and health status of children improves, so too does their ability to attend school and achieve. Therefore, "Efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education."<sup>1</sup>
- because one of the most important determinants of a child's health is the educational status of the mother. Therefore, efforts to increase the school attendance and improve the health education of girls can have a profound benefit.

---

<sup>1</sup> National Commission on the Role of the School and the Community in Improving Adolescent Health. (1990). Code Blue. Alexandria, Virginia: National Association of State Boards of Education; p. 9.

- because schools themselves are an important channel of communication for health education messages (and potentially of health services as well) to the student, the family, and the community as a whole.
- because of the relationship that needs to be strengthened between in-school learning and out-of-school health behaviour.
- because education for life skills guides people to think critically about health and social issues, encourages them to work collaboratively on solving problems, and provides them with the confidence and expertise to participate fully in community activities.

The experience of the past four decades has demonstrated that comprehensive school health education can have a profound influence on students' health knowledge, attitudes, and behaviours. Often in collaboration with WHO and other international organizations, many countries have carried out carefully designed programmes, though few have been evaluated. Although little outcome data exists concerning changes in health behaviour in youth as a result of school health education programmes, recently there is new evidence of changes in students' health knowledge, attitudes, and most important, some evidence of changes in reported behaviour.<sup>2</sup>

The health challenges facing school-age children and youth, and to which health education programmes must be directed, are complex and challenging. Their complexity arises because the health status is largely a product of both the environmental conditions in which children live, and the lifestyles they adopt. Among the health and nutritional conditions that have been linked with failure to attend school or poor academic performance in developing countries are nutritional deficiencies, helminthic and other infections, physical and mental disabilities, and reproductive problems (adolescent pregnancy, and sexually transmitted diseases). Many of the lifestyle- or behaviour-related health problems identified in recent reports about youth in developed countries (e.g., drinking, smoking, HIV/AIDS, violence, suicide as well as accidents/injuries) are becoming issues of concern among school-age youth in many developing countries as well.

---

<sup>2</sup> See Ross JG, Nelson GD, Kolbe LJ (eds). (1991). Teenage Health Teaching Modules Evaluation. *Journal of School Health*. Vol. 61, No. 1:19-42; Also Connell DB, Turner RR, Mason EF. (1985). Summary of findings of the School Health Education Evaluation: Health Promotion Effectiveness, Implementation and Costs. *Journal of School Health*. Vol. 55, No. 8:316-321.

The health problems of developing and developed countries may differ, but it is also important to appreciate the similarities as well. For example, many developing countries are now experiencing increases in heart disease, cancer, injuries, and other causes of death and disability long associated with the industrialized nations. The pandemic of HIV/AIDS threatens young people in both developing and developed countries. And, throughout the world, disregard for the environment has resulted in damage to the ecosystem and the proliferation of pollution-related diseases. All of these problems pose important questions for the development and implementation of school health education programmes.

## II. THE CONCEPT OF COMPREHENSIVE SCHOOL HEALTH EDUCATION

School health programmes include three related components: a school health services component, a school environment component, and a health education/instructional component. This consultation recognised all three, but focused on the health education component, which to be truly effective must be comprehensive. The health education component must collaborate with, and be conceptually related to the other two components, and consider the whole child in the context of living conditions in local communities.

School health education is comprehensive when it

- **views health holistically**, addressing the interrelatedness of health problems and the factors that influence health, within the context of the human and material environment and other conditions of life;
- **utilizes all educational opportunities for health**: formal and informal, standard and innovative curriculum and pedagogy, and by drawing upon services and opportunities available within and outside of the school;
- **strives to harmonize the health messages** from the various sources that influence students, including messages from the media, advertising, the community, the health and development systems, family and peers, and the school;
- **empowers children and youth to act for healthy living and to promote conditions supportive of health.**

Socioeconomic, cultural, psychosocial, environmental, and genetic factors influence health and behaviour. Students learn from a variety of sources, in a

variety of settings, and by a variety of ways. Comprehensive school health education must be developed within the context of these realities and help to interpret and address them.

A comprehensive school health education programme includes a broad spectrum of activities that take place within and outside of schools in their surrounding communities. They are designed to enable children and youth to enhance their health, and to develop to their fullest potential by achieving health as well as by acquiring education. Comprehensive school health education is reinforced by, and in turn reinforces community health and education programmes.

### III. GENERAL PRINCIPLES TO GUIDE ACTION

Schools have the potential to reach a billion children worldwide. Therefore, development of international and national policies and action plans that include and give a high priority to comprehensive school health education can have a powerful and lasting impact. Recognizing each country's unique health problems, values, resources, and organizational structures, the consultation offers these guiding principles for action.

Developing and strengthening a comprehensive school health education programme:

- requires political will and commitment as well as policy, legislative, and fiscal support at international, national, and local levels.
- requires advocacy at all levels and through all channels, including the media, to reach policy-makers and other influential individuals and groups.
- requires integration into national educational and health policies.
- should capitalize on and join with global efforts such as education for life skills, and worldwide concern over such issues as environmental degradation, AIDS and drug abuse. Through such movements as Health for All and Education for All, leaders are exploring ways in which education and health professionals can work together to advance healthy development of children worldwide. It is essential to build on these efforts.
- can be championed by a group of committed professionals, visionaries, and citizens.

- calls for alliances among various sectors of society, including all relevant ministries and agencies, as well as teachers, health workers, parents, youth, media, and others.
- must inspire and ensure the participation of teachers and teachers' organizations.
- must focus on participative learning and engage children in community action projects for effective learning.
- must strive to increase the school attendance of all children, particularly girls. Sixty percent of the 105 million school-age children who do not attend school are female. Because the educational status of a mother has been shown to be an important determinant of a child's health, special efforts must be made to increase the educational participation of girls and young women. This is essential to address both their health and well-being, and the health of future generations.

#### IV. CRITICAL TASKS

School health education programmes, like other large-scale societal initiatives, follow a process that includes formulating policies that reflect a clear understanding of the problem, designing and implementing practical interventions, and evaluating the results. And while different programmes will grow in ways best adapted to their national and cultural realities, the critical tasks in the process include

- policy development
- creating a coordinating mechanism
- programme development and implementation
- research and evaluation

These tasks are not meant to be a prescribed sequence of actions. Indeed, some may need to take place simultaneously or to overlap. The important link between them is to determine where and how it is most practical to intervene. Action for a coordinated approach to comprehensive school health education, can be guided by the suggested strategies that follow. Although the tasks may seem complex, a small group of committed individuals, professionals, and other interested persons can initiate the process.

## V. STRATEGIES FOR ACTION

In putting into practice the general principles described previously, this section describes the key strategies for action. It is recognized that individual countries present a wide variety of physical, social, cultural, health, economic, and political circumstances to which these strategies or approaches must be adapted. The focus here is on actions to be taken at national and local levels.

### POLICY DEVELOPMENT: Creating Political Support

For comprehensive school health education to be a national priority, it is necessary for advocates and policy-makers to reach a common understanding of the issues involved, consensus on direction and goals, resources required, and benefits to be achieved. The process of creating political support for a policy on CSHE is a critical step. This calls for creative advocacy efforts. The following sequence of events is but one illustration of how a strategic plan might be designed.

- activation of a nucleus of committed individuals to initiate the process and advocate for school health education.
- gaining an understanding of how national policies are developed and assigned priority; the identification of key decision-makers and how they are reached. Their roles and responsibilities for policy development tasks within and across sectors at the national, regional, and local levels should be clearly defined.
- gathering all available data (on health problems, and behaviours of children, such as smoking, substance abuse, and teenage pregnancy) as well as evidence on effective interventions in schools so that it can be used by political parties and governments, and for background papers, documents and in forums.
- organizing and presenting such data to policy/decision-makers in a clear, understandable, concise, and persuasive manner. The case should demonstrate that CSHE is politically viable, feasible, and cost effective.
- forming of alliances with initial stakeholders (e.g., parents, teachers) and influential groups (e.g., religious and political figures, organizations and institutions) with other interested parties such as media, professional organizations, voluntary non-governmental organizations and mass organizations (trade unions, women, youth and teachers organizations).

Of particular importance is a collaborative arrangement between education and health. Other sectors such as social welfare, communications, food and agriculture, housing, industry, and transportation, as they affect health and education should also be involved.

- securing of human, material, financial and community resources to support school health education.
- stimulating the interest of international organizations, foundations, business and development agencies, and professional groups.

## COORDINATING MECHANISM

An essential element in the process of developing or strengthening CSHE is the creation at all levels (i.e., national, state, local) of mechanisms that are charged with the responsibility to transform policy into action. These coordinating mechanisms provide direction, guidance, monitoring, and linkages to the key players. Key functions and activities of these groups follow:

- An important step in the process of developing and strengthening CSHE is the establishment of a joint committee of the ministries of health and education that could also include other appropriate ministries with responsibility for programme development, resource identification and allocation. The joint committee would play the lead role in coordinating CSHE planning and programming. It should be chaired by a nationally respected figure and should include representatives from all influential sectors and ministries. Such a committee could develop policy papers and strategies that can be disseminated through the health and education structure (particularly to teachers and health workers). After consultations with a wide range of people at the local level, the resulting policies and strategies can be used to influence decision-makers.
- The joint committee could assign issue-specific task forces that would address such topics as curriculum and resource materials, teacher preparation and supervision, and monitoring and assessment with the support of interested parties. The task forces will be made up of subject experts. For example, the curriculum task force would draw from professionals working with existing agencies/institutions concerned with curriculum development, training and research.

- The joint committee should work towards the establishment of an advisory council at the highest level to advise on policy matters and to provide an overview and guidance on programme direction. The advisory council, which could be built upon the intersectoral commission described above, could include representatives from all relevant sectors, academics and professionals from the education and health sectors, influential public figures, and policy-makers. The council may meet once or twice a year.
- The focal point or an executive unit responsible for the day to day planning, implementing, and coordinating school health education programmes could be housed preferably in the Ministry of Education with a technical counterpart in the Ministry of Health. The resources of the unit will depend upon the nature and extent of the tasks involved. The unit could draw upon the expertise and support of an informal group of professionals, public figures, teachers and parents.
- Interministerial assignment of roles and responsibilities and accountabilities for managing the programme at various levels should be clearly defined.
- Coordinating mechanisms similar to those established at the national level need to be put in place at the regional, provincial, state, and local levels. These will require both technical and financial support from higher levels, and may have to be done in a phased manner, depending on availability of resources.

## PROGRAMME DEVELOPMENT AND IMPLEMENTATION

Development of a programme must be based upon a sound rationale with goals that are realistic in light of prevailing conditions and available resources. The issues that need special attention are described below.

### 1. Needs Assessment

- A needs assessment is an essential step in programme planning and development. It should identify the health needs and problems of children in school, their knowledge, values and practices, the nature and extent of existing programmes, a review of content and teaching methods in schools and teacher training programmes, and available resources for implementing the programme.

- Data from existing reports and surveys should be carefully reviewed before deciding on the necessity to undertake a survey of current needs. The data collected during the assessment should be used in determining the nature, scope and sequence of the health content to be taught, so that they are appropriate for different age levels and within the context of local culture.

## **2. Action Plans**

- Plans to guide action at the national or local levels should be focused on the short term but remain within the context of long-term goals.
- Plans should be flexible and adaptable to changes in national plans and availability of resources.
- Planned activities should include adequate financial, material, and human resources. External sources such as international agencies and bilateral donors, in addition to those locally available, could also be tapped when appropriate.
- Topical global and regional issues such as population growth, environmental protection, human rights education, AIDS, and substance abuse have been able to attract funds and a place in the school curriculum. Skills must be cultivated to use these opportunities to promote a comprehensive approach to school health education.
- During the planning process, planners should endeavour to obtain the active involvement of principals, teachers, pupils, and parents.

## **3. Health Instruction**

Health instruction should be an integral part of the total curriculum. Health can be taught as a separate subject, be infused into existing subjects, or both; it can be enhanced through school and community-based projects.

The school health education curricula should

- enable children to acquire health knowledge, health promoting values, and to practice health promoting behaviour.
- offer a planned, sequentially developed programme throughout the child's school life. This programme should aim at being appropriate to the age and developmental stages of the pupil and be sensitive to local cultural values.

- Even where health is taught as a separate subject it should be integrated into other subject areas.
- consider including, but not be limited to topics such as: personal and dental hygiene; nutrition, food safety and dietary habits; exercise and fitness, water, basic sanitation and environmental issues; lifestyles, tobacco, alcohol and drug abuse; human sexuality, unintended pregnancy, HIV and other STDs; mental health, coping and life skills; intentional and accidental injuries; common communicable and noncommunicable diseases.
- allocate adequate time to cover health issues so that improvements can be made in attitudes and behaviours, as well as knowledge.
- be based on participatory learning through the use of active learning methods, such as role play, small group discussions, case studies, and interactive radio and community action projects, which can go beyond the classroom and can help pupils to explore and practice positive health behaviours. Such active learning allows students to gain experience as agents of change in these various settings.
- include health education messages that are not only easy for students to understand themselves, but easy for them to explain to others, leading to the follow-up of messages from child to child and child to family and community. The development, testing, production and proper use of both teaching and learning materials are key elements in providing adequate school health education.
- consider children, parents, and others not just as target audiences but also as active disseminators of health messages to their families, communities, and others.
- ensure that health messages communicated by teachers are reinforced by their own personal behaviour and lifestyles. These should also be reinforced by educational programmes in the community.

#### **4. Educational Opportunities Beyond the Classroom**

The school environment offers many opportunities to learn about health. Teachers must seek out such opportunities for both planned and incidental teaching. School health services, school meals, the school environment, and various events in the school and community offer teaching opportunities.

- Through the health services provided to children in school, health professionals and teachers can talk about health and reinforce the health instruction of the classroom. Medical examination screening or treatment for health problems provides an excellent opportunity for the school nurse to individually counsel or advise students and parents. Teachers with appropriate training can help in identifying children with health problems. The school nurse can act as the coordinator between the health services and classroom instruction.
- Meals at school, whether provided or sold in school or brought from home, provide educational opportunities. Proper nutrition, personal hygiene, and food safety are natural topics for health education. It is also important that health-enhancing standards must be applied to the management of school cafeterias and food vendors.
- Mothers and community members could be involved in school meal programmes; this will provide a valuable educational opportunity.
- Special events such as assemblies and discussions on current issues provide opportunities to address health and related problems.
- Regional and local audiovisual resource centers could be utilized, where available, for obtaining useful learning materials.
- Foster a multichannel approach using all available technologies and materials, such as interactive radio or other forms of distance education for promoting healthy behaviour.
- The total school environment, including physical and the psychosocial ambiance, are critical for students to acquire healthy values and habits and should be consistent with and reinforce health instruction and practice.
- School buildings and surroundings should be safe and health promotive. Lighting, heating, ventilation, safe water, and sanitation should be adequate. Persons trained in first aid should be available.

## **5. School-Community Relationship**

Schools and communities are natural partners in health promotion and disease prevention. Schools can tap community resources for learning about and practicing good health habits. Communities can offer key support to schools for the critical role they play in promoting health.

- The community provides a good setting for students to better understand and practice what they learn about health in the classroom. Community resources for this purpose are available in various forms. Community leaders, religions and social institutions, voluntary agencies, businesses, parents and youth groups could be involved in students' projects in the community. Health workers, and community members can also be involved.
- School-community projects not only provide valuable learning opportunities for children but could also be designed to involve, inform and facilitate education of parents, family members, and others in the community. It is important that parents and key exemplars understand and reinforce what the school curriculum seeks to achieve.
- School-community projects not only provide valuable learning opportunities for children, but could also be designed to involve, inform and facilitate education of parents, family members and others in the community. It is important that parents and key exemplars understand and reinforce what the school curriculum seeks to achieve. At the same time their views and inputs into the school health curriculum and classroom experience can be extremely productive.
- Headmasters can play a key role in stimulating these interactions. Another mechanism would be the creation of a health committee at the school level, led by health workers and community leaders who can help to create and focus projects to be carried out by students, parents, and other volunteers.

## **6. Teacher Training**

Teacher training, both pre-service and in-service, is one of the major factors in a successful school health education programme. Education and training to inspire and equip teachers with knowledge and skills to make a curriculum exciting is essential. Such training should also include activities to promote the teachers' own positive health behaviours to enhance their role as models. Ongoing support to teachers and monitoring of performance is necessary for quality teaching, as is granting teachers of health education equal status to teachers of academic subjects.

Teacher training institutions have a critical role to play in such functions as the preparation of teachers for health education, providing technical support to schools, and promoting research and evaluation of school health programmes.

Consequently, the following should be undertaken:

- review and upgrade teacher training at the pre-service, in-service and continuing education levels with a view to preparing them for the application of a comprehensive approach;
- teacher training programmes should ensure that student teachers educators receive field experience; use training methods and resources that are practical, interactive, and can be replicated in the classroom; and ensure that all student teachers have a minimum health education training;
- carefully design and implement summer workshops and short courses on a comprehensive approach to school health education to upgrade the teachers' abilities;
- train health teachers and staff, as well as non-teaching school personnel to play an educational role;
- develop mechanisms for continuing education and supportive supervision to maintain and enhance quality of teaching.

## RESEARCH AND EVALUATION

### 1. Research

Research data are needed to drive agenda setting as well as for advocacy. Also, baseline data on the health of children, quality of school health services, the environment of schools, and the health knowledge, skills and practices of pupils are essential for evaluating the CSHE programme. For example, baseline data should include the health behaviour of school children and identification of health needs and information on local living conditions. These are necessary for programme development and evaluation. Baseline data is necessary to plot trends and monitor effectiveness of interventions. Research to develop and test innovative educational techniques and approaches is an important but often neglected area which deserves added attention.

### 2. Evaluation

Each country must find ways to address the following questions, from national to local levels:

- Is the CSHE curriculum being implemented as intended?

- Is the CSHE curriculum achieving the desired effect on children's health knowledge, attitudes, and health behaviours, and is this change also influencing the health of families and the community?

Formative (process) and summative (impact) evaluation provide information that can be invaluable in reshaping and revising programme development. Formative evaluation assesses how well the programme is working. Summative evaluation measures the impact of the programme on the target population. A few points should be kept in mind:

- During the planning stage, it is necessary to prepare the framework for evaluation which includes specifying programme objectives, selecting educational methods and interventions to be assessed, and identifying indicators to measure the achievement of objectives as well as their effectiveness. The methodologies for collecting, analyzing, and using the data also need to be specified.
- Ways must be found based on available resources to address evaluation, to see if the CSHE programme is being implemented as intended and that the desired results are achieved. It includes measuring preset objectives, using appropriate indicators to measure children's health knowledge, attitudes, and health behaviour and teacher performance in curriculum implementation, and also, if feasible, the influence on family health practices.
- The challenge lies in developing tools that are practical as well as valid and sensitive in measuring changes. Evaluation will remain a distant dream unless attention is paid to developing tools that are easy to use and effective.

### **3. Utilization of Findings**

Evaluation of process and impact is important to monitor ongoing and long-term progress. Feedback of research and evaluation results to policy-makers, administrators, sponsors, teachers, and the community is an important part of programme management. A mechanism is needed for the rapid and clear communication of new information on technology and validated innovations from researchers to planners and practitioners for application. All research findings of significance should be systematically promoted through various channels including the media and followed up by seminars and discussions to raise awareness, create political support, and ensure action.

## ACTIONS AT THE INTERNATIONAL LEVEL

Global organizations such as the United Nations and its specialized agencies, particularly WHO, UNESCO, and UNICEF can contribute by showing leadership. Their continued support is invaluable in advancing the comprehensive approach. They should foster policy and strategy development; encourage research particularly on effective interventions; facilitate the exchange of information and experiences on an ongoing basis; and provide technical support to countries in developing national capability. Support should be extended for institution strengthening, human resource development and organization of regional and national workshops involving the ministries of education and health and other appropriate sectors.

The International Agencies should be active participants in the promotional efforts for CSHE which needs to be put on the agenda of future conferences and be incorporated into the current global initiatives of Health for All and Education for All.

## VI. MEETING THE CHALLENGE

Educating children for health through schools should receive the highest priority, not only from the point of view of health, but also from the point of view of education. Yet too few children have access to such programmes and their implementation remains a major challenge throughout the world.

At the same time, educating children for health in schools is being recognized globally as an effective and efficient way to influence health behaviour. Evidence points to significant improvements in students' health at minimum cost. And, although progress has been slow, most countries have made some attempts at school health education.

Advocacy for school health education is an immediate need and should be sustained, well-organized, and based firmly on scientific evidence. Those with expertise in health and education must play a major role, but so, too, must all citizens who care about the future of their children and their nation. It only takes a few committed individuals to initiate the process of change and innovation and act as a catalyst, drawing others in from across all sectors.

Key players also need to be identified and involved early in the process. Critical to any success is the active support of the ministries of health and education, along with school officials and teachers, students, parents and the community.

Mechanisms need to be in place to coordinate the development of areas such as teacher training, curriculum, teaching/learning resources, etc.

Human and financial resources within and outside the education and health sectors need to be identified and secured early as well. Potential resources available from international agencies and institutions should not be overlooked.

In each country, advocates will have to look at the specific conditions (policies, resources, political climate, etc.) before deciding when, where and how to initiate the process towards educating children for health in a comprehensive way. But, although the starting point will vary from country to country, generating political and professional commitment early in the process is critical. Evidence of effectiveness, when well promoted through influential groups and the media can quickly put the issue on a nation's agenda. This will help capture the interest of community leaders to champion the issue.

Initial activities should build upon what already exists. Expertise available both within and outside government should be mobilized around topical issues of common concerns such as AIDS, alcohol, drugs or tobacco. These offer an entry point to get involved and gradually build towards comprehensive school health education programmes.

Examples of success stories of student involvement in national programmes such as immunization and sanitation should be highlighted as models of the expanded programme of school health education.

Still, questions remain unanswered. We do not yet know everything about school health education. But we do understand the dimensions of the health and education needs of children and youth. And we have a growing understanding of what programmes work and under what circumstances. Much of what we still need to know will be learned through designing, implementing, and evaluating school health education programmes.

What we know very clearly are the consequences of not acting. And because those consequences for children, their families, communities, and nations are unacceptable; the challenge to implement effective comprehensive school health education must be met. Our investment in children's health today will ensure a healthier world tomorrow.

## SOME SCHOOL HEALTH EDUCATION EXPERIENCES FROM COUNTRIES PARTICIPATING IN THE CONSULTATION

Every country around the globe has some form of on-going school health education programme which might lend itself to a more comprehensive approach.

School health education experiences presented by participants from the 16 countries have been summarized and are annexed. The processes through which school health education has evolved, and some of the approaches used in these countries, can be good learning experiences.



**Bahrain Implements the Action-Oriented School Health Curriculum for Primary Schools: a prototype prepared for the Eastern Mediterranean Countries by WHO/UNICEF/UNESCO/IESCO**

The State of Bahrain adopted the Action-Oriented School Health Curriculum for Primary Schools in October 1988.

The following phases were used to adapt and implement the prototype curriculum.

***Planning phase***

1. A joint Expert Committee with representatives from the Health and Education Ministries was formed to supervise implementation and provide needed resources.
2. A National Coordinator for health education was identified to chair the Expert Committee and deal with international agencies.
3. The Department of Curriculum, Ministry of Education is responsible for adapting, implementing, monitoring and evaluating the curriculum.
4. A Task Force, composed of curriculum specialists, was formed to integrate health topics in other subjects, follow-up implementation, prepare resource materials, design evaluation tools and monitor and evaluate the project.
5. A preliminary investigation of all selected schools for implementation were conducted before implementation started.

***Implementation phase***

1. During 1989/90 the project was implemented in 30% of schools and in 1991/92, the project was implemented in 71% of the schools.
2. Training workshops were held for teachers during this period covering objectives, contents and teaching methods, focusing on problem-solving and field experiences.



Box 1 (continued)

3. For each education block teaching aids were developed.
4. Schools that developed the best education block exchanged experiences with other schools.
5. The Ministry of Health arranged for health workers to participate in the teaching, where parents were also invited to attend. Student visits were arranged to health institutions.
6. The Ministry of Education distributed teaching aids and arranged for sharing experiences between schools.
7. The Ministry of the Interior, Department of Traffic, organized a campaign on road safety. The Department of Civil Defence arranged visits and demonstrations on safety and accidents. Parents were actively involved in these sessions.
8. Other institutions involved were the Central Council Corporation. Local councils played a role in promoting environmental health awareness and organizing cleaning week campaigns.
9. Schools visited shopping centers and learned about available foods, food safety and hygiene.
10. Factories were visited to learn about socio-economic development.

***Evaluation phase***

1. Tests were developed to measure knowledge and skills.
2. All phases of the project were evaluated.
3. The project has been extended to cover 57.4% of elementary schools during 1991/92 □