



Proceedings of the First Meeting and Creation of

THE CARIBBEAN
NETWORK OF
HEALTH-PROMOTING
SCHOOLS



PAN AMERICAN HEALTH ORGANIZATION
Regional Office of the
WORLD HEALTH ORGANIZATION

Celebrating 100 Years of Health

Pan American Health Organization
World Health Organization

And

Office of Caribbean Program Coordination
Pan American Health Organization

PROCEEDINGS

**First Meeting and Creation of the
Caribbean Network of Health-Promoting Schools**
Bridgetown, Barbados, 26-28 November 2001



**Pan American
Health Organization**

*Regional Office of the
World Health Organization*

Washington, DC
July 2002

PAHO HQ Library Cataloguing-in-Publication

Ippolito-Shepherd, Josefa

Proceedings - First Meeting and Creation of the Caribbean Network of Health-Promoting Schools
Washington, D.C.: PAHO, © 2002.
xl, 285p.

ISBN 92 75 12395 0

I. Title II. Author

1. HEALTH EDUCATION
2. HEALTH PROMOTION
3. HEALTH-PROMOTING SCHOOLS
4. SCHOOL HEALTH
5. STAFF DEVELOPMENT
6. NETWORKS

NLM WA590.S548p 2002

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Acknowledgements



*The deepest thanks are expressed
to the following individuals and organizations
for their generous support of this effort:*

The countries' representatives for their wisdom, energy, and participation in this meeting, and especially for their presentations on the status and trends of school health activities in their respective countries.

The invited speakers, Dr. Benjamín Puertas, Prof. Antonio Saéz, Dr. Lourdes Laurido de Soto, and Eng. Leo Nederveen, who kindly gave their time to share their experiences, wisdom, and guidance with the development and implementation of school health activities.

The Centers for Disease Control and Prevention for the participation of Mr. Charles Gollmar, who presented on behalf of WHO and who provided significant insight throughout the meeting.

The participants from United Nations Agencies, Governmental and Non Governmental Organizations, and the Private Sector, whose participation enriched the group discussions.

The Office of Caribbean Program Coordination of the Pan American Health Organization, Bridgetown, Barbados, for hosting the First Meeting and Creation of the Caribbean Network of Health-Promoting Schools, and in particular to Ms. Patricia Brandon for sharing her knowledge and wisdom about the Health and Family Life Education Program and Ms. Veta Brown for her insightful comments throughout the meeting and during the elaboration of this document.

The World Health Organization for the generous sponsorship of this event. Special thanks are extended to Mr. Jack Jones for his continuous support and encouragement throughout the planning process of this meeting.

Colgate-Palmolive for providing funding in support of the meeting. Special thanks are extended to Ms. Diana Grina, Global Director, Professional and Government Relations, for her kind support of school health activities and to Mr. Kevin McNish for his participation in the meeting.

The WHO Collaborating Center to Promote Health through Schools and Communities at Education Development Center, Inc., particularly Ms. Cheryl Vince Whitman, Senior Vice President and Director of Health and Human Development Programs, for providing guidance and support of global school health efforts during her participation in this meeting; Stephanie M. Malloy, Writer/Research Associate, for summarizing, compiling and organizing the materials, for the first draft of this document; Nancy Gilbert and Shai Fuxman, who also provided invaluable assistance with the preparation of the first draft of this document.

Dr. Ernest Pate, Coordinator of the Family Health and Population Program, Division of Health Promotion and Protection, for sharing his practical knowledge about the Caribbean Region.

Acknowledgements

Ms. Maria Angelica Fleetwood, Office Assistant to the Health-Promoting Schools Regional Initiative, for her logistical support during the planning and conduction of this event.

Ms. Laura Vanderbloemen for her review and comments to earlier drafts of this document.

Ms. Alicia Beltrán for her review and comments to the final version of the Proceedings.

Mr. Miki Fernández for his collaboration with the coordination of the graphic design process and Mr. O. C. “Chris” Fredricks, Jr. for the coordination of the printing of the document.

Last, but not least, special thanks to Dr. Maria Teresa Cerqueira, Director, Division of Health Promotion and Protection for sharing her avant-garde vision on the significance of building alliances through the creation of International Networks of Health-Promoting Schools, and especially for her support during the planning and execution of this meeting and preparation of this document.

Preface

Networks of Health-Promoting Schools facilitate the exchange of knowledge and experiences of successful implementation of health promotion and health education activities, materials, and tools, both within and among countries. This First Meeting and Creation of the Caribbean Network of Health-Promoting Schools was instrumental in facilitating and strengthening mechanisms for the exchange of knowledge and experiences about school health, to promote the healthy development and learning of young people. It provided an opportunity for participants to discuss priority public health issues affecting school-age children and adolescents and to identify action areas directed to improve the capacity of the school system to effectively promote the health of students, to keep them engaged in education, to promote the health of teachers and other workers in the school setting, and also to support teachers and parents with the responsibility to implement the related projects and activities.

The Caribbean countries have been promoting health education in schools through the CARICOM Health and Family Life Education (HFLE) Program, focussing on strengthening life-skills based approach to health learning in schools, teacher training colleges, and community institutions. The Pan American Health Organization's Regional Health-Promoting Schools Initiative is directed to strengthen the capacity of the education and health sectors to promote the health, learning potential, and well-being of school-age children and adolescents, teachers, and other members of the community, as well as to engage community members in actions directed to improve healthy development at the local level. The Initiative assists education and health sectors and other relevant partners to define school health priorities and to implement actions that facilitate the creation and/or improvement of healthy and supportive physical and psychosocial environments. As such, the Initiative complements, embraces, and expands the work of the HFLE Programs being implemented in the Caribbean Region.

This document reflects the commitments of the countries to be involved in creating the Caribbean Network of Health-Promoting Schools. The countries' summaries of the school health activities, prepared prior to the meeting and following specific guidelines provided for this purpose, provide a valuable source of information for assessing the status and trends of HFLE in the Caribbean, which in itself is a means for sharing experiences of successful school health activities. We trust that this document will be a valuable source of information and will provide baseline data, as the Member States move forward to incorporate the elements of the Health-Promoting Schools Initiative, as a complement to the HFLE activities currently underway in the Caribbean Region.

George A. O. Alleyne
Director

Presentation

The Region of the Americas has achieved significant improvements in health and quality of life, as evidenced by increased life expectancy, access to clean water, and decrease in infant mortality due to infectious diseases. However, Member States continue to struggle to further improve their living conditions and quality of life. To facilitate these efforts, health promotion has been embraced as a powerful public health strategy.

The Caribbean Conference on Health Promotion (Trinidad and Tobago, 1993) endorsed health promotion and protection and reinforced the principles and key areas identified in the Ottawa Charter. As schools have a central role in these efforts, The PAHO/WHO Health-Promoting Schools Regional Initiative has supported efforts to strengthen and expand traditional school health practices through the promotion of joint efforts between the health, education, and other pertinent sectors, as well as parents and communities. These efforts have facilitated strategic planning and implementation of school based health programs, the creation and maintenance of supportive environments, and the provision of health care services and respective referral, healthy meals, psychological counseling, and active living.

A major element of the Initiative has been the creation and development of Networks that take into account the cultural identity of the Member States to provide environments and opportunities to share knowledge and experiences of their models of comprehensive school health. The role of these networks cannot be overemphasized, as these provide the opportunity to meet and discuss all school health related matters, and build and/or strengthen alliances with regional and international agencies and institutions to gain support for and build the capacity of comprehensive school health programs, as the Health and Family Life Education (HFLE) Program.

This First Meeting and Creation of the Caribbean Network of Health-Promoting Schools has provided the opportunity and the space for the exchange of ideas, opinions, experiences, and knowledge, as to discuss possible future collaboration within and among countries. This Proceedings document reflects well the status and trends of school health in the Caribbean and is a solid baseline data to further strengthen school health activities and programs to better the quality of life of schoolchildren in the Caribbean. All participants are to be commended for this significant effort.

María Teresa Cerqueira, PhD
Director
Division of Health Promotion
and Protection

Note

The results from the First Meeting and Creation of the Caribbean Network of Health-Promoting Schools (CNHPS), as demonstrated by the richness of the presentations and discussions held throughout this event, and documented in these Proceedings, far exceeded our hope and expectations for this meeting. But this is only the beginning. There is still a long, but certainly promising and exciting road to travel if we want to achieve sustainable and excellent integrated school health programs directed to better the health, well-being, and the quality of life of children and adolescents of the Caribbean Region.

As we distribute these Proceedings throughout the Region, it is our hope that the data contained in this document will be considered and used to strengthen, as well as to expand, school health and related activities and networks. This in turn, we hope, will lead to the planning, implementation, and evaluation of comprehensive and sustainable school health programs, as envisioned by the Health-Promoting Schools Regional Initiative. We also hope that these data will facilitate the planning and conduction of the II Meeting of the Caribbean Network of Health-Promoting Schools, as agreed on November 28, 2001 by the Founding Members of the CNHPS.

As this document is being studied and considered for strengthening and expanding school health programs in the Caribbean Region, it is our expectation that these data will compliment other available information on the HFLE Program and that will facilitate the continued improvement of the education, health, well-being, and quality of life of Caribbean children and adolescents, their teachers and parents, and of other school personnel and surrounding communities.

Josefa Ippolito-Shepherd, PhD
Regional Health Education Advisor

Executive Summary

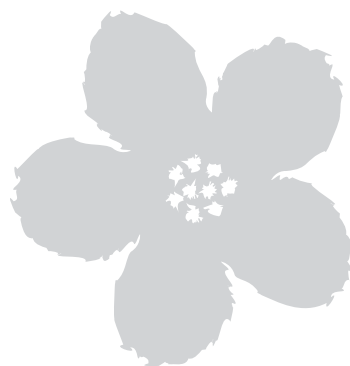
The First Meeting and Creation of the Caribbean Network of Health-Promoting Schools

On 26-28 November 2001, the Pan American Health Organization/World Health Organization (PAHO/WHO) convened a meeting of Caribbean school health and education professionals. This meeting, held at the PAHO Office of Caribbean Program Coordination (CPC) in Bridgetown, Barbados, brought together key representatives from the Ministries of Health and Education of 14 Caribbean countries, as well as other international and regional experts in the field of school health promotion and health education.

During the three-day meeting, designees from each of the participating Caribbean countries described their countries' status, trends, and experiences in implementing school health programs and activities. Presentations included descriptions and discussions of WHO's school health initiatives worldwide and available methods and surveillance instruments for assessing risk factors in school-age children; the Health-Promoting Schools Initiative in the Americas, aspects of Caribbean life that influence the promotion of health in young people, the evolving role of schools in promoting the health and development, and especially the Health and Family Life Education (HFLE) Program in the Caribbean.

Invited presenters from various international and regional organizations gave presentations on critical issues to consider when implementing strategies and activities, within the context of the Health-Promoting Schools Regional Initiative. These included experiences of Health-Promoting Schools and Networks in Latin America, Spain, Puerto Rico, and Ecuador, in an effort to share the wisdom of other countries and regions that have developed similar initiatives. Key communications strategies used by the Latin American Network were presented, including an innovative program called "Prosamusa" that uses music to teach health and hygiene skills to children in the Andes. The innovative School-Health Promotion initiatives in Spain emphasized the importance of communication and technology to enhance programs and make information-sharing easier. Other presentations included the development of the Caribbean Network of Health-Promoting Schools and school health related activities in Puerto Rico, including the Youth Risk Behavior Surveillance; the development of the Healthy Spaces Project in Loja, Ecuador; and the Rapid Assessment and Action Planning Process (RAAPP), a method to assess countries' capacities to deliver school health programs followed by inter-agency planning and action.

Following the series of country reports and technical presentations, the participants discussed the creation of the Caribbean Network of Health-Promoting Schools (CNHPS). Working first in small work groups, and then with their colleagues at large, the participants formulated the vision, mission, objectives, example activities, terms of reference, plan of action, and an initial organizational structure for the CNHPS, including responsibilities for the CNHPS Focal Point and of the country representatives, and, on 28 November 2001 signed a Statement to establish the CNHPS, and as such the Caribbean Network of Health-Promoting School was created.



Caribbean Network of Health-Promoting Schools: First Meeting and Constituent Assembly

26-28 November 2001
Bridgetown, Barbados

Introduction

The initiative to strengthen health promotion and health education in schools with a more comprehensive perspective, as outlined by the Health-Promoting Schools Initiative, was proposed and accepted at The First Meeting and Creation of the Caribbean Network of Health-Promoting Schools held in the Office of Caribbean Program Coordination in Bridgetown, Barbados. The Meeting was attended by representatives of the education and health sectors of 14 countries, who identified the areas demanding the greatest support and formulated recommendations to implement the Initiative (PAHO/WHO, Series HSS/SILOS No. 37, 1995).

One of the principal recommendations was to strengthen the Health and Family Life Education (HFLE) Programs through the development and/or strengthening of health promotion and health education strategies and activities, placing strong emphasis on: *comprehensive health education, including life skills training; healthy schools environments and surroundings; and on health services and nutrition*. In undertaking this Initiative, the schools, communities, and local health services, within the context of healthy municipalities and communities, assume the commitment to strengthen and exercise their capacity to develop health promotion knowledge, attitudes, and practices, and to prevent risk factors and conditions in school age children and adolescents.

The European Network of Health-Promoting Schools

The Network of Health-Promoting Schools came into being as a result of the recommendations made by the European Conference on Promotion of Health Education (Strasbourg, 1990). Experts in health and education, as well as politicians and researchers, noted that strengthening health promotion and health education in schools required the implementation of various activities and mechanisms to promote the exchange of experiences and information. An Initiative was subsequently proposed to form and strengthen a Network of Health-Promoting Schools, to foster the adoption of conceptual and operational strategies to improve the health of the entire educational community: students, teachers, parents, and workers in the education sector.

In European countries, this common effort won the support of the World Health Organization (WHO) and the Council of Ministers of the European Community. This support encouraged the introduction of health education in the schools, helped to form a rational framework for innovation, fostered equitable redistribution of the resources available for health promotion and health education, and allowed for the dissemination of exemplary practices. In 1993 the

First Meeting and Constituent Assembly

European Network of Health-Promoting Schools was formally established (ENHPS), with hundreds of participating schools in 27 countries.

Since its establishment, the ENHPS has scored several successes that have attracted an increasingly growing number of schools in several countries. This has been achieved through a series of activities, including the following:

- technical and administrative assistance in the areas of health promotion, health education, and organizational development;
- the exchange of information at periodic meetings of national coordinators, representatives, and student leaders, and through the creation of a database that maintains the Network's development process up-to-date;
- training workshops and seminars for coordinators, teachers, student leaders, and parents;
- the accumulation of funds through financial support provided by various sources, which are used in activities to benefit the Network;
- the dissemination of educational materials in the schools to promote health and healthy lifestyles;
- the designation of focal points to maintain communication with various national and international institutions in the health and education sectors;
- the promotion of opportunities to share experiences with other institutions that participate in the Network and share similar concerns; and
- the publication of the ENHPS Newsletter with the active participation of students in schools belonging to the Network.

The Latin American Network of Health-Promoting Schools

The experience of the European Network served as a point of departure for the development of the Latin American Network of Health-Promoting Schools (LANHPS).

The formation of the LANHPS, which took into account the cultural identity of the countries of the American Region, seeks to attain objectives similar to those of its counterpart on the European Continent. Several factors were considered in setting up and for maintaining such a Network, including: keeping the Network as decentralized as possible while maintaining a flexible organization that would ensure effective management and coordination. The establishment of the LANHPS included the following activities and actions:

- the constitution of an Inter-American Committee whose Secretariat duties could rotate to all the Member Countries;
- agreement on the guiding principles and the Terms of Reference of the Network and on the commitment of the countries and the schools;
- the appointment of two Coordinators in each Member Country, one from the education sector and the other from the health sector;

First Meeting and Constituent Assembly

- the formulation of criteria for membership in the Network and for the recognition of countries and schools;
- agreement on the functions of the Secretariat and of the Coordinators;
- the creation and updating of a directory of the Member Countries and schools; and
- the implementation of the Constituent Assembly and the organization of annual meetings of national Coordinators.

Schools requesting membership in the Latin American Network of Health-Promoting Schools must commit themselves to promoting, developing, implementing, and evaluating (process and impact) the Initiative's activities.

Objectives of the Latin American Network of Health-Promoting Schools

1. Facilitate the formation of knowledge, attitudes, and practices of good nutrition and healthy lifestyles in students and other members of the educational community;
2. provide students with the essential abilities and skills for making responsible decisions with regard to their personal health that will contribute toward the development and the safety of their surroundings;
3. make possible full physical, psychological, emotional, and social development, in addition to high self-esteem and a positive self-image among students and in the entire educational community;
4. promote health and healthy lifestyles and provide students and educational workers with options for learning, gaining experience, and living in healthy environments and surroundings;
5. develop a sense of responsibility and a commitment to individual, family, and social participation in actions to improve health;
6. promote positive and constructive relations among all the members of the educational community and encourage care for the environment and the surroundings;
7. expand the concept of health services and good nutrition in order to transform them into educational resources that support learning and assist the community in using the health systems and services in a rational manner;
8. provide an environment and framework for work and study that promote health, taking into account the conditions of school buildings, the availability of water, the health and nutrition services, sports and recreation, and the concept of safety for all;
9. formulate clear-cut objectives for the promotion of health and safety for the school community.
10. integrate health promotion and health education into the school curricula in a rational manner through the use of methodologies that facilitate the participation of students in the educational process; and
11. identify and employ the resources available in the community to carry out health promotion and health education activities.

Terms of Reference for the Latin American Network of Health-Promoting Schools

- Promote the concept of the Health-Promoting Schools Initiative;
- strengthen the institutional capacity for the development of school health programs with a gender appropriate approach to insure that there are no disadvantages for female students;
- create a forum to exchange experiences and insure continuation of the activities;
- promote training programs for the development of skills for the health and education personnel;
- promote the development and exchange of innovative, creative, and effective educational materials;
- promote the use of participatory methodologies that facilitate the “education of intelligence and not the memory”; and
- promote the communication within and among Network participants, using electronic means whenever possible.

Functions of the Latin American Network Secretariat

- Disseminate pertinent and relevant information at the regional level and in each Member Country;
- provide technical and administrative assistance in the areas of health promotion, health education, and organizational development;
- exchange pertinent and relevant information (meetings, encounters, database);
- organize training workshops and seminars for coordinators, teachers, student leaders, and parents;
- reorient human, physical, and financial resources so that every institution can make better use of the means available;
- exchange and disseminate to schools educational materials that promote health and healthy lifestyles;
- interact with national and international institutions working in the health and education sectors; and
- publish a newsletter with the active participation of students in schools belonging to the network.

The Caribbean Network of Health-Promoting Schools

The experience of the European and Latin American Networks served as the base of departure for the development of the Caribbean Network of Health-Promoting Schools (CNHPS).

First Meeting and Constituent Assembly

On November 26-28, 2001, the Pan American Health Organization (PAHO) convened a meeting of Caribbean school health and education professionals. This meeting, held at the PAHO Office of Caribbean Program Coordination in Bridgetown, Barbados, brought together key representatives from the Ministries of Health and Education in 14 Caribbean countries, as well as other international and regional experts in the field of school-health promotion.

During the three-day meeting, designees from each of the participating Caribbean countries described their countries' status, trends, and experiences in implementing school-health programs and activities. Invited presenters from various international and regional organizations gave presentations on critical issues to consider when implementing activities within the context of the Health-Promoting Schools Initiative. Charles Gollmar, representing the World Health Organization (WHO), provided an overview of WHO's school-health initiatives worldwide and discussed available methods and surveillance instruments for assessing risk factors in school-age children. Dr. Josefa Ippolito-Shepherd from The Health-Promoting Schools Regional Initiative, PAHO/WHO discussed the background of the Health-Promoting Schools Initiative in the Americas. Pat Brandon from the PAHO Office of the Caribbean Program Coordination, PAHO/WHO set the regional stage for the meeting, sketching those aspects of Caribbean life that influence the promotion of health in young people, and discussing the evolving role of schools in promoting health and development, and especially describing the Health and Family Life Education Program in the Caribbean.

Drs. Benjamin Puertas, Antonio Saéz, Lourdes E. Soto de Laurido, and Eng. Leo Nederveen described the experiences of Health-Promoting Schools and Networks in Latin America, Spain, and Puerto Rico, in an effort to share the wisdom of other countries and regions that have developed similar initiatives. Dr. Puertas discussed key communications strategies used by the Latin American Network and also presented an innovative program "Prosamusica" that uses music to teach health and hygiene skills to children in the Andes. Dr. Saéz described the innovative School-Health Promotion initiatives in Spain and emphasized the importance of communication and technology to enhance programs and make information-sharing easier. Cheryl Vince Whitman described the Rapid Assessment and Action Planning Process (RAAPP), a method for countries to assess their capacities to deliver school health programs and interagency planning and action.

During the second half of the meeting, following the series of country reports and technical presentations, the participants worked diligently to begin creating the CNHPS. Working first in small work groups and then with their colleagues at large, the participants formulated the vision, mission, objectives, example activities, terms of reference, plan of action, and an initial organizational structure for the CNHPS, including responsibilities for the CNHPS Focal Point and of the country representatives. At the close of the meeting on November 28, 2001, 27 representatives from 14 Caribbean countries signed a Statement to establish the CNHPS, witnessed by 13 representatives from international and regional agencies.

Vision of the Caribbean Network of Health-Promoting Schools

Healthy communities through Health-Promoting Schools across the Caribbean

Mission of the Caribbean Network of Health-Promoting Schools

The CNHPS will share knowledge, skills, and resources within and among Member Countries and build and/or strengthen alliances with regional and international agencies and institutions to gain support for and build the capacity of the Health-Promoting Schools Initiative.

Objectives of the Caribbean Network of Health-Promoting Schools

By the end of the year 2002, the CNHPS should be able to:

1. support countries in improving and strengthening Health-Promoting Schools Initiative;
2. facilitate ongoing communication between and among member countries, related agencies and individuals;
3. strengthen the capacity of government ministries to work together to foster Health-Promoting Schools Initiatives;
4. establish common and complementary activities in collaboration with CPC/PAHO, CFNI/PAHO, PAHO-PWR Offices, HPP/HPF/HED/PAHO-HQ, WHO, UNICEF, UNESCO, UNDCP, FAO, and other technical and funding agencies;
5. build and strengthen alliances among all stakeholders within Member Countries to advocate for and promote the HPS Initiative in the Caribbean; and
6. facilitate the development or adaptation of Health-Promoting Schools policies

Terms of Reference of the Caribbean Network of Health-Promoting Schools

The CNHPS will serve the Caribbean Region to:

- build the capacity to advocate for Health-Promoting School communities;
- create alliances for the development of Health-Promoting Schools within and among the countries;
- mobilize resources for sharing within and among the countries;
- strengthen national capacities;
- initiate and coordinate research to improve school health programmes;
- publish research findings;
- foster the production of publications and resources;
- establish criteria for Health-Promoting Schools; and
- monitor and evaluate Health-Promoting Schools programmes.

Plan of Action of the Caribbean Network of Health-Promoting Schools

The following is a plan of action proposed to formalize the newly created CNHPS:

1. Notify government and stakeholders of the creation of the CNHPS (*soon after meeting and ongoing*);
2. ratify and obtain formal agreement for the creation of the CNHPS (*soon after meeting*);
3. continue with the development of the organizational structure of the CNHPS – work is to be continued by the CNHPS Focal Point and Advisory Board (Barbados, Trinidad and Tobago, Saint Lucia, Dominica), CPC/PAHO, CFNI/PAHO, PAHO-PWR Offices, and CNHPS Technical Secretariat (*first quarter of 2002*);
4. advocate for the development of National Health-Promoting Schools Networks among key stakeholders and interest groups (Ministries of Youth, Sports, Human Services, Social Development, etc.) (*soon after meeting and ongoing*);
5. develop and distribute the CNHPS Newsletter (*first semester of 2002*); and
6. conduct Second Meeting of CNHPS (*by November 2002*).

Organizational Structure of the Caribbean Network of Health-Promoting Schools

A preliminary Organizational Structure for the CNHPS was drafted by the end of the meeting on November 28, 2001. The participants agreed that an Advisory Board be established to provide support to the newly appointed CNHPS Focal Point, consisting of representatives from Barbados, Dominica, Saint Lucia, Trinidad and Tobago, CPC/PAHO, CFNI/PAHO, PAHO-PWR Offices, and CNHPS Technical Secretariat, who will continue to work to further develop and clarify the organizational structure of the network.

The Organizational Structure of the CNHPS has two levels:

1. *International level*, composed of the CNHPS Focal Point, the Technical Secretariat (HPP/HPF/HED/PAHO-HQ and Focal Points from CPC/PAHO, CFNI/PAHO, and other PAHO-PWR Offices), and specially created Work Groups/Committees.
2. *National level*, composed by Functional Committees (Mixed Commissions) of each Member Country, which are the Coordinators for the countries' Health-Promoting Schools and for the networks

At the international level, the CNHPS Focal Point will lead, manage, and coordinate the CNHPS's activities. The first CNHPS Focal Point will be based in Barbados and will rotate every two years to other countries (see chart below). The first CNHPS Focal Point will be led by Erdiston's Teachers' College, Barbados, with technical and administrative support from the Advisory Board (representatives from Dominica, Saint Lucia, and Trinidad and Tobago), the CNHPS Technical Secretariat, CPC/PAHO, CFNI/PAHO, and other PAHO-PWRs Offices.

First Meeting and Constituent Assembly

Years	CNHPS Focal Point	Advisory Board
2002 – 2003	Barbados	Dominica, Saint Lucia, Trinidad and Tobago
2004 – 2005	Bahamas	
2006 – 2007	Trinidad and Tobago	

No special Work Groups/Committees were formed at this first meeting, except for the specially created Advisory Board to the CNHPS Focal Point.

The CNHPS Technical Secretariat will provide technical and administrative support to the national networks to facilitate the work of the Networks and to interact with other national and international organizations that support the development of the CNHPS and their Health-Promoting Schools.

At the *national level*, each Member Country will form a Functional Committee (Mixed Commissions) to serve as the country's liaison to the CNHPS Focal Point and to the CNHPS Technical Secretariat. The Functional Committee will be comprised of representatives from the Ministry of Health and Ministry of Education and other government agencies (e.g., agriculture, sports, youth, social development, etc.), NGOs, PTAs, statutory bodies, media, universities/colleges, CBOs, student councils, youth groups, teachers unions, etc.

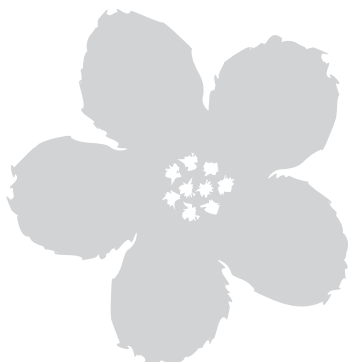
Member Countries can contact all members of the CNHPS, including the CNHPS Focal Point, the CPC/PAHO, CFNI/PAHO, PAHO-PWRs Offices, CNHPS Technical Secretariat, and international agencies directly to interact with one another, as needed and desired. Requests to PAHO-HQ, CPC/PAHO, CFNI/PAHO, and to other PAHO-PWR Offices will follow the standard procedures for requesting technical and administrative support for the strengthening of the CNHPS and Health-Promoting Schools related activities.

Responsibilities of Caribbean Network of Health-Promoting Schools Focal Point

1. Coordinate CNHPS activities;
2. inform regional bodies about process and progress of CNHPS;
3. process formal requests for technical and administrative support to the CPC/PAHO, CFNI/PAHO, PAHO-PWR Offices, and to CNHPS Technical Secretariat, including convening *ad hoc* meetings directed to strengthen the Network;
4. coordinate the development of the CNHPS Newsletter (with technical, administrative, and financial support of the CNHPS Technical Secretariat); and
5. encourage the development of the baseline data for the status and trends of the Health-Promoting Schools in the Caribbean Region (in collaboration with the CNHPS Technical Secretariat)

Responsibilities of Country Representatives

1. Establish a national Functional Committee or integrate into existing intersectoral committees, preferably cabinet-appointed;
2. ensure that the national Functional Committee has the following representation:
 - Government, e.g., health education, sports, youth, social development, planning,
 - NGOs
 - PTAs
 - Statutory bodies
 - Media
 - Universities/colleges
 - Community-based organizations
 - Student councils
 - Youth groups
 - Teachers unions
3. identify head of committee at the national level with relevant support (e.g., administrative and secretarial); and
4. convene a second CNHPS meeting between June and November 2002.



Agreement of the Formation of the Caribbean Network for Health-Promoting Schools

Participants agreement on the establishment of the Caribbean Network of Health Promoting Schools

At a meeting on Health-Promoting Schools convened by the Pan American Health Organization in Barbados from 26-28 November 2001, professionals representing the Ministries of Health and Education of CARICOM and Associate Member States, the Commonwealth of Puerto Rico, and other regional institutions, recognizing the relationship between health and learning, called for the development of a Caribbean Network of Health-Promoting Schools as an important and significant process through which school communities might assume more control of and improve their health.

This cooperative action of the Network coincides with those being taken in the hemisphere in keeping with the plans and actions for the implementation of the Health Promotion Strategy as highlighted in the Caribbean Charter for Health Promotion.

The urgency for action is underpinned by the need to strengthen existing structures for improving the social, emotional, spiritual, psychosocial, and physical well being of students, school personnel, families, and communities.

Therefore, we the undersigned hereby create the Caribbean Network for Health-Promoting Schools.

Dated this 28th day of November, 2001.

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myra Bennett	<u>Myra Bennett</u>	Min. of Education - Dominica
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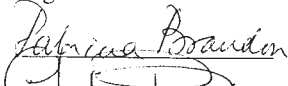
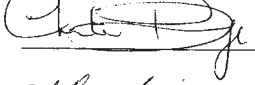
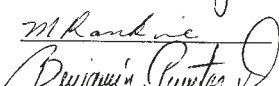


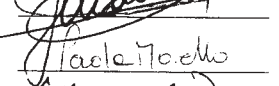
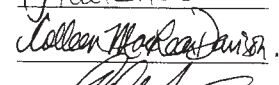
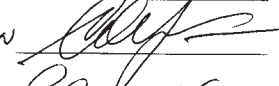
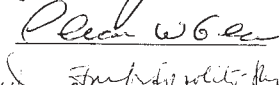
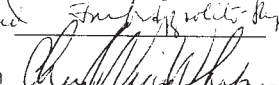
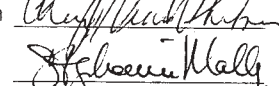
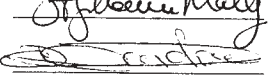
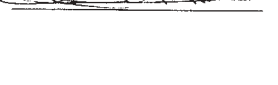

Agreement of the Formation of the Caribbean Network for Health-Promoting Schools

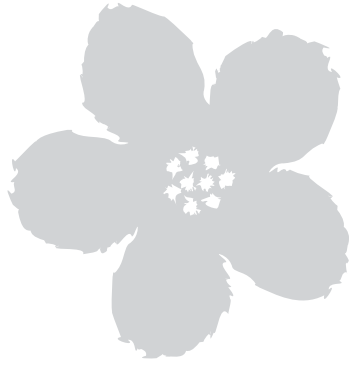
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Agreement of the Formation of the Caribbean Network for Health-Promoting Schools

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First Meeting and Creation of the Caribbean Network of Health-Promoting Schools

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Agenda



Saturday, 24 November

Arrival of PAHO/WHO staff

Sunday, 25 November

Arrival of Participants

Monday, 26 November

- 8:30 Welcome and Opening Remarks
Ms. Veta Brown, CPC/PAHO
Dr. Maria Teresa Cerqueira, PAHO/WHO
(Presented by Dr. Josefa Ippolito-Shepherd, PAHO/WHO)
- 9:15 Introductions of Participants
Ms. Patricia Brandon, CPC/PAHO
- 9:35 Objectives, agenda, Expected Results, Meeting Methodology
Dr. Josefa Ippolito-Shepherd, PAHO/WHO
- 9:45 Schools and Health in the CARICOM Caribbean
Ms. Patricia Brandon, CPC/PAHO
- 9:55 The Global WHO Initiative for School Health
Mr. Charles Gollmar, WHO
- 10:15 The Health-Promoting Schools Initiative
Dr. Josefa Ippolito-Shepherd, PAHO/WHO
- 10:30 Refreshment break
- 11:00 Country Presentations
Bahamas, Barbados, Dominica
- 11:30 Plenary discussion
- 12:00 Lunch
- 13:30 Country Presentations
Grenada, Guyana, Jamaica
- 14:00 Plenary discussion
- 14:30 Country Presentations
Puerto Rico, Saint Lucia, St Vincent, and the Grenadines
- 15:10 Plenary discussion
- 15:30 Refreshment break
- 16:00 Country Presentations
St. Kitts-Nevis, Suriname, Trinidad and Tobago
- 16:40 Plenary discussion

Agenda

Tuesday, 27 November

- 8:00 The Health-Promoting School Initiative in the Americas
Dr. Josefa Ippolito-Shepherd, PAHO/WHO
- 8:15 Status and trends of health education and health promotion within
the school environment
Dr. Benjamin Puertas
- 8:30 Methods and instruments for the surveillance of risk factors and
practices of school age children and adolescents
Mr. Charles Gollmar, WHO
- 8.45 Experiences of Health-Promoting Schools and Networks
Dr. Benjamín Puertas: The Latin American Experience
Prof. Antonio Saéz: The Spanish Experience
Dr. Lourdes E. Soto de Laurido: The Puerto Rico Experience
Eng. Leo Nederveen: The Loa Experience
- 10:00 Plenary Discussion
- 10:30 Refreshment break
- 11:00 Components for the formation of HPS Networks — Panel
Dr. Benjamín Puertas
Mr. Charles Gollmar, WHO
Prof. Antonio Saéz
Eng. Leo Nederveen
- 11:30 Plenary discussion
- 12:00 Rapid Assessment Tools (RAT) and Diagnostic Methods and
Instruments
Ms. Cheryl Vince Whitman, EDC
- 12:15 Plenary discussion
- 12:45 Lunch break
- 14:00 Proposal for the creation of Caribbean Network of Health-
Promoting Schools and the gathering of baseline data (interests and
benefits to countries in creating such a Network at this time, and
possible priority areas for action)
Dr. Josefa Ippolito-Shepherd, PAHO/WHO
Ms. Patricia Brandon, PAHO/CPC
- 14:30 Plenary discussion
- 15:00 Work groups to discuss the creation of the CNHPS and to elaborate
proposal, principles, goals, terms of reference, structure, resources,
and functions of the Secretariat. Selection of Moderators and
Rapporteurs for each group

Agenda

- 16:00 Refreshment break
16:30 Plenary – presentation of preliminary proposals by work groups

Wednesday, 28 November

- 8:15 Summary of preliminary proposals for the formation of the Caribbean Network of HPS
Rapporteur Group I
Rapporteur Group II
Rapporteur Group III
- 8:45 Communication and interchange of information -Bulletin of the LANHPS
Dr. Benjamín Puertas
Prof. Antonio Saéz
Eng. Leo Nederveen
- 9:00 Discussion by work groups (to elaborate the final proposal for the CNHPS, taking into account the comments of all participants)
Preparation of summary document
- 10:30 Refreshment break
- 11:00 Discussion by work groups (to elaborate a Plan of Action to implement the proposal, interchange of materials and information, and the production of the bulletin of the CNHPS)
Preparation of summary document
- 12:30 Lunch break
- 14:00 Work group discussions and integration for the Plan of Action for the CNHPS
- 15:00 Plenary – Presentation of terms of reference, organizational structure, goals, objectives, functions of the CNHPS, Letter of Intention, and plan of action for its development and maintenance
- 16:00 Refreshment break
- 16:15 Commitment of participating countries
Signature of Letter of Intention
- 17:00 Closure of Meeting
Dr. Josefa Ippolito-Shepherd, PAHO/WHO
Ms. Veta Brown, CPC/PAHO

Thursday, 29 November

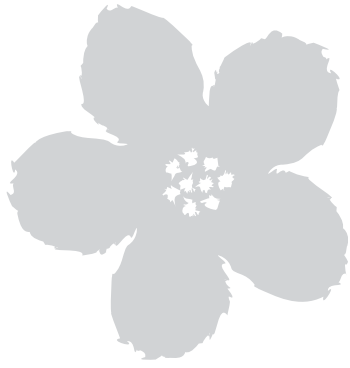
- Departure of participants
Departure of PAHO/WHO staff



Pictures kindly provided by
Ms. Cheryl Vince Whitman, EDC

PROCEEDINGS
First Meeting and
Creation of the
Caribbean
Network of
Health-Promoting
Schools





Welcome and Opening Remarks

Veta Brown, *Caribbean Program Coordinator, Pan American Health Organization (PAHO), Office of Caribbean Program Coordination (CPC)*

Ms. Veta Brown, Caribbean Program Coordinator for the Pan American Health Organization, welcomed the participants to the First Meeting and Creation of the Caribbean Network of Health-Promoting Schools and extended greetings from Sir George Alleyne, Director of PAHO. Ms. Brown emphasized that the Caribbean consists of a diverse group of countries characterized by multiple cultures and multiple languages, and that any Caribbean initiative must take this diversity into consideration. The challenge of this emerging network will be to identify those issues these countries share in common and can address collectively, relying on one another as resources in an ongoing effort to create Health-Promoting Schools.

Ms. Brown reminded the group of key questions and critical health issues that must continue to drive their efforts to promote health in the Caribbean: What are the determinants of health? How do we examine the environmental, political, and socioeconomic issues that affect the health of people in our countries? How will we address the impact of HIV/AIDS and drugs on the health of the population? Any work being done in Health-Promoting Schools must address these critical health issues.

Acknowledging the large workloads of these dedicated participants, Ms. Brown invited them to build upon the work they have already done through collaboration and coordination, thereby avoiding the need to “reinvent the wheel.” She also stressed the importance of building alliances and networks and including the many stakeholders in the process.

Ms. Brown concluded by encouraging the group to be very active participants in the process: “This cannot be an exercise for the sake of an exercise or for the purpose of producing a publication,” she urged. “Keep foremost in your mind the thoughts of how you will make a change once you return home.”



Strengthening Health Promotion Planning for Action in the Americas

Dr. Maria Teresa Cerqueira, Director, Division of Health Promotion and Protection, PAHO/WHO¹

Introduction

The Region of the Americas has achieved significant progress in life expectancy, access to clean water, and immunization coverage. Infant mortality due to infectious diseases has steadily declined. Yet, Member States continue to struggle with persistent poverty and poor living conditions associated with great inequities in income and wealth distribution. Countries continue struggling to reduce maternal mortality, a clear indication of these inequities. Countries are also working to improve basic sanitation systems; to manage new and emerging diseases, such as tuberculosis, cholera, dengue, and HIV/AIDS; and to deal with increasing non-communicable diseases associated with poor eating habits and more sedentary lifestyles.

In addition, the growing burden of mental illness and recognition of the magnitude of mental health problems require urgent action from health authorities and community leaders. Many adolescents and older adults suffer from depression and other mental illness and several countries of the Region have high rates of child and teen suicide. Illicit drug use, stress, and alcoholism continue to rise, presenting an extraordinary challenge for families, communities, and the social sector, especially the health and education sectors. The number of smokers continues to increase, while it is known that tobacco use is the leading cause of preventable death in the Americas. Violence is an increasing concern for public health everywhere, especially neglect and abuse against women, children and the elderly. Countries are struggling to provide supportive environments for individuals and families, especially children and older adults, ensuring health, quality of life, and dignity.

Health Promotion

The importance of Health Promotion, as a powerful public health strategy, emerged from the framework put forth in the Ottawa Charter (1986). Canada has produced much of the conceptual and operational guidelines in this field. After the Lalonde Report (1974) on the Health of Canadians, which concluded that lifestyles and environmental conditions contributed more to the health of Canadians than the health services, the public health community convened the First International Conference on Health Promotion in Ottawa. The Charter that resulted from this conference was a major breaking point in public health thinking. It posits that health is produced in the context of people's daily life and in the places where people live, work, study, and play.

¹ Presented by Dr. Josefa Ippolito-Shepherd, Regional Health Education Advisor, Health-Promoting Schools Regional Initiative, Program of Family Health and Population, Division of Health Promotion and Protection, PAHO/WHO

Welcome and Opening Remarks

Health promotion as a process is directed at achieving outcomes over a long term with specific results in the medium and short term. Specific outcomes differ, but they involve citizen and community participation and contribute to improvement in quality of life.

Effective health promotion actions strengthen the skills and capabilities of individuals, organizations, and communities to act and improve the determinants of health. Member States can achieve significant progress in reducing tobacco use and protecting nonsmokers by increasing taxes on tobacco and by eliminating smoking from public places. A municipality or community can implement a combination of measures directed to tobacco control, including fiscal and social policy, advocacy for smoke free spaces, negotiation and advocacy to stop advertising, and school-based life skills education programs to strengthen self esteem and the development of healthy behaviors.

Health promotion is providing evidence of effectiveness in improving health and quality of life, which indicates that a comprehensive approach, using a combination of the five Ottawa strategies, is effective. Promoting health in certain settings such as schools, workplaces, cities, and communities improves the health status of populations and the quality of life in those spaces. There is evidence that people, including those most affected by poverty and adversity, need to be involved in defining health promotion actions and in making decisions to ensure effectiveness and sustainability of community programs.

However, despite the evidence of the effectiveness of health promotion strategies, few countries in the Region have considered it as an important investment and an essential element for social and economic development, and few have destined adequate resources to this essential public health strategy. A commitment to strengthen health promotion planning for action is necessary to ensure that communities and societies are able to address the determinants of health and increase equity in health. PAHO/WHO, through its Division of Health Promotion and Protection, provides technical cooperation in health promotion and stimulates collaboration among Member States to strengthen health promotion planning for action, establish healthy public policy, and create supportive environments.

The PAHO Directing Council resolution (1993) and the Regional Plan of Action for Health Promotion (1995-1998) stimulated the development of health promotion in the American Region. The objectives of this Regional Plan of Action included the promotion of healthy public policies (food and nutrition, tobacco, alcohol and drugs, violence and environment); to create healthy options for the population; and to develop healthy cities and communities as settings for health promotion actions. The Plan specified three target areas: environments, behaviors and lifestyles, and health services.

The PAHO's Strategic and Programmatic Orientations (SPOs 1999-2002) defined the priority for technical cooperation to create jointly with the countries a culture for health promotion. The Orientations supported the development of healthy spaces, healthy public policies, and other health promotion strategies in the program areas:

- mental health and psychiatric reform
- sexual and reproductive health
- maternal mortality
- adolescent health
- aging and health
- micronutrient nutrition
- maternal and child nutrition

Global and Regional Commitment

The platform provided by the Ottawa Charter was ratified by subsequent international and regional conferences. The Adelaide Recommendations (Australia 1988) provided an in-depth review of the concept of public policy and outlined ways toward establishing healthy public policy. The Sundsvall Statement (Sweden, 1991) built on the concept of creating supportive environments and provided examples of good practice. The Bogota Declaration (Colombia, 1992) highlighted the relationship between health and development and called for a renewed commitment to solidarity and equity in health and deplored the impact of violence on the health of individuals and communities. It summoned the political will of people and leaders to modify social conditions and make marginality, inequality, abuse, and environmental destruction unacceptable.

The Caribbean Conference on Health Promotion (Trinidad and Tobago, 1993) endorsed health promotion and protection and reinforced the principles and key areas identified in the Ottawa Charter. It set forth strategic approaches for intersectoral activities and called for a renewed commitment to community participation in decision-making processes, social communication, and the achievement of greater equity in health.

The Jakarta Declaration (Indonesia, 1997) reiterated the global commitment to the strategies put forth in the Ottawa Charter and provided a clearer understanding of the critical importance of building partnerships for health. It called for new players and identified key ingredients aimed at improving health and quality of life later adopted by WHO Member States. With each international conference, WHO and its partners have restated the commitment to increase the infrastructure and strengthen technical cooperation in health promotion, build partnerships, and adopt an evidence-based approach to policy and practice.

The Fifth Global Conference on Health Promotion (Mexico, 2000) produced a set of critical papers that clarify and outlined the key ingredients for health promotion, as well as guidelines for strengthening health promotion plans of action. The commitment embraced by Member States includes the following:

- To position the promotion of health as a fundamental priority in local, regional, national, and international policies and programs;
- to take the leading role in ensuring the active participation of all sectors and civil society in the implementation of health-promoting actions to strengthen and expand partnerships for health;
- to support the preparation of countrywide plans of action for promoting health, if necessary drawing on the expertise in this area of WHO and its partners. These plans will vary according to the national context, but will follow a basic framework agreed upon during the Fifth Global Conference on Health Promotion;
- to establish or strengthen national and international networks to promote health; and
- to inform the Director-General of the World Health Organization of the progress made in the performance of the above actions.

Healthy Municipalities and Communities in the Americas

In the last decade, almost every country in the Region has adopted the Healthy Municipalities and Communities Movement. The municipalities that have implemented the health promotion strategy have developed a holistic-comprehensive framework that starts with a participatory need assessment and planning process. Jointly with community groups; NGOs; representatives from health and other relevant sectors; municipal teams, led by Mayors, implement health promotion strategies to improve the determinants of health and equity.

Networks provide an opportunity and space for Mayors, local authorities, and community leaders to exchange ideas and opinions, to share experiences and knowledge gained as they implement health promotion at the local level, as well as to discuss possible future collaboration. The key factor in the success of this health promotion strategy is that it builds and strengthens a social pact among key players to promote health with people and their communities. It builds on and expands local health promotion experiences and involves the participation of all stakeholders. The Network of Healthy Municipalities and Communities in the Americas was founded in 1997 in Boca del Rio, Veracruz, Mexico.

Health-Promoting Schools

Schools should have a central role, not as passive recipients of health interventions, but as active partners in effective integrated school health programs with multiple components, including support and cooperation of parents, community agencies, and actively enforced community-wide policy.

Historically, schools have carried out a variety of health and nutrition activities, mostly focused on disease prevention and control, including periodic medical and dental exams and visual and auditive screening, school feeding, and mass vaccination campaigns. The PAHO/WHO Health-Promoting Schools Regional Initiative is strengthening and expanding these traditional practices through joint efforts between the health and education sectors. The Initiative facilitates strategic planning and implementation of school based health programs, including the delivery of comprehensive and skill based health education that facilitate the adoption of healthy lifestyles and behaviors; the creation and maintenance of supportive environments that are conducive to learning and the maintenance of healthy practices; and the provision of health care services and respective referral, healthy meals, psychological counseling, and physical education. By establishing networks, the Initiative has provided an environment and opportunities for countries to share knowledge and experiences and to improve their models of school health.

The Health-Promoting Schools Regional Initiative, a global strategy launched in our Region in 1995, is directed to improve the health of children, teachers, parents, and other members of the school community. The Initiative addresses three main components:

- *Comprehensive health education and life skills training*, for the acquisition of information, knowledge, and skills that facilitate the adoption and maintenance of healthy behaviors;
- *Healthy and supportive environments*, to create and maintain enabling school environ-

ments and surroundings supportive for health and learning, and for the development of positive attitudes and relationships between children and staff; and

- *Health and nutrition services*, directed to strengthen coordination and collaboration between the health, education, and other sectors, to facilitate the delivery of health care and nutrition services for the school population.

Progress and Lessons Learned

Among the lessons learned are the experiences with participatory local planning in the Healthy Municipalities and Communities. In a few countries, health promotion is positioned at high political levels as an essential strategy for social and human development. Such is the case in Chile where health promotion is a national priority and is committed to a national plan for action called Vida Chile.

Health promotion in Canada highlights how the development of relevant infrastructures enables concepts to be transformed into effective policy and health promotion programs. The lessons learned in Canada and other countries illustrate the essential components for the development of effective health promotion and lead to a greater understanding of the factors that have limited its effectiveness. A strong conceptual basis for action has clearly been a positive guiding force in the development of health promotion.

Engagement of academic institutions with an explicit research agenda and with programs for the training and development of human resources in health promotion is crucial in the development and implementation of health promotion plans of action. Canada and the United States of America provide evidence of the importance of this component for effective health promotion. Chile, as well, has created a network of universities and developed a clearinghouse with health promotion documents and materials for training of local health teams, in collaboration with the Center for Health Promotion at the University of Toronto.

Strong, aware, and committed leadership at all levels of the health sector is key for health promotion policies and programs and especially to influence the health sector reform agenda. Health promotion concepts, goals, and strategies in the reform agenda are critical for the involvement of health systems and services.

A committed and strong partnership base among stakeholders plays a crucial role in the progress of health promotion. Multi-sectoral action for health is essential to successful health promotion. The role of different networks cannot be overemphasized in bringing to the negotiation table various levels of government officials, professional and community organizations, and the private sector to develop, implement, and evaluate health promotion plans for action. The Mexican Network of Municipalities for Health is a good example of this. The Network jointly with the Ministry of Health planned and carried out national meetings and regional thematic meetings key to building the capacity of new Mayors that entered the network. The National Network also supported State Networks with meetings, workshops, and other local capacity-building activities.

Integrating Health Promotion Strategies

PAHO technical cooperation focuses on strengthening health promotion planning for action. Countries are supported in setting targets to address their priorities and in building capacity at the national and local level to develop, implement, and evaluate health promotion plans for action.

The Division of Health Promotion and Protection is committed to this process and has begun to integrate the technical areas managed by the programs and centers with the health promotion strategies, including:

- the creation of healthy and supportive environments in the community, school, and workplace;
- the establishment of healthy public policy at national, local, and institutional levels, and the development of guidelines to assess their impact;
- the strengthening of community action for health by implementing training modules to facilitate community participation and support Member States to work with NGOs and other community groups;
- the development of personal skills, using the health literacy framework, health education, and social communication techniques;
- the reorientation of health systems and services by supporting countries to implement more integrated models of community, family, and school health, including mental health;
- strengthening surveillance systems with social and behavioral information; and
- supporting research and evaluation to advance knowledge and best practices.

A New Strategic Plan of Action

A major challenge for PAHO's technical cooperation is to integrate the technical areas within a conceptual and methodological framework of health promotion. A strategic planning process is underway involving the Regional Programs, the Centers (CFNI, CLAP, CEPIS, and INCAP), Health Promotion Focal Points in the PAHO Country Offices, Ministries of Health, and other sectors, and health promotion professionals, particularly those in the PAHO Collaborating Centers. The purpose of this strategic planning process is to continue integrating the content in the technical program areas with the strategies for health promotion. This process of integration and consolidation of the Strategic Plan of Action for the next five years will be achieved by continued systematic consultation and working meetings with Regional, Centers, and country staff to assess progress and make necessary adjustments. An advisory Committee provides insights and suggestions, identify content areas that need greater integration with health promotion strategies, and identify gaps in knowledge for further research.

A second major challenge will be to position health promotion high on the political agenda of the Organization. This will be achieved by advocating that Member States strengthen health promotion planning for action, by disseminating effective health promotion experiences, and by mobilizing resources to support pilot and demonstration projects. A regional forum is

Strengthening Health Promotion Planning for Action in the Americas

planned to be held in 2002 to assess progress in health promotion planning for action. Inter-American Partnerships with other institutions, such as the Inter American Development Bank and the World Bank within the context of the Shared Agenda, will also strengthen health promotion planning for action.

A third challenge is to secure the infrastructure and resources necessary to strengthen health promotion planning for action, to be achieved by:

- strengthening the development and training of human resources, especially building capacity of PAHO and Health Ministry staff responsible for health promotion and protection;
- the preparation of project and research proposals to mobilize needed resources;
- increasing the evidence base of health promotion effectiveness by increasing the evaluation of health promotion interventions; and
- establishing new partnerships and strengthening existing ones, especially with WHO Collaborating Centers in Health Promotion.

Priorities

A priority for health promotion in the next five years will be to establish smoke-free environments in public places such as schools, health centers, childcare facilities, government workplaces, and in the hospitality sector. This will be accomplished by:

- building capacity for youth advocacy and community partnerships to support smoke-free environment;
- a multifaceted public education campaign to inform the public, parents, teachers, and health workers of the risks of second-hand smoke and actions they can take to eliminate exposure; and
- developing guidelines to establish policies at national, local, and institutional level to establish smoke-free spaces, and curb tobacco promotion and demand.

Creating Supportive Environments

In coordination with other units in PAHO, HPP will support Member States in creating and strengthening the Healthy Spaces Initiatives, especially municipalities, communities, schools, and workplaces, ensuring that the spaces where people live, study, work, and play have a positive influence on their health. Thus, technical cooperation will focus on improving the physical and psychosocial environments with interventions to provide clean water, basic sanitation, and basic health services in schools, workplaces, and communities. Policies and public education campaigns will be carried out to raise awareness and strengthen healthy behaviors and lifestyles.

Gender equity and respect for diversity will be encouraged as part of the organizational behavior and cultural values in the school, community and workplace. Countries will be supported in increasing the protective factors in designated healthy spaces and in strengthening collabo-

Welcome and Opening Remarks

ration among NGOs and other community groups to protect women and children from abuse, violence, and neglect, and protect people, families, and communities from drug and alcohol abuse.

The year 2001 is dedicated to the theme of mental health. Countries will be encouraged to review the mental health situation in schools, workplaces, and communities and include this priority in their plans of action. Many aspects concerning mental health are now better understood, and there is considerable evidence that mental health promotion reduces depression, suicides, and risk behavior problems. Countries will be supported in implementing early education programs that have resulted in fewer learning problems with small children and involve parents in creating a more positive home and family environment for children to grow and develop.

Countries will also be supported in implementing Life Skills Education in schools, as studies show that Life Skills Education is effective in promoting healthy development and reducing risk behavior in children and adolescents. A model of mental health promotion and prevention of violence in schools will be developed. Countries will be supported in implementing workplace health promotion interventions that have shown positive results in reducing stress levels, increasing job satisfaction, and reducing sick leave.

Healthy Public Policies

Working groups will be established to stimulate collaboration among Member States in developing guidelines for healthy public policy at the national, local (municipal), and organization-level, and to evaluate their health impact. In coordination with other units and organizations, HPP will strengthen and extend such public policy initiatives as food and nutrition security in Central America and baby-friendly hospitals to encourage breast-feeding. The Regional Program will provide technical cooperation to establish public policies that promote healthy and safe motherhood by increasing equitable access to quality essential obstetric care and improve nutritional intake during pregnancy. Policy and legislation will be developed to protect sexual and reproductive rights and establish the infrastructure that allows individuals to exercise those rights. HPP will support countries in the development of guidelines to promote healthy aging through public policies and in the establishment of public policies to promote mental health across the life cycle, with special emphasis on capacity-building in families, community schools, and workplaces.

Strengthening Community Action for Health

Countries will be supported in the implementation of local participatory planning involving local authorities such as mayors, and community leaders, teachers, and people in general, in basic needs assessment, priority setting, planning, and developing policies and programs. Member States will be supported in developing, implementing, and evaluating interventions at national and local level to encourage good nutrition and active living throughout the life course such as “Agita São Paulo.” In coordination with other units, HPP will support countries to build community capacity in health literacy and to establish partnerships and carry out a multifaceted public education campaign with children, adolescents, and adults to adopt

Strengthening Health Promotion Planning for Action in the Americas

healthy lifestyles and minimize risk behaviors. Community action will be strengthened to provide access to social services for the elderly, promote good nutrition and active healthy lifestyles, and to encourage their participation in social support networks. HPP will support countries to develop a community-based model to deal with depression and suicide and create materials on mental health promotion directed at families, teachers, religious leaders and other members of the community.

Development of Personal Skills

Schoolchildren and adolescents will be involved early on in developing personal skills.

School-based mental health programs and Life Skills Education will be strengthened. Countries will be supported in implementing Life Skills Education to effectively contribute to higher literacy and reduced dropout rates associated with a decrease in health risk behaviors, such as smoking, substance abuse, and teen pregnancy. Materials to support parents and teachers with Life Skills Education will be developed. Materials to promote health literacy directed at Mayors, teachers, church leaders, and other decision-makers will be fostered. Countries will be assisted in developing activities to enable the elderly to participate in decisions that affect them and in adopting and maintaining healthy life skills throughout the life course. Countries will be supported in setting targets for dietary behaviors and physical activity and in monitoring individual and collective behavior change using lifestyle surveys or other comparable methods.

Reorienting Health Systems and Services

Countries will be supported to strengthen the role of the health sector to advocate for health promotion, for greater intersectoral coordination and for increased investments in health promotion. Ministries of Health will be supported in fostering opportunities for social participation in the decisions concerning community health care. In coordination with other units, HPP will develop new and expanded models for community, family, and school health services. Countries will be supported in the reorientation of health services with a greater focus on bridging the equity gap (gender, ethnic origin, age, etc.) and strengthening community-based care. Countries will be supported in the reorientation of health services to assure safe motherhood and youth-friendly services, especially to promote breastfeeding. Materials on mental health promotion for primary health care providers will be developed. Training materials on the promotion of good nutrition and active living will be prepared for community health workers.

There are various networks of municipalities, schools, professional associations, universities, and other institutions and groups involved in health promotion actions in the Region. The Network of Healthy Municipalities and Communities of the Americas could effectively disseminate good practices in health promotion if they are supported in developing technical cooperation among municipalities and across borders. If Mayors are to succeed in putting health on the local development agenda, actions must focus on orienting this group as to the most effective interventions to improve health and quality of life. The Networks of Health-Promoting Schools could be a more effective advocate for placing health promotion and Life

Welcome and Opening Remarks

Skills Education in the education agenda if health sector efforts are supported and coordination with the education sector is strengthened to provide the necessary knowledge and skills to teachers and parents. PAHO/WHO has contributed to the creation of several networks. However, despite a growing consensus that networking is an effective strategy, few groups have adequate resources to maintain active communication among all the members of the network. A greater effort is needed to support the mobilization of resources for the networks so they may become major players in disseminating knowledge and skills in health promotion.



Conclusions

Health promotion in health and development is a long-term investment. The evidence of health promotion effectiveness suggests that if properly implemented, it could save resources in the medium and long term. Member Countries are urged to consider the development of appropriate infrastructures for the strengthening of health promotion planning for action to meet the challenges of the new millennium in the Americas.

Strengthening Health Promotion Planning for Action in the Americas



Health Promotion Promoción de la Salud

Maria Teresa Cerqueira, Director
Division of Health Promotion and
Protection

Organización Panamericana de la Salud • Organización Mundial de la Salud

<h3><i>Situation Analysis</i></h3> <ul style="list-style-type: none"> • Poverty and inequities • Lifestyles and risk behaviors <ul style="list-style-type: none"> • Tobacco is a major killer • Alcohol and other addictions • Obesity and sedentary living • HIV/AIDS and STI • Burden of mental illness <ul style="list-style-type: none"> • Depression and suicide • Abuse and violence • Maternal mortality • Population aging 	<h3><i>Análisis de Situación</i></h3> <ul style="list-style-type: none"> • Pobreza e inequidades • Estilos de vida y conductas de riesgo <ul style="list-style-type: none"> • Tabaco - causa de muerte • Alcohol y otras adicciones • Obesidad y vida sedentaria • VIH-SIDA e ITS • Carga de enfermedad mental <ul style="list-style-type: none"> • Depresión y suicidio • Abuso y violencia • Mortalidad materna • Envejecimiento de la población
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Conceptual Framework Health Promotion

- The Ottawa Charter (86)
- Healthy Public Policy (Adelaide 88)
- Healthy and Supportive Environments (Sundsvall 91)
- Bogota Charter (92)
- Caribbean Charter (93)
- Jakarta Declaration (97)

Marco Conceptual de Promoción de la Salud

- Carta de Ottawa (86)
- Política Pública Saludable (Adelaide 88)
- Entornos Saludables (Sundsvall 91)
- Carta de Bogotá (92)
- Carta del Caribe (93)
- Declaración de Jakarta (97)






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The Mexico Declaration


- Position Health Promotion on the agenda
- Active participation of all sectors and civil society
- Countrywide plans of action
- Networks to promote health
- Report to Member States

La Declaración de México

- Posicionar la promoción de la salud en la agenda
- Participación activa de todos los sectores y la sociedad civil
- Planes de acción
- Redes de promoción de la salud
- Informe a Estados Miembros

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Plan regional de acción 95-98

Espacios saludables
Redes y consorcio
Salud de la familia y la población
Salud mental y tabaco
Alimentación y nutrición

Regional Plan of Action 95-98

Healthy spaces
Networks and consortium
Family and population health
Mental health and tobacco
Food and nutrition



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SPOs 1999-2002 Health Promotion and Protection (HPP)

Mental health and psychiatric reform
Sexual and reproductive health
Maternal mortality (LAMM)
Adolescent health
Aging and health
Micronutrient nutrition
Maternal and child nutrition

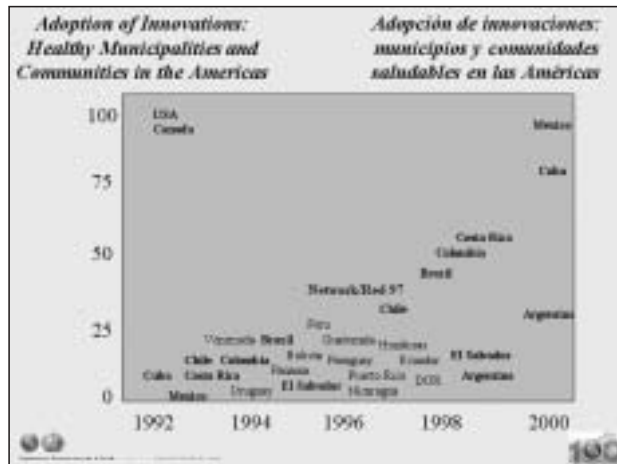
OEPs 1999-2002 Promoción y Protección de la Salud (HPP)

Salud mental y reforma psiquiátrica
Salud sexual y reproductiva
Mortalidad materna (LAMM)
Salud del adolescente
Envejecimiento sano
Micronutrientes
Nutrición materna-infantil

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Welcome and Opening Remarks



Progress and Lessons Learned

Progreso y Lecciones Aprendidas

- Relevant infrastructures developed effective policy and programs
- Engaging academic institutions in training, research, development, and evaluation
- Participatory local planning

- Implementación de políticas y programas eficaces mediante estructuras relevantes
- Involucrar a las instituciones académicas en capacitación, desarrollo y evaluación
- Planificación local participativa

Progress and Lessons Learned

Progreso y lecciones aprendidas

- Strong, aware, and committed leadership at all levels
- A committed and strong partnership base
- Involving all stakeholders
- Intersectorial action
- Multiple strategies

- Liderazgo fuerte, informado y comprometido en todo nivel
- Alianzas fuertes y comprometidas
- Involucrando a todos los actores relevantes
- Acción intersectorial
- Estrategias múltiples



A New Strategic Plan of Action



Un nuevo plan de acción estratégica


- A new direction
- Integrated approach
- Beyond lifestyle and behavior change
- Embracing the key strategies of health promotion in:
 - family health and population
 - food and nutrition
 - mental health

- Un rumbo nuevo
- Enfoque integral
- Más allá de estilos de vida y cambios de conducta
- Incorporando las estrategias de promoción de la salud en:
 - salud de la familia y población
 - alimentación y nutrición
 - salud mental

Strengthening Health Promotion Planning for Action in the Americas

<p>Priorities</p> <ul style="list-style-type: none"> • Smoke-Free Americas • Mental health <ul style="list-style-type: none"> • Depression & suicide • Abuse & violence • Sexual & reproductive health <ul style="list-style-type: none"> • Safe motherhood • Maternal mortality • Breast-feeding • Child and adolescent health and development • Healthy aging • Healthy eating and active living • Capacity building • Evidence: surveillance & evaluation 	<p>Prioridades</p> <ul style="list-style-type: none"> • Américas Libre de Humo • Salud mental <ul style="list-style-type: none"> • Depresión y suicidio • Abuso y violencia • Salud sexual y reproductiva <ul style="list-style-type: none"> • Maternidad segura • Mortalidad materna • Lactancia • Salud y desarrollo en la niñez y adolescencia • Envejecimiento sano • Alimentación sana y vida activa • Construir capacidad • Evidencia: vigilancia y evaluación
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Creando ambientes saludables:

- Escuelas
- Lugares de trabajo
- Municipios y comunidades

Creating Supportive Environments:


- Schools
- Workplaces
- Municipalities and communities




Healthy Public Policies



- Family and population health
- Mental health
- Tobacco and other addictions
- Food and nutrition






Políticas públicas saludables

- Salud de la familia y población
- Salud mental
- Tabaco y otras adicciones
- Alimentación y nutrición






Fortalecer la acción comunitaria en salud

- Empoderamiento
- Participación
- Construcción de capacidades
- Evidencia - Evaluación
- Alianzas nuevas y viejas

Strengthening Community Action for Health

- Empowerment
- Participation
- Capacity building
- Evidence base
- Partnerships old and new







Desarrollo de habilidades para la vida

- Alfabetización en salud
- Comunicación social
- Educación en salud
- Enseñanza de habilidades para la vida

Developing Personal Life Skills

- Health Literacy
- Social Communication
- Health Education
- Life Skills Education





Elder friendly
Adultos mayores

Reorientando los sistemas y servicios de salud

- Promoción de salud en la Reforma
- Coordinación intersectorial
- Participación comunitaria

Salud mental
Mental health

Reorienting Health Systems and Services

- Health promotion and Reform
- Intersectoral coordination
- Community involvement



Family health
Salud familiar



Youth
Jóvenes

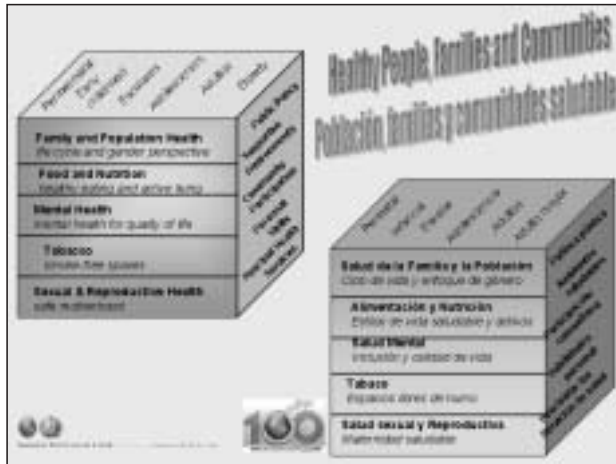


Lactancia
Breastfeeding





Welcome and Opening Remarks





Overview of the Meeting Agenda, Objectives, Expected Results, and Methodology

Josefa Ippolito-Shepherd, Ph.D., Regional Health Education Advisor, Program of Family Health and Population, Division of Health Promotion and Protection, PAHO/WHO

Dr. Ippolito-Shepherd reviewed for participants the agenda of the meeting and described the purpose and goals behind the creation of a Caribbean Network of Health-Promoting Schools. She then proposed a list of objectives and expected results for the Network, stressing that the participants would have the opportunity to create their own vision, mission, and objectives based on the needs of Health-Promoting Schools in the Caribbean Region. A description of the meeting methodology was also presented.

Purpose for the First Meeting and Creation of the Caribbean Network of Health-Promoting Schools

To strengthen mechanisms for the exchange of knowledge and experiences, to promote the harmonious and comprehensive development of young people and their health.

Goal of the Meeting

To facilitate the development of the organizational structure of the Network at both the international level (General Council, Technical Secretariat, and Working Committees) and at the national level (Mixed Commissions of each Member State: schools coordinating group and networks).

Objectives of the Meeting

1. To examine the concepts of Health-Promoting Schools Initiative and their relevance to the Caribbean;
2. to identify ways of using the Health-Promoting Schools Initiative to strengthen the current capacity of systems to promote the health of students, teachers, families, and communities;
3. to define an organizational structure, functions, mechanisms, and membership of the Network at both the international and national levels, consistent with existing governmental and institutional frameworks; and
4. to define a plan of action, which addresses cultural and language diversities within the Region, for implementing the Health-Promoting Schools Initiative at national and Caribbean level, including the creation of smoke-free places in schools.

Proposed Objectives of the Caribbean Network of Health-Promoting Schools

1. To support countries in improving health and development of school children and adolescents;
2. to help Caribbean countries to implement healthy policies in schools;
3. to strengthen ties with community organization;
4. to increase parent involvement in the health and well-being of children and adolescents, to facilitate the acquisition and maintenance of healthy behaviors lifestyles;
5. to disseminate successful health promotion and health education knowledge and practices regarding smoke free schools, sex education, food and nutrition, physical activity, drug education, life skill education, healthy spaces – free from violence and abuse, suicide prevention, mental health, healthy lifestyles, etc.;
6. to provide incentives for closer collaboration between the Ministries of Health and Education for the healthy development of young people;
7. to advocate and promote the added value of a Caribbean Network of Health-Promoting Schools to stakeholders, especially those who are currently working with HPS issues; and
8. to strengthen the capacity of Ministries of Education and Health to foster Health-Promoting Schools.

Expected Results/Benefits of the Caribbean Network of Health-Promoting Schools

As result of being a constituent Member, countries of the Caribbean Network of Health-Promoting Schools, will:

1. Promote the development and training of human resources in the areas of health promotion, health education, community participation, planning, and multisectorial project management, and other actions that favor the health and education of those who study, teach, and work within the school system;
2. promote research projects applied to health promotion and health education in direct collaboration with universities, government agencies, NGOs, union entities, and the private sector;
3. support the preparation, analysis, dissemination, and exchange of health promotion and health education materials at the school sites;
4. organize forums, workshops, working groups, seminars, and other events that will facilitate the study, analysis, and debate on the contents and methodologies of health promotion at school sites;
5. promote the sharing of health education and health promotion experiences in the school setting, as well as the dissemination of successful program experiences, and the promotion of critical debates;

Overview of the Meeting Agenda, Objectives, Expected Results, and Methodology

6. encourage the interest of the politicians, private sector, and civil society toward implementation of Health-Promoting Schools;
7. promote the evaluation of school-based health education and health promotion projects and activities carried out within the framework of the Network, as well as of the process on the development of the Network; and
8. encourage the preparation of a newsletter with the collaboration of all the Member Countries, to display experiences and progress on school-based health promotion and health education activities, as well as on national network activities.

Meeting Methodology

1. Series of presentations to place the Caribbean Network of Health-Promoting Schools in the context of global and regional Health-Promoting Schools Initiatives.
2. Countries' presentations on experiences in instituting HFLE Programs. Documents and presentations prepared in accordance to guidelines provided to participants prior to meeting (Appendix I and II), which will place presentations in a geographic, cultural, and political context. Each country will discuss the development of the HFLE Programs, including formal policies enacted, coordinating mechanisms, educational materials and publications developed, teacher training, community involvement, surveillance and monitoring processes, and evaluation. Participants were encouraged to present on the lessons learned in implementing school health activities and their perceived needs for strengthening their programs, and to identify plans for the future of the Caribbean Network of Health-Promoting Schools.
3. Plenary discussions to give participants the opportunity to examine common themes that emerge, including successes, challenges, and needs to be addressed collaboratively in the future.
4. Plenary presentations by experts on strategies and guidelines for conducting assessments and forming networks. The goals of these presentations are to share lessons learned by similar networks.
5. Work Groups to discuss the creation and development of the network, including the vision and mission statements, preliminary structure, and set of objectives, and a plan of action for formalizing the network.
6. Ratification of formal agreement to establish the Caribbean Network of Health-Promoting Schools, to be witnessed by representatives attending this international event.

Welcome and Opening Remarks



FIRST MEETING AND CREATION OF THE CARIBBEAN NETWORK OF HEALTH-PROMOTING SCHOOLS

Bridgetown, Barbados 26-28 November 2001

Josefa Ippolito-Shepherd, Ph.D
Health Education Advisor

Pan American Health Organization 2001

Purpose for the First Meeting and Creation of CNHPS

To strengthen mechanisms for
the exchange of knowledge and
experiences, to promote the
harmonious and comprehensive
development of young people
and their health

Pan American Health Organization 2001

Goal of the Meeting

To facilitate the development of the organizational
structure of the Network:

- International level (General Council, Technical Secretariat, and working committees)
- national level (Joint commissions of each Member State: schools coordinating group and networks)

Pan American Health Organization 2001

Objectives of the Meeting

- To examine the concepts of the Health-Promoting Schools Initiative and their relevance to the Caribbean
- To identify ways of using the Health-Promoting Schools Initiative to strengthen the current capacity of systems to promote the health of students, teachers, families, and communities
- To define an organizational structure, functions, mechanisms, and membership of the Network at both international and national levels, consistent with existing governmental and institutional frameworks
- To define a plan of action, which addresses cultural and language diversities within the region, for implementing the Health-Promoting Schools Initiative at national and Caribbean level, including the creation of smoke-free spaces in schools

Pan American Health Organization 2001

PROPOSED OBJECTIVES OF THE CNHPS

- to support countries in improving health and development of school children and adolescents
- to help Caribbean countries to implement healthy policies in schools
- to strengthen ties with community organizations
- to increase parent involvement in the health and well-being of children and adolescents, to facilitate the acquisition and maintenance of healthy behaviors and lifestyles
- to disseminate successful health promotion and health education knowledge and practices regarding smoke free schools, sex education, food and nutrition, physical activity, drug education, life skill education, healthy spaces - free from violence and abuse, suicide prevention, mental health, healthy lifestyles, etc;

Pan American Health Organization 2001

Overview of the Meeting Agenda, Objectives, Expected Results, and Methodology

PROPOSED OBJECTIVES OF THE CNHPS

- to provide incentives for closer collaboration between the MoH and MoE for the healthy development of young people
- to advocate and promote the added value of CNHPS to stakeholders, especially those who are currently working with HPS issues
- to strengthen the capacity of MoH and MoE to foster Health-Promoting Schools

Pan American Health Organization 2001

Expected Results/Benefits of the CNHPS

As result of being a constituent Member, countries of the Caribbean Network of Health-Promoting Schools, will:

- promote the development and training of human resources in areas of health promotion, health education, community participation, planning and multisectorial project management, and other actions that favor the health and education of those who study, teach, and work within the schools system
- promote research projects applied to health promotion in direct collaboration with universities, government agencies, NGO's, union entities, and the private sector
- support the preparation, analysis, dissemination, and exchange of health promotion educational materials at the school

Pan American Health Organization 2001

Expected Results/Benefits of the CNHPS

- organize forums, workshops, working groups, seminars, and other events that will facilitate the study, analysis, and debate on the contents and methodologies of health promotion at school sites
- promote the sharing of education and health promotion experiences in school settings, as well as the dissemination of successful program experiences and the promotion of critical debates
- encourage the interest of the politicians, private sector, and civil society toward implementation of HPS
- promote the evaluation of school-based health promotion projects and activities carried out within the framework of the Network as well as of the process on the development of the Network
- encourage the preparation of a newsletter with the collaboration of all the Member Countries, to display experiences and progress on school-based health promotion activities, as well as on national network activities

Pan American Health Organization 2001



Schools and Health in the CARICOM Caribbean: Promoting the Well-being of Young People

Patricia Brandon, Advisor in Health Promotion and Education, PAHO/CPC

Ms. Brandon set the regional stage for the meeting, sketching those aspects of Caribbean life influencing the promotion of health in young people and discussing the evolving role of schools in promoting the health and development in the CARICOM Caribbean. The following is a brief summary of her presentation, based on her slide overview, which follows.

Defining the Caribbean is a matter of history, not only geography. The Caribbean is made up of five political and linguistic communities: French, English, American, Dutch, and Spanish. Very often, a definition of the Caribbean depends on your vantage point. It is only within the last 20 years that people have tried to surmount the lines of culture, language, and political jurisdictions within the Caribbean.

The Caribbean countries cover a wide geographical area. Most countries have small populations under 300,000. The countries have small infrastructures, with few people doing more than one task, making policy and change difficult. Children under 15 years comprised about 30% of the population in 1995. One-third of the population is of school age. Thus, the work of Health-Promoting Schools has the potential of reaching a sizable number of people.

Vulnerability is a hallmark of Caribbean life. Most countries, with the exception of Guyana, Trinidad, Belize, and Suriname, have a narrow natural resource base. The economies, based largely on tourism, agriculture, and manufacturing are vulnerable to global changes; the effects of the September 11 terrorist attacks on tourism, for example, may mean that tough economic times are ahead for the Caribbean Region. Further, the environment in the Region is characteristically fragile, vulnerable to natural disasters that can dramatically affect the health and socioeconomic environment.

Meanwhile, many Caribbean countries have seen marked improvements, including an increase in per capita income (although this varies considerably), diversified employment opportunities, enhanced quality of housing and food availability, and an ever-improving access to communication, transportation, and technology.

In the area of education, Caribbean countries have maintained access of children to primary education, increased access to secondary education, and made improvements in the quality of teacher preparation through Teacher's Colleges and through Health and Family Life Education Programs in particular. In the area of health, the Region has seen a decrease in infant mortality, an increase in life expectancy, a reduction in infectious diseases, immunization rates of 95 – 100 percent, and improved access to community-based health care services.

The recent global economic downturns, diminished revenues and social spending, and the increasing fragmentation of families and community pose particular challenges to the Region. The education sector faces challenges in maintaining quality at primary schools, recruiting and

Welcome and Opening Remarks

retaining qualified teachers, and inadequate maintenance of school facilities. The health sector has seen a steady emergence of new threats to people's health and welfare, including violence, unintentional injury, drug abuse, HIV/AIDS, obesity, and teen pregnancy, to name a few.

Children and youth are particularly vulnerable to violence, drug abuse, HIV/AIDS, STDs, teen pregnancy, obesity, hunger, and poverty. Schools see an increased level of school failure, repetition or dropouts. The school environment remains inadequately safe in many schools, posing additional health risks to children.


Caribbean responses to these problems have come in several waves or phases. The first phase was more reactive in nature, characterized by multiple vertical projects, multiple and often duplicative curricula, and increased in-service training for teachers. As education and health professionals moved forward, they began to focus on planning, coordination, and systems development. They emphasized interagency coordination and began to rethink the scope and focus of Health and Family Life Education and health learning. The conceptual framework for promoting health evolved into an effort to teach underlying behavioral strategies, life skills, and management of the environment. An increase in research and a growing focus on policy development has helped to establish foundations upon which Health-Promoting Schools can be built.

Moving forward, the health and education sectors will need to focus on maintaining interagency coordination and inter-country interchange, communicating to policy makers the educational and developmental benefits of interactive approaches to health promotion, extending and expanding school health services, and strengthening parent involvement. Developing methodologies for ongoing evaluation of health and family life programs, and developing replicable models for these programs will be instrumental to ensure the continued growth and success of the Health-Promoting Schools Initiative in the Caribbean and beyond.

Schools and Health in the CARICOM Caribbean: Promoting the Well-being of Young People

**Schools and Health
in the Caricom Caribbean**

*Promoting the Wellbeing of Young
People*

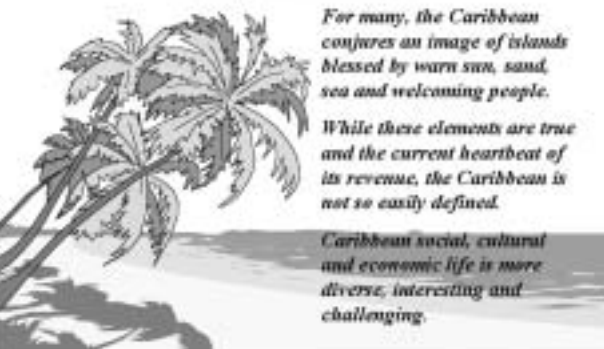


Sun, Sand and Sea

For many, the Caribbean conjures an image of islands blessed by warm sun, sand, sea and welcoming people.


While these elements are true and the current heartbeat of its revenue, the Caribbean is not so easily defined.

Caribbean social, cultural and economic life is more diverse, interesting and challenging.




~ Presentation Objectives ~

- Sketch those aspects of Caribbean life influencing the promotion of health in young people
- Provide a bird's eye view of the evolving role and relationship of schools and health in promoting the health and development in the Caricom Caribbean



~ Defining the Caribbean ~
A Matter of History not Just Geography



~ Defining The Caribbean ~
Independence & Collaboration



~ Towards a New Identity ~
Moving to a Caribbean Commonwealth



Welcome and Opening Remarks

~ The People ~


Wide geographical areas - small populations
(most under 300,000)

Small infrastructures - few people doing more than one task
making policy and change difficult.



Children < 15 yrs
comprised about 30%
of the population in
1995

~ The Socio-Economic Environment ~ Vulnerability - The Hallmark

- Narrow natural resource base for most
Except Canada, Trinidad, Belize and Suriname
- Open economies vulnerable to global changes
Agriculture Tourism Manufacturing
- Fragile environment - natural disasters 
- Small human resource infrastructure 

~ Caribbean Development ~ Achievement - Highlights

General Standard of Living:

- Increase in per capita income - (variation)
- Diversified employment opportunities
- Food availability consumption
- Housing quality
- Access to communication, transport, technologies



~ Caribbean Development ~ Achievement - Highlights

Education:

- Maintained access of primary schools
- Increased access to secondary education
- Improvements in quality and levels of teacher preparation
- Increased number of primary and secondary school facilities
- Improved educational attainment:
Literacy, vocational, academic skills



~ Caribbean Development ~ Achievement - Highlights

Health Status:

- Falls in infant mortality
- Improvements in life expectancy at birth
- Reduction in infectious diseases
- Immunization coverage
- Access to community-based tertiary care services improved
 - Hygiene integrated in primary core curriculum
- Improvement in school sanitary facilities



~ Caribbean Development ~ Challenges - Highlights

General:

- Economic downturns - uncertain growth
- Increased poverty - globalization and marginalization
- Working age population outstripping job creation
- Diminished revenues - social spending
- Managing - expansion in communication transportation
- Fragmented families and communities



Schools and Health in the CARICOM Caribbean: Promoting the Well-being of Young People

~ Caribbean Development ~ Challenges - Highlights

Education:

- Increasing access & reducing variations in quality at pre and secondary schools
- Maintaining quality at primary schools
- Recruitment and retention of teachers
- Inadequate maintenance of school facilities
- Expanding training in teaching and change strategies



~ Caribbean Development ~ Challenges - Highlights

Health:

- Serial emergence of "new" threats to health and welfare
 - Violence, accidents, drug abuse, obesity, Aids, STD's, teenage pregnancy, Chronic NCD's
- Vulnerability of children and youth
- Environmental health and degradation - increased urgency
- Increasing demand and expectations for health services
- Diminished revenues and service capacity



~ Caribbean Development Challenges ~ Impact on Children and Youth

Some Highlights:

- Increasing vulnerability to violence, drug abuse, Aids, STD's, teenage pregnancy, obesity, hunger, poverty, homelessness;
- Increased school failure: repetition and drop outs
- Inadequacies in safety and quality of school environment
- Limited family support and supervision
- Diminished revenues for education and health services



Caribbean Responses~ Schools and Health Revival: First Phase

Reactive Approach

- Multiple vertical projects
- Multiple curricula- some on same topics
- Increased in-service training
- Extension of immunization coverage
- Exciting one-off projects
- Piloting of Adolescent Youth Services (out-of-school)



Caribbean Responses~ Schools and Health Revival: Second Phase

Education Reform

- Improving quality in primary education
- Increasing access to secondary
- Improving standards, access to early childhood education
- Focus on strategies for remedial action
- Increasing use of communication technology
- Devising systems for interchange of information and skills



Caribbean Responses~ Schools and Health Revival: Second Phase

Focus on Planning, Coordination and System

- Interagency coordination and intersectoral coordination
- Rethinking scope and focus of HPLE and health learning
- Increase in research and information for planning
- Development of policy for HPLE
- Revision in curriculum conceptual framework
- Focus on in-service teacher preparation
- Expanded repertoire of teaching/learning strategies
- Increased attention to evaluation - learning



Welcome and Opening Remarks

Caribbean Responses~ Schools and Health Revival: Second Phase

School Health and Supportive Environments

- Intensifying immunization coverage
- Introducing child health passports (1-4 years)
- Rapid physical inspection
- School feeding programs - targeted and general
- Healthy food canteens
- Participatory environmental improvement projects



Caribbean Effects Schools and Health Revival

Mixed and Uncertain

- More is reported happening in countries at technical level
- Policies in support of HFLE developed not ratified
- Capacity for conducting in-country training increasing
- Linkages with parent/community groups being revitalized
- Attributable impact unknown - not designed



~ Caribbean Challenges Sustaining School and Health Action 2001 and Beyond ~

Some Challenges

- Maintaining inter-agency coordination and inter-country interchange
- Communicating educational and development benefits to policy makers
- Developing effective strategy for school failures and out-of-school youth
- Extending school health services
- Selling utility of interactive approaches
- Strengthening parent involvement in school HFLE programs
- Developing appropriate indicators, information systems and methodologies for ongoing evaluation
- Developing replicable models of application of whole school/community approach

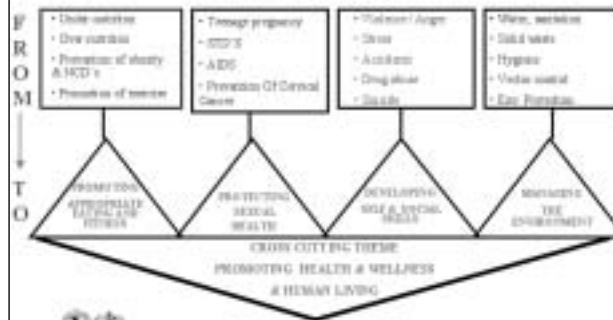


~ Caribbean Challenges Sustaining School and Health Action 2001 and Beyond ~

- Finding balance between local, national and international action



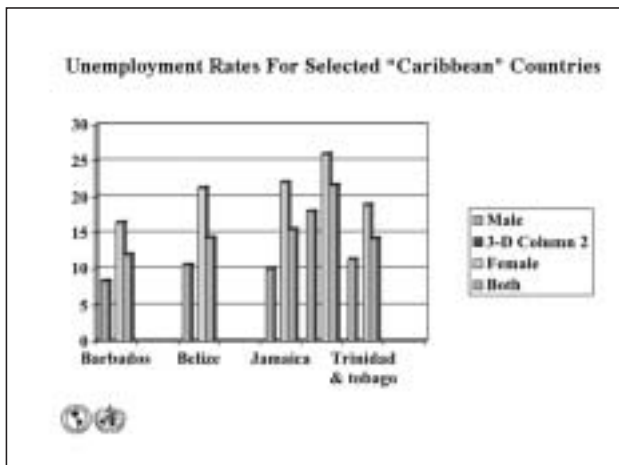
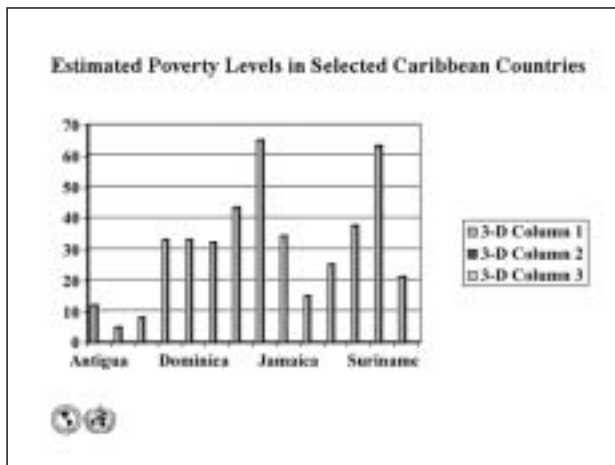
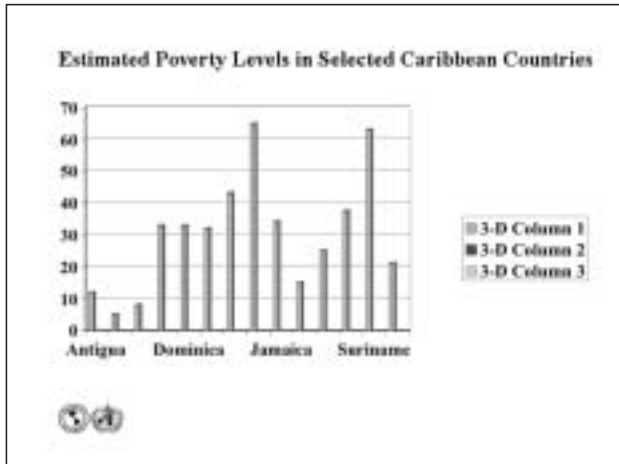
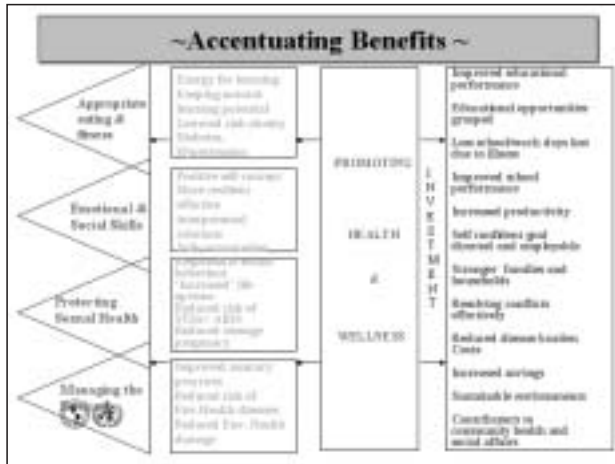
RECONCEPTUALISING HEALTH LEARNING FRAMEWORK REORGANISING & FOCUSING CURRICULA ON FIVE UNDERLYING BEHAVIOURAL THEMES



~ Accentuating Skills Practice Benefits ~



Schools and Health in the CARICOM Caribbean: Promoting the Well-being of Young People





The Global WHO Initiative for School Health

Charles Gollmar, WHO

Charles Gollmar provided an overview of the World Health Organization's (WHO) Global School Health Initiative. The following is a brief summary of his presentation. A copy of his presentation follows.

What is a Health-Promoting School? A school that constantly strengthens its capacity as a healthy setting for living, learning, and working. A Health-Promoting School strives to improve the health of students, school staff, families, and community members by engaging the entire community in its efforts.

WHO uses four strategies to help countries and localities develop Health-Promoting Schools:

1. Consolidating research and expert opinion to describe the nature and effectiveness of school health programs. WHO conducts assessments to establish baseline data on health promotion in schools and monitor progress toward implementing the Health-Promoting Schools initiative:
 - Thematic Study on School Health and Nutrition
 - Status of School Health Policies Survey
 - Questionnaire for School Personnel Tobacco Use Surveys
 - Rapid Assessment and Action Planning Process
2. Building the capacity to advocate for and implement the components of an effective school health program. Many people promote health in schools, but they do not always have the capacity to bring their efforts and knowledge to the people in charge so that it can actually happen. WHO creates frameworks and technical assistance materials that enable Health-Promoting Schools programs to meet established criteria and demonstrate their compliance to policy makers. Resources completed include:
 - Education for All (EFA) Framework for Action
 - Local Action: Creating Health-Promoting Schools
 - WHO Information Series on School Health
 - Skills-Building Seminars: School Health/HIV/AIDS prevention
 - Health-Promoting Schools/Sun Protection for Schools
3. Strengthening national capacities to plan, implement, and evaluate policies and programs to improve health through schools. Some examples of national projects include:
 - Indonesia – RAAPP
 - China – Tobacco Use Prevention
 - China – HIV/AIDS Project
 - Namibia – Health-Promoting School Initiative

Welcome and Opening Remarks

4. Creating networks and alliances for concerted efforts to improve school health. Resources include:

- Improving Health through Schools: National and International Strategies
- Regional Networks for the Development of Health-Promoting Schools
- School Health Component/Mega Country Network
- UNAIDS Co-sponsors Working Group on School Health Education and HIV Prevention FRESH

WHO's Global School Health Initiative already has five Health-Promoting Schools networks in place:

1. European Network of Health-Promoting Schools (established in 1991)
2. Pacific Regional Network for the Development of Health-Promoting Schools (1995)
3. Latin American Network for Health-Promoting Schools (1996)
4. South African Network for the Development of Health-Promoting Schools (1996)
5. Southeast Asian Regional Network for the Development of Health-Promoting Schools (1997)

Currently, WHO is supporting two emerging networks:

1. West African Network (for French-speaking countries)
2. Caribbean Network of Health-Promoting Schools

The School Health Component of the Mega-Country Network is a network of officials responsible for school health from ministries of health and education in countries with large school-age populations, including Bangladesh, Brazil, China, India, Indonesia, Mexico, Nigeria, Pakistan, Russian Federation, and the United States.

WHO is also involved in the FRESH (Focusing Resources for Effective School Health) Framework, an interagency agreement between WHO, UNICEF, UNESCO, and the World Bank to improve health through schools. FRESH calls for the implementation of four components of an effective school health programme:

1. School health policies
2. Water and sanitation
3. Skills-based health education, including life skills
4. School health services

Internationally the UN agencies are now speaking with one voice on school health, working together to promote the implementation of all four components in all schools.


WHO Global School Health Initiative



**WHO'S
Global
School
Health
Initiative**




WHO Global School Health Initiative



**Barriers to
Improving Health
through Schools**

- ❑ Inadequate vision and strategic planning
- ❑ Inadequate understanding and acceptance of programmes
- ❑ Lack of responsibility and accountability
- ❑ Inadequate collaboration and coordination
- ❑ Lack of programme infrastructure

WHO Global School Health Initiative



**Global School
Health Initiative**

To help make all schools "health promoting schools"

WHO Global School Health Initiative



**What in the
World is
A Health
Promoting
School?**



WHO Global School Health Initiative



**A Health Promoting
School is :**



a school constantly strengthening its capacity as a healthy setting for living, learning and working.

WHO Global School Health Initiative




**A Health Promoting
School
strives to:**



- improve the health of school personnel, families and community members
- engage health and education officials, teachers, students, parents and community members to make the school a healthy place
- implement policies and practices that improve an individual's self-esteem, provide opportunities for success and acknowledge personal achievements
- foster health and learning with all measures at its disposal

Welcome and Opening Remarks





WHO Global School Health Initiative

How is WHO helping schools to become Health Promoting Schools?

Four strategies:

- Consolidating research and expert opinion
- Building capacity to advocate
- Assessing and strengthening national capacities
- Creating networks and alliances





WHO Global School Health Initiative

Consolidating research and expert opinion to describe the nature and effectiveness of school health programs.

Resources/Products completed:



- Status of School Health Policies Survey
- Thematic Study on School Health and Nutrition
- Questionnaire for School Personnel Tobacco Use Surveys (GSPS)
- Rapid Assessment and Action Planning Process



WHO Global School Health Initiative

Four strategies:

- Consolidating research and expert opinion
- Building capacity to advocate
- Assessing and strengthening national capacities
- Creating networks and alliances





WHO Global School Health Initiative

Building capacity to advocate for and implement the components of an effective school health program to reduce priority health problems.

Resources/products completed:



- EFA Framework For Action
- Local Action: Creating Health Promoting Schools
- Skills-building Seminar on School Health HIV/AIDS Prevention
- Health Promoting Schools/Sun Protection for Schools



WHO Global School Health Initiative

EFA Framework For Action
What is it?

- Commitment by MOEs, UN Agencies to achieve Education for All
- Goals and strategies to be achieved by 2015
- Framework for concerted and co-ordinated efforts
- World Bank: No feasible national action plan will go unfunded.
- Big, big opportunity for institutionalising "School Health Programmes"




WHO Global School Health Initiative

EFA Framework For Action

"To improve health and education, and foster early commitment to both, WHO pledges to join with UNESCO, UNICEF, the World Bank, Education International and other international partners, in taking a FRESH start toward school health. ...

An effective school health programme, consisting of four core components – health-related policies, water and sanitation, skills-based health education and school health services – can be one of the most cost-effective investments a nation can make to simultaneously improve education and health."

Geneva Declaration, April 2000



The Global WHO Initiative for School Health

WHO Global School Health Initiative

Four strategies:

- Consolidating research and expert opinion
- Building capacity to advocate
- Assessing and strengthening national capacities
- Creating networks and alliances

WHO Global School Health Initiative

Assessing and strengthening national capacities to plan, implement and evaluate policies and programs to improve health through schools

National Projects completed:

- Indonesia - RAAPP
- China - Tobacco Use Prevention
- China - HIV/AIDS Project
- Namibia - Health Promoting School Initiative

WHO Global School Health Initiative

Four strategies:

- Consolidating research and expert opinion
- Building capacity to advocate
- Assessing and strengthening national capacities
- Creating networks and alliances

WHO Global School Health Initiative

Creating networks and alliances for concerted efforts to improve school health.

Resources/products completed:

- Improving Health Through Schools: National and International Strategies
- Regional Networks for the Development of Health Promoting Schools
- School Health Component/Mega Country Network
- UNAIDS Co-sponsors Working Group on School Health Education and HIV Prevention FRESH

WHO Global School Health Initiative

WHO Networks for the Development of Health-Promoting Schools

WHO EUROPE - European Network of Health Promoting Schools (2001)

WHO AMERICAS - Latin American Network (2004)

WHO AFRO - South African Network for the Development of Health Promoting Schools (2001)

WHO SEARO - Regional Network for the Development of Health Promoting Schools (2001)

WHO WPRO - Regional Network for the Development of Health Promoting Schools (2001)

WHO Global School Health Initiative

Regional Networks for the Development of Health Promoting Schools


New this year:

Western African Network (French speaking countries)

Planned this year:

Caribbean Network of Health-Promoting Schools

Welcome and Opening Remarks




WHO Global School Health Initiative

Creating networks and alliances for concerted efforts to improve school health

Resources/products completed:

- Improving Health Through Schools: National and International Strategies
- Regional Networks for the Development of Health Promoting Schools
- School Health Component/Mega Country Network
- UNAIDS Co-sponsors Working Group on School Health Education and HIV Prevention
- FRESH




WHO Global School Health Initiative

School Health Component/Mega Country Network

What is it?

Network of officials responsible for School Health from MOH and MOE in countries with large school age populations:

Bangladesh	Brazil
China	India
Indonesia	Mexico
Nigeria	Pakistan
Russian Federation	USA




WHO Global School Health Initiative

School Health Component/Mega Country Network

What does NHP do to help improve school health with Mega Country officials?

- Annual networking meetings to address identified needs - with UN partners
- National assessments
- Health Promoting School projects
- Virtual network on the WHO web-site




WHO Global School Health Initiative

Creating networks and alliances for concerted efforts to improve school health

Resources/products completed:

- Improving Health Through Schools: National and International Strategies
- Regional Networks for the Development of Health Promoting Schools
- School Health Component/Mega Country Network
- FRESH





WHO Global School Health Initiative

FRESH

What is it?

- An interagency agreement between WHO, UNICEF, UNESCO and the World Bank
- A Framework for improving health through schools





WHO Global School Health Initiative

FRESH

What is fresh *about* FRESH?

Not a lot – technically:

- FRESH calls for the implementation of four components of an effective school health programme:
 - School health policies
 - Water and sanitation as first steps in creating a health supportive environment
 - Skills based health education including life skills
 - School health services



WHO Global School Health Initiative

FRESH

What is fresh *about* FRESH?

A whole lot – politically:

- UN agencies are:
 - Speaking with one voice on school health
 - Really working together
 - Promoting the implementation all four components –



The Health-Promoting Schools Regional Initiative

Josefa Ippolito-Shepherd, Ph.D., Regional Health Education Advisor, Health-Promoting Schools Regional Initiative, Program of Family Health and Population, Division of Health Promotion and Protection, PAHO/WHO

Introduction

The Health-Promoting Schools Initiative is a global strategy directed to strengthening health promotion and health education where children, parents, teachers, and other members of the school community live, learn, work, and play. Through technical cooperation with and among Member Countries, the Initiative aims to build consensus between the health and education sectors. It also aims to establish relevant partnerships with other appropriate sectors, to create, maintain, and/or enhance healthy and supportive physical and psycho-social environments (i.e., protective factors/conditions), and to facilitate the learning of life skills for the adoption and maintenance of healthy lifestyles and behaviors by school children and adolescents and others close to them.

The Initiative provides a comprehensive vision and a multidisciplinary approach. Children in the context of their daily life, within their family, community, and society are the central actors of this Initiative. The major focus is on the acquisition of knowledge and skills that facilitate self-reliance for individual as well as for collective health seeking behavior, including preventing the adoption of risk behaviors. A critical-reflexive analysis of values, attitudes, behaviors, social conditions, and lifestyles is encouraged; strengthening those that favor health and human development, that facilitate the participation of all the members of the educational community, that contribute to promoting socially egalitarian relations among the genders, that encourage the construction of citizenship and democracy, and those that strengthen traditions of solidarity, community spirit, and human rights.

The Health-Promoting Schools Regional Initiative

This Initiative strives to contribute to future generations of people and communities with the appropriate knowledge, skills, abilities, and behaviors that are basic and vital to caring for their own health as well as for the health of their families and community. The main purpose is the development and strengthening of the capacity of the health and education systems and services to design, develop, implement, sustain, and evaluate their Health-Promoting Schools. This Initiative is being welcomed with a great deal of enthusiasm. It is one of the few approaches that is facilitating and that has been instrumental in forging partnerships between and among the education and health sectors, as well as between the World Bank and PAHO/WHO.

Schools have for a long time facilitated the health and nutrition related activities. Periodic medical and dental exams and visual and auditive screening are a few examples of these prac-

Welcome and Opening Remarks

tices. In Latin American and Caribbean countries, the implementation of this Initiative is facilitating primary health services and schools to work together, improving their ability to detect and offer assistance to children and young people in a timely fashion, detaining and preventing the adoption of risk behaviors, such as smoking, consumption of alcoholic beverages, substance abuse, early and risky sexual practices, and early pregnancy.

A Health-Promoting School is a school that:

- *Implements policies* that support individual and collective well-being and dignity, and provides multiple opportunities for growth and development for children and adolescent, within the context of learning and success for the school community, including teachers, students, and families;
- *Implements strategies that encourage and support learning and health*, fostering these with every element at its disposal, engaging health and education officials, teachers, school administrators, parents, health providers, and community leaders in the development of planned school health activities (i.e., comprehensive health education and life skill training; reinforcing protective factors while reducing risk behaviors; providing access to school health care, nutrition, and physical activity);
- *Involves all school and community members* in making decisions and carrying out interventions to promote learning, healthy lifestyles, and community health promotion projects (i.e., health fairs), including teachers, parents, students, community leaders, and NGOs;
- *Has a plan of action* to improve the physical and psychosocial environment throughout the school and the surrounding community, such as policy and regulations for spaces free from smoke, drugs, abuse, and any form of violence; and by providing appropriate *access to clean water and sanitary facilities and choice of healthy foods*; and strives to set *examples* through the creation of healthy school environments and by spreading activities beyond the classroom and into the community (i.e., Health Day activities);
- *Implements actions to assess and improve the health of students*, school personnel, families, and community members; and works with community leaders to ensure access to nutrition, physical activity, counseling, health care, and respective referral services;
- *Provides relevant and effective teacher training and health education materials*; and
- *Has a local health and education committee* with active participation of PTAs, NGOs, and community organizations.

Components

The Health-Promoting Schools Initiative has three main components:

1. *Comprehensive school health and life skills education* - directed toward the acquisition of knowledge, as well as the development and adoption of abilities and skills that facilitate the achievement of an optimum level of health and quality of life. It takes into account the

The Health-Promoting Schools Regional Initiative

particular needs of the students, in each stage of their development and in accord with their individual social, cultural, and gender characteristics, and based on positive values known to strengthen the schoolchildren's personal, family and community life skills and abilities.

2. *Healthy and supportive environments and surroundings* - directed to facilitate the development and strengthening of the capacity of the school to create and maintain environments and surroundings that are supportive for health and learning. It includes basic sanitation and clean water; clean and structurally adequate physical spaces, safe from accidents; as well as support networks for healthy and safe psychosocial surroundings, free from physical, verbal and/or emotional abuse, assault or violence. It includes teacher training and health promotion, as well as individualized activities directed to promote health for parent-teacher associations and community organizations.
3. *Adequate health services and food and nutrition programs* - directed to strengthen the relationship between the school staff, the health team, and other relevant sectors, as well as to increase their understanding of each other's roles and their capacity to complement and strengthen each other. It emphasizes early and appropriate attention to schoolchildren, to detect and prevent health problems, including risk factors and unhealthy behaviors and conditions.

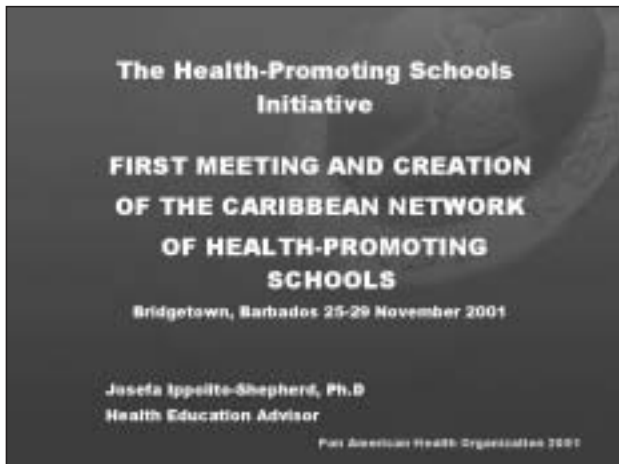
Regional Strategy

1. The dissemination of information, including proposed methodology for the implementation of the strategy and countries' experiences with the design, planning, and implementation of the Initiative.
2. The development of project profiles for presentation to potential donor agencies.
3. The analysis and updating of joint policies between the education and health sectors, including a review of the current legislation and policy that defines sector mandates and responsibilities for school health.
4. The consolidation and strengthening of intersectoral coordination mechanisms, including the activation or formation of joint commissions to formulate public policies, to carry out need assessment exercises and analysis of problems and needs, to review the state-of-the-art of health education curricula, and to follow up on the results of process and impact evaluations.
5. The development, implementation, and evaluation of the plans and programs to implement the components of health promotion and education in the schools including:
 - incorporation of 'gender approach' into the study content area;
 - curriculum design, with innovative and comprehensive school health education content and methods, especially the learning of life skills;
 - integration of health issues transversally in other areas in support of education reform processes;

Welcome and Opening Remarks

- training of teachers and other personnel of the health and education sectors;
 - production of educational materials;
 - development and delivery of health services and school feeding programs (i.e., breakfast, snack, lunch);
 - physical activities and active living beyond sport practice; and
 - projects and activities to establish and maintain healthy and supportive environments and surroundings.
6. The involvement of parent-teacher associations, community organizations, representatives of the health sector and other sectors. This is essential to encourage leaders and decision-makers to include the Initiative in local developmental plans.
 7. To develop and implement programs directed to form significant articulation between schools and the working world.
 8. To design and carry out relevant research to identify the conditions and risk behaviors in the school age population and to monitor trends in smoking, sex, alcohol, drugs, and violence, using the Youth Risk Behavior Surveillance (YRBS) mechanism.

The Health-Promoting Schools Regional Initiative



PURPOSE

The development and strengthening of countries' capacity to design, develop, implement, maintain, and expand their health-promoting schools.

Pan American Health Organization 2001

A Health-Promoting School:

- **Fosters health and learning**
- **Provides access to clean water and sanitary facilities**
- **Strives to provide healthy and nurturing environments, free from smoke, drugs, abuse, and any form of violence**
- **Provides healthy food choices**

Pan American Health Organization 2001

A Health-Promoting School: (cont.)

- **Engages health and education officials, teachers, school administrators, parents, health providers, and community leaders in:**
 - » **promoting health**
 - » **strengthening protective factors**
 - » **providing role models**
 - » **reducing risk factors**

Pan American Health Organization 2001

A Health-Promoting School: (cont.)

- **Provides comprehensive health education, school health services, and community projects for students and others**
- **Implements policies, practices, and other measures that assure individual well-being and dignity, and provides multiple opportunities for growth, achievement, and success**
- **Strives to improve the health of students, school personnel, families, and community members, and works with community leaders to help them facilitate community contributions to health education**
- **Provides relevant and effective teacher training and materials**

Pan American Health Organization 2001

Components of the Health-Promoting Schools Initiative

- **Comprehensive School Health Education and Life Skills Training**
- **Healthy and Supportive Environments and Surroundings**
- **Adequate Health Services and Food Nutrition Programs**

Pan American Health Organization 2001

Regional Strategy

- **Dissemination of information**
- **Development of project profiles**
- **Analysis and updating of joint policies between the education and health sectors**
- **Consolidation and strengthening of intersectoral coordination mechanisms**

Pan American Health Organization 2001

The Health-Promoting Schools Regional Initiative

Regional Strategy (cont.)

- Development of program plans
 - Incorporation of gender approach
 - Curriculum design
 - Integration of health issues, transversally, in other areas of study
 - Training of teachers and other personnel of the health and education sectors

Pan American Health Organization 2001

Regional Strategy (cont.)

- Development of program plans
 - Production of educational materials
 - Development and delivery of health services and school feeding programs
 - Physical activity and active living
 - Healthy and supportive environments and surroundings

Pan American Health Organization 2001

Regional Strategy (cont.)

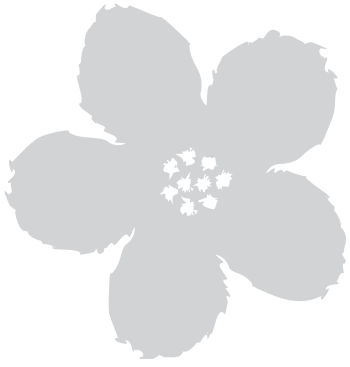
- Involvement of parent-teacher associations, community organizations, representatives of the health sector and other sectors
- Programs with articulation between schools and the working world
- Research

Pan American Health Organization 2001

Regional Projects and Activities

- Latin American Network of Health - Promoting Schools
- Rapid Assessment Process and Tools (RAP and RAT)
- Videos and other information materials
- Network Newsletter "Experiences"
- Partnership between the World Bank and PAHO/WHO
- Implementation of Life Skills training within the school

Pan American Health Organization 2001



Country Presentations



Antigua and Barbuda

Maureen L. Lewis, Health and Family Life Education Coordinator, Ministry of Education

Julienne Williams, Health Educator, Ministry of Health

Introduction

Antigua, the largest of the Leeward Islands OECS States, is a relatively flat coral island, which like its sister Barbuda, is ringed with coral reefs and white sand beaches. As well as being a transportation hub for the region, Antigua is a major tourist destination, with the hospitality industry largely replacing the traditional sugar-based economy.

Capital	St. John's
Population	77,426 (2001 Census)
Area	171 sq. Miles
Currency	Eastern Caribbean Dollar (US\$1.00 = EC\$2.70)
Number of Primary Schools (1999 - 2000)	30 Government 27 Private
Early Childhood Centers	110
Primary School Enrolment	13,070
Number of Primary School Teachers	703
Secondary School Enrolment	5,318
Number of Secondary School Teachers	394
Tertiary Enrolment (1999 - 2000)	866

The Government's educational policy is predicated on the philosophy that each individual must first be socialized as a human being and secondly as an economic unit of production. As a result, the educational system is expected to develop creative/ innovative and adaptable men and women; and in the process, identify, nurture and cultivate as fully as possible each child's capability, aptitude, skill and strength.

The literacy rate in Antigua and Barbuda stands at 88.7%. There is free and compulsory education for children 5-16 years.

The OECS Education Reform Strategy is working in harmony with the different sectors to provide quality education. A review of the Reform Strategy revealed that with the rapid changes

in the society and economies in the region, the Strategy for Educational Reform needed to be reviewed and updated.

Under the Strategy for harmonizing the educational System in the OECS, one of the major activities is the reviewing of the programme of teacher preparation in light of current trends and challenges. Health and Family Life is now included in the teacher training preparation at the Antigua State College.

Government

Antigua and Barbuda gained political independence from Britain on 1st on November, 1981. The Prime Minister is head of government. Parliament consists of the House of Representatives which has seventeen (17) elected members, with two (2) appointees; the Senate has seventeen (17) seats. The Barbuda Council has nine (9) elected members with two (2) appointed members. Democratic elections are held every five (5) years.

The Socioeconomic Situation in Antigua: The Dominance of the Tourism Sector

The economy of Antigua and Barbuda displays a heavy reliance on tourism as its main revenue earner. The tourism sector in 1999 accounted for approximately 63% of GDP, the second highest percentage of all sectors. There is no personal tax.

Growth Rate of GDP

For the period 1992-1999, GDP continued to increase except for the 1995 period due to damage from hurricanes.

Antigua and Barbuda boasts of a tropical climate with 365 beaches- one for every day of the year. There are many activities during the entire year. Some of the most popular activities are Sailing Week, Carnival and Test Match Cricket. Antigua boasts of its cricketers Sir Vivian Richards, Richie Richardson and Curtly Ambrose. The Antigua Recreation Grounds was the place where Brian Lara made 365 runs in a test match. Cycling, tennis, golf, horseback riding, drag racing, hiking and water sports are some of the sporting activities.

Health and Family Life Education Programme

The Health and Family Life Education Programme began in earnest in June 1999 when a Coordinator was assigned. The focal point of the programme is in the Ministry of Education. We were invited to participate in a number of training programmes in the region and these were very helpful in getting the project off to a good start. UNICEF has been a major financial support for our programme. The Advanced Fertility Management Unit- U.W.I was responsible for the training of teachers, health educators, and family life educators in a regional programme. Approximately forty (40) persons have been trained to a certificate level.

Antigua and Barbuda

A National Coordinating committee (NCC) was set up comprised of:

- the HFLE Coordinator
- a media representative
- a representative- Union of Teachers
- two representative- Antigua State College
- Christian Council Representative
- Representative- Early Childhood Education
- Representative- Home Economics Supervisor
- Director of Youth Skills
- Youth /Community Development Officer
- Substance Abuse Officer
- Programme Manager- Alliance for Social Wellbeing
- Executive Director -Antigua Planned Parenthood Association (A.P.PA)
- Executive Director Gender Affairs
- Medical Officer of Health
- 2 Health Educators
- Chief Welfare Officer
- Director, Child and Family Guidance Centre
- Rep- Antigua and Barbuda Police Service
- AIDS Programme Manager
- Superintendent- Public Health Nurses
- Curriculum Development Officer
- Chairman, Barbuda Council
- Social Sector Planner- Ministry of Health
- National Parent Teachers' Association
- Coordinator- Project Lifestyle

The National Coordinating Committee (NCC) is responsible for the following:

- Finalizing the National policy on HFLE:
- Developing a plan of action and budget for the implementation of the policy
- Supporting the Ministries which are involved with the sustainability of HFLE at all levels

Country Presentations

- Assisting government to develop, monitor and evaluate the HFLE programme at the national level.
- Provide guidance and support to the Ministry of Education for the mobilization and use resources for the initiatives at the national level.
- Members of the national committee on the HFLE may be requested to facilitate workshop or training sessions at the national and regional levels.

The NCC is sub-divided into three (3) main sub-committees, namely Policy Development, Curriculum Writing, and Public Education and Information. The National Coordinating Committee meets once a month.

Health and Family Life Education Program Methodology

Health Promotion and Health Education

Antigua and Barbuda has adapted the Caribbean Charter for Health Promotion. The health education department in the Ministry of Health functions in collaboration with the community health services promoting primary health care with the assistance of the UNFPA, PAHO, UNICEF, and other international agencies.

During the period 1992 – 1995, the adolescent health service was the only facility on the island meeting the health needs of adolescents 9 – 19 years of age, and young adults 20 – 25 years of age. This was a major health promotion project in the Ministry of Health. The services targeted a vital segment of the population, preparing them for adulthood, and at the same time, aiming to reduce the adolescent fertility rate in Antigua/Barbuda.

The facility mainly catered not only to their physical development, but also served to enhance the psychological and personal development of adolescents. As a spin-off of this project, parenting education programmes for adolescent parents and parents of adolescents came on stream. Life skills and good child-rearing practices were the main focus of the parenting education program.

Family Life Education sessions were being taught in schools from 1984 to the present. This was done on an ad-hoc basis in approximately eleven schools on the island (Antigua). The new focus of Health and Family Life Education is presently addressed by the national HFLE committee, which has made tremendous strides in having HFLE formally incorporated into the schools' curriculum.

Project Lifestyle, which is a school-based program aiming at promoting nutrition, fitness, and positive attitudes, is also part of health promotion and health education in Antigua/Barbuda.

Through the annual health fairs held by the Health Education Unit, the level of awareness of the general public – with respect to hypertension, diabetes, coronary heart conditions, cancers, vision care, and STDs – was heightened.

The AIDS Secretariat, which came on stream during the early 1990s, is also involved in health education and health promotion. Their activities include dissemination of information in schools and through national seminars and workshops.

The Drug Information Centre, which aims at reducing drug use and abuse among teenagers and in the wider society, works in collaboration with the community health department and the mental health department in promoting mental health in Antigua/Barbuda.

Healthy Environment

In the Ministry of Health, the Central Board of Health (CBH) is responsible for the environmental health services in Antigua/Barbuda. These services include:

- food safety and all its components
- liquid waste management
- regulation of solid waste management
- overseeing domestic animal rearing
- water control
- institutional sanitation
- the monitoring of the waste treatment plant
- monitoring of drinking water supply
- street and drainage cleaning

Water Supply: The CBH and APUA (Antigua Public Utilities Authority) work closely to ensure that all water provided for consumption is safe and potable. The WHO standards on drinking water are used as a guideline by both departments. The APUA drinking water system has achieved the WHO standards for several years and monitoring of all water supplies is continuous. However the CBH's monitoring surveillance program acts as a backup, independent monitoring of routine testing done by the APUA.

Households with cisterns, tanks, and outdoor catchments are encouraged to purify their water supply before use.

Marine and Coastal Waters: The Ministry of Health has launched a project to monitor several beaches used for recreational purposes, and the main objective of this project is to protect human health and support marine population. The Environmental Awareness Group (EAG), a national non-governmental organization, is involved in year-round efforts to raise the awareness of the general public with respect to marine life, the beaches, and the overall symbiosis between the human and physical components of the country.

Several ministries, including the Ministry of Tourism, Ministry of Agriculture, and Ministry of Health, along with various NGOs such as the EAG, Lion's Club, Optimist Club, and Solid Waste Management Department work together to maintain the general aesthetics of the country. Recently, a massive clean-up campaign was carried out in Antigua and Barbuda, which has given the entire country a facelift.

General Social Atmosphere of the Society: Because of its qualities as a peaceful, religious society, Antigua and Barbuda has always been a welcome retreat to many people from around the

Country Presentations

world. In recent times, however, with technological advances and socio-economic changes, the face of the Antiguan/Barbudan society has also changed. There has been an increase in crime, as well as an increased tendency by persons in positions of power to misuse and abuse public property and finances. There has also been a breakdown in the structure of the family, and a decline in the quality of interpersonal relationships, all of which undoubtedly have had serious repercussions on communities and the society at large. The Ministry of Health, in collaboration with the Ministry of Social Welfare and Social Improvement, face the task of implementing various programs to address these concerns.

Nutrition and Health Services

The Ministry of Health is responsible for primary, secondary, and tertiary health care in Antigua/Barbuda. Over the last twenty years, much emphasis has been placed on primary health care. The community health services have achieved a high standard of prevention as well as health care maintenance for children and adults in the country. There is a vibrant EPI program with 98% immunization coverage.

The Maternal and Child Health Program shows notable decreases in the perinatal, neonatal infant, and maternal mortality rates. The Child Health Services in the Community Health Department is commended for a high standard of nutrition maintained in the 0 – 5-year age group. However, in recent times, there has been concern with obesity in the 5 – 19 year age group of children.

Children under 16 years and Adults over 60 years receive free medical attention in the district clinics across the country. The segment of the population with the non-communicable diseases are closely monitored in the clinics, and the medications for the following diseases are provided through the Medical Benefits Scheme:

- Hypertension
- Diabetes-Mellitus
- Cardiovascular diseases
- Glaucoma
- Sickle-cell Anemia
- Lunacy
- Asthma

Continuous surveillance of communicable diseases is carried out to determine the onset of any possible outbreaks. In 1995 – 1996, there was a significant increase in the number of cases of acute respiratory disease. The occasional cases of gastroenteritis, dengue, pulmonary tuberculosis, and periodic imported cases of malaria, legionnaire's disease, and certain food poisoning, are identified through this measure. These usually require extensive epidemiological investigation involving the Caribbean Epidemiology Centre (CAREC) in Trinidad.

Generally speaking, the health of the public of Antigua/Barbuda is above average, with respect to other third world countries.

However, it is noted that the non-communicable diseases are the most common among the general population, and are mainly lifestyle-related (e.g. undesirable eating habits, sedentary lifestyle, ineffective prioritizing). The social consciousness of the population needs to be more focused in the area of healthy living. Health promotion in the society needs to be seriously addressed.

Current Situation of the Health and Family Life Education Program

Participation in School Health Network

Health and Family Life Education is now officially included in the schools curriculum, starting at preschool through to grade school. Plans are in place to include all schools up to tertiary level. The HFLE policy, which was developed in 1999, was passed and accepted by the government of Antigua and Barbuda, and a coordinating mechanism is in place to implement the activities of HFLE.

Participation in school health networking is done through the Health and Family Life National Committee. During the HFLE Month, annual school programs are carried out where schools have the opportunity to participate in exhibitions, essay competitions, poster competitions, and nutrition and healthy lifestyle projects.

Community Participation

The Public Information and Education Committee for HFLE is responsible for Parenting Education Programs and the PTA Sensitization Programs in the schools, both in Antigua and Barbuda. The Public Information Committee works in close collaboration with the Community Health Department to implement the Parenting Education Program in the community. There are two workshops annually, which aim at improving family life, and increasing the skills of parents in child-rearing practices. There are ongoing education sessions with the Parent Teachers Associations of the preschools, primary schools, and secondary schools of the country.

In May 2001, the Cabinet of Antigua and Barbuda approved the national policy on HFLE. The curriculum for pre-school to grade six (6) has been prepared. The pre-school to grade two curriculum is being piloted in ten (10) schools including Barbuda and full implementation should take place in September 2002.

The public education and information sub-committee continues to hold educational sessions with Parent Teacher Association, church and community groups. A video has been produced from a creative media workshop with some young people. This video has been used as a teaching tool.

HFLE month is celebrated annually in October and a programme of activities is implemented. This includes a church service, HFLE day in schools, essay/art/poster competition in schools, message by Minister of Health, interactive radio and television programmes and training workshops for parents and teachers.

The training and retraining of health workers and teachers have been areas of priority. A refresher course was conducted for those participants who were trained in 1989-1995. The U.W.I training team conducted the sessions.

Country Presentations

Two (2) participants attended the Teachers' Training Workshop and are presently tutors at the Teachers' Training College in the first and second year HFLE programme there. The HFLE module is compulsory for certification at the Teacher Training Level.

Each activity/ programme is evaluated utilizing different methods- oral evaluation, written evaluation. The participants and presenters evaluate the sessions.

Much intersectorial collaboration is taking place and this is obvious from the response from the sectors. A cadre-training workshop is on going to train persons to create a team to provide technical assistance in some areas of programme delivery.

Lessons Learned

Intersectorial cooperation and collaboration are necessary for the future development of a nation especially as we face a shortage of financial and human resources.

Future Plans and Felt Needs

As HFLE programme becomes a core subject on the schools' curriculum at the college level and primary level, it is necessary to have more office space and equipment. Equipment includes a video camera, photocopier, TV, VCR, fax machine, power point projector, lap top computer. At present, we have to borrow or do without as many sectors do not possess this equipment.

Additional staffing is also required. There are approximately fifty-seven (57) primary schools to be visited in order to monitor and evaluate the programme.

More government funding should be allocated for the programme.



Barbados

Ms. Maxine Moore, Erdiston Teachers' Training College²

General Context of the Country

Geography

- Barbados is one of the CARICOM member states and the most easterly of the Caribbean islands
- Area of 166 square miles, 21 miles long by 14 miles wide
- Divided into 11 parishes
- 260,000 persons

History

- The original inhabitants of Barbados were Amerindians
- In 1627 the island was settled by the English. The Governor General was of British origin
- Barbados became an independent nation in 1966 and named its first native Governor General

Social Culture

- Present population are descendants of Africans, Europeans, and Indians
- Population is predominantly Anglican; however there are over 100 different religious denominations

Political

- Barbados has the oldest parliament in the Commonwealth Caribbean
- Its system of government is based on the Westminster system
- Two parliamentary houses: House of Assembly and the Senate
- Prime Minister and Governor General

² This summary was prepared by the official note taker at the conference, based on Ms. Moore's presentation.

Economy

- Tourism is the primary industry in Barbados
- Other industries include manufacturing, informatics, sugar, and petroleum.

Education

- Barbados has a well-organized private and public educational system. As far back as the 1950s and 1960s Barbados had a very large private education system; this declined in the 1970s, and by the 1980s there were only about 5 private secondary schools and these were subsidized by the government.
- The system includes early childhood education (infant, nursery, primary, secondary, tertiary).
- Education is compulsory throughout the island and is free, even at the tertiary level.
- Barbados has a national curriculum; contributions are made by educators and other stakeholders, including trade unions, private sector, national council of PTAs, teachers, and representatives from the ministries of health, education, and community development.

Health and Family Life Programme

Overview

- A hygiene programme was established to look at personal hygiene and some aspects of environmental health. During the 1980s, the programme was called Health Education and was provided at the primary level. At the secondary level, the programme was integrated with subjects such as home economics, science, and biology.
- At the Secondary level during the mid-1980s, Health Education was introduced as a single subject and delivered by guidance counselors. In 1993 the Health Education curriculum was revised at the Primary and Secondary School levels.
- In 1995, and again in 2000, as part of the Curriculum Reform Initiative by the Ministry of Education, the programme was further revised and renamed Health and Family Life Education.
- The programme places emphasis on social and emotional learning, a life skills-based approach to teaching and learning, as well as strategies and methodologies to deal with emerging diseases and other social issues.
- The programme is based on the PAHO model and the Life Skills Based approach.

Materials and Curricula

- HFLE uses reference materials including the Internet, journals and d books, resource persons, HFLE Curriculum, and other HFLE publications.

Barbados

- The HFLE curriculum is used in all primary and secondary schools.
- Educators are trained in evolving technology at the Teacher's College. The teachers' unions produce publications from their Health and Family Life Committees.

HFLE Methodology

- HFLE is regulated under the Ministry of Education, Youth Affairs, and Sport.
- A number of committees are involved in the development of the curriculum; these committees are accountable to the National Curriculum Development Council.
- The Ministries of Health and Education promote the Life Skills Based Training program. Erdiston Teachers' Training College, schools, polyclinics, and NGOs facilitate the programme.

Healthy Environment

- Since Barbados is made up of coral and limestone, the island's underground water is potable. All schools have pure drinking water.
- Barbados also has a desalinated water plant.
- The Sanitation Service Authority is the agency responsible for maintaining a healthy environment.

Nutrition and Health Services

- The National Nutritional Centre is responsible for primary health care and nutrition. Dietitians staff the Queen Elizabeth Hospital, geriatric hospitals, and psychiatric hospitals.
- Principals are ensuring that fruits and vegetables are served as snacks.
- Every morning, fresh milk is delivered to early childhood and primary schools.
- Primary, Secondary, and tertiary schools have access to health care and rehabilitation
- There is a polyclinic in each parish.
- In St. Michael's, a large parish, the HFLE program is conducted collaboratively between the public health nurses at the polyclinics and the schools.
- There is a system of referral between the polyclinics and the schools.

Current Situation of the HFLE Programme

UNICEF, PAHO, WHO, and FAO provide educational resources to Barbados' HFLE Programme. The Parent Teachers Association, community groups, youth groups, and NGOs participate in the HFLE programme at the community level.

Evaluation

- Training is evaluated through summative and formative procedures and alternative assessment such as portfolios, performance tasks, and observations. Have moved to a system of continual assessment.
- Evaluation includes all the stakeholders in education and health.
- Publications are developed by agencies including PAREDOS, UNICEF, PAHO, etc.

Lessons Learned

The life skills-based approach has proven extremely useful and successful in Barbados' system. It has been adopted at all levels for all students. Teachers and public health nurses educate students and the public about HIV/AIDS and Human Sexuality.

Future Plans

- Increase the comfort level when dealing with sensitive issues in HFLE.
- Ensure that HFLE programmes reach all members of the community.
- Continue to incorporate authentic situations using interactive strategies such as role-play, simulations, and resource persons.
- Ensure regular review of the programme to facilitate the changing needs of the society.

HEALTH & FAMILY LIFE EDUCATION PROGRAMMES IN BARBADOS

Introduction

This presentation addresses the development and current status of Health and Family Life Education in Barbados against the backdrop of the social, cultural and historical landscape of the country.

2

GENERAL CONTEXT OF BARBADOS

Geography:

- Barbados is one of the CARICOM member states and is the most easterly of the Caribbean islands
- It has an area of 166 square miles, 21 miles long by 14 miles wide
- It is divided into 11 parishes

4

History:

- The original inhabitants were the Amerindians
- In 1627 the island was settled by the English
- Barbados became an independent nation in 1966

5

Social Culture:

- The present population are descendents of Africans, Europeans and Indians
- The cultural practices are derived from these ancestors
- The population is predominantly Anglican, however there are over 100 different religious denominations

6

Political:

- Barbados has the oldest parliament in the Commonwealth Caribbean
- Its system of government is based on the Westminster system

7

Political:

- The two parliamentary houses are the House of Assembly and the Senate
- There is a Prime Minister and a Governor General

8

Economy:

- The primary industry is tourism
- Other industries are:
 - Manufacturing
 - Informatics
 - Sugar
 - Petroleum

9

Education:

- The country has a well organized private and public educational system
- The system includes:
 - Early Childhood Education
 - Primary Education
 - Secondary Education
 - Tertiary Education

10

Education:

- There is a national curriculum
- Contributions to the curriculum are made by educators and other stakeholders

11

Health & Family Life Programme

- A hygiene programme was established several years ago. During the 1980's it was called Health Education and was done at the Primary Level.
- Prior to 1980, at the Secondary Level, Health Education was integrated with subjects such as Home Economics, Science and Biology.

12

Health & Family Life Programme

- At the Secondary level during the mid-1980's Health Education was introduced as a single subject and delivered by guidance counsellors
- In 1993 the Health Education curriculum was revised at the Primary and Secondary Levels

13

Health & Family Life Programme

- In 1995 and again in 2000, as part of the Curriculum Reform initiative by the Ministry of Education, the programme was further revised and renamed Health and family Life Education
- Emphasis is placed on social and emotional learning, a life skills based approach to teaching and learning, as well as strategies and methodologies to deal with emerging diseases and other social issues

14

Health & Family Life Programme

- Reference materials used include:
 - The Internet
 - Current Journals and Books
 - Resource persons
 - Health and Family Education Curriculum
 - Health and Family Life Education Publications

15

HFLE Methodology

- The regulatory agency is the Ministry of Education, Youth Affairs and Sport
- There are a number of committees involved in the development of the curriculum, which are accountable to the National Curriculum Development Council

16

Health Promotion and Health Education


- There is a Life Skills Based Training programme which is promoted by the Ministries of Health and Education
- This programme is facilitated by Erdiston Teachers' Training College, schools, polyclinics and NGO's

17

Healthy Environment

- Since Barbados is made up of coral limestone, our underground water is potable. There is also desalinated water plant.
- The Sanitation Service Authority is the agency responsible for maintaining a healthy environment


18



Nutrition and Health Services

- The National Nutritional Centre is responsible for primary health care nutrition
- There are dieticians at the Queen Elizabeth Hospital, geriatric hospitals and psychiatric hospitals

19



Nutrition and Health Services

- There is primary, secondary and tertiary health care as well as rehabilitation
- These are available to all members of the population
- There is a system of referral between the polyclinics and the various hospitals

20



Nutrition and Health Services

- The system is monitored by the Ministry of Health
 - Chief Medical Officer
 - The Chief Nursing Officer
 - The Chief Public Health Nurse
 - Chief Public Health Environmental Officer


21



Current Situation of HLFE programme

- Policy is developed jointly by the Ministries of Health and Education and ratified by Cabinet
- The programme is coordinated by:
 - Ministry of Education
 - Tutors at the Teachers' College
 - Guidance Counsellors
 - Public Health Nurses


22



Current Situation of HLFE programme

- The programme is implemented at the school, college and at the polyclinics
- Educational materials are tested and piloted in primary and secondary schools and the polyclinics. They are also reviewed by the Curriculum Development Council

23



Current Situation of HLFE programme

- The country participates in school health networks organized by PAHO, WHO, UNICEF, FAO, NCSA and other NGO's
- Training of personnel is conducted at Erdiston Teachers' Training College and UWI School of Continuing Education, UNICEF, PAHO

24

Current Situation of HLFE programme

- Educational resources are provided by UNICEF, PAHO, WHO and FAO
- There is participation in the programme at the community level by groups such as:
 - The Parent Teachers Association
 - Community Groups
 - Youth Groups
 - NGO's

25

Current Situation of HLFE programme

- Training is evaluated through Summative and Formative procedures and alternative assessment such as:
 - Portfolios
 - Performance tasks
 - Observations

26

Current Situation of HLFE programme

- The evaluation process includes all the stakeholders in education and health
- Publications are developed by agencies including:
 - FAREDOS
 - UNICEF
 - PAHO
 - Barbados Family Planning Association
 - National Council on Substance Abuse
 - Ministries of Health and Education

27

Lessons Learned

- The life skills-based approach has been adopted by students at all levels in their day to day activities
- Teachers and public health nurses are educating students and the public about HIV/AIDS and Human Sexuality

28

Future Plans

- Increasing the comfort level when dealing with sensitive issues in HFLE
- Ensure that HFLE programmes reach all members of the community
- Continue to incorporate authentic situations using interactive strategies such as role play, simulations and resource persons

29

Future Plans

- Regular review of the programme to facilitate the changing needs of the society

30



The Bahamas

Glenda Rolle, Senior Education Officer, Ministry of Education, Youth and Sports

A. Background Information

Education in the Commonwealth of the Bahamas embraces a philosophy, which portrays our nation's ideals, values, beliefs and customs. Inherent in this is the belief that all human beings have an undeniable right to receive an education, one that will enable them to understand their privileges and live up to their responsibilities in the society. The Ministry of Education, Youth and Sports seeks to fulfil this philosophy through the implementation of programmes such as Health and Family life Education.

Health is defined as a “*state of complete mental, social, physical and spiritual well-being and not merely the absence of disease.*” Many factors such as heredity, environment, lifestyle and the medical system influence health, but lifestyle is the primary indicator of wellness.

Health and Family Life Education is a holistic, proactive approach to health education; designed to promote healthy psychosocial development whilst providing a rationale, integrated approach to addressing the health and social problems we now face. This programme promotes healthy lifestyle practices in all individuals and takes into account both the affective and cognitive domains of learning.

Surveys among the Bahamian population have shown that individuals enjoy improvement in a number of areas of health. However, there are still many behaviours and risk factors present, which cause concern, such as HIV/AIDS, obesity, unintended pregnancies violence and abuse. These concerns underline the need for increased awareness of health issues and self-management skills among the general population.

The Ministries of Education and Health have developed a successful working relationship with other Government Organizations and NGOs in the promotion of Health and Family Life Education in the Bahamas. Activities that have successfully implemented as a result of this collaborative effort included the Annual AIDS Awareness Month activities, World Health Day, National Drug Council awareness Month activities, the Caribbean Youth Health Survey and Reproductive Health Education activities.

It is now time for the evolution of Health and Family Life Education to the next stage of development, into the promotion of health schools throughout The Commonwealth of the Bahamas.

B. General Context of The Bahamas

Made up of more than 700 islands and cays scattered over 100,00 sq. miles of crystal clear waters, The Bahamas is as diverse as life itself. Soft sandy beaches and swaying palm trees compete with reminders of a fascinating and colourful past, spinning nature and history into a rich tapestry of island life and culture.

Country Presentations

Join us on a tour.

The Bahamas capital city, Nassau, is located on this 21-by seven-mile island. Market although not as bustling as previous years, still attract cruise ship passengers and a business community in the downtown area are a marked contrast to the peaceful powder-white beaches, striking scenery and eco-area outside the city limits.

Paradise Island

Paradise Island connected by two one-way bridges to downtown Nassau is dominated by Sun International's Atlantis resort and its spectacular marine habitat.

Grand Bahama

Grand Bahama from west to east is for lovers. You can enjoy the Eco adventures explore national parks and wetlands on foot and by Kayak, bicycle or boat. Beautiful beaches stretch as far as the eyes can see and delightful fishing villages are a joy to visit.

The downtown business area of Freeport is the 10-acre Internal Bazaar, where themed sections take visitors to three countries for shopping, dining and entertainment. A colourful straw market rounds out the Bahamian section of the attraction.

In Lucaya, a brightly painted waterside market place serves as the center of activity, where nightly live entertainment in Count Basie Square keeps the marina hopping. Water sports are big here, including encounters with dolphins, scuba diving, snorkeling and glass bottom boat rides.

Eleuthera

This long and narrow island brings visitors back again and again. Stunning vistas include sparkling beaches and the Glass Window Bridge, which separates the deep waters of the Atlantic from the Great Bahama Bank.

Tiny Harbour Island, off the northern end of Eleuthera, is famous for its stunning pink sand beaches and Georgian architecture. Travel is mostly by golf cart and bicycle, making it easy to stop for a chat with friendly residents.

The picturesque fishing community of Spanish Wells, also off the northern tip of Eleuthera, is responsible for a large amount of The Bahamas' crawfish and scale fish catch.

Bimini

This tiny island, totaling nine square miles, is famous for its deep-sea fishing as well as its popularity in the 1930's with frequent resident Ernest Hemingway. In the 1960's Bimini waters revealed more than game fish – the "Bimini Road" and an ancient temple-like structure were found near the coastline.

Abaco

Famous for its candy-striped lighthouse, the subject of countless photos, this friendly town on Elbow Cay oozes charm; Hope Town residents have a knack for making the simplest items into works of art.

Boaters have appreciated the 169-ft lighthouse in this remote section of Abaco since 1836, when it was built. Now that the lighthouse is automated, the lighthouse keeper's quarters serve as the research base for the Bahamas Marine Survey.

San Salvador

Believed by many to be the first landfall of Christopher Columbus in the New World, the island of San Salvador was the home to Club Med, Columbus Isle whose doors were closed because of the recent hurricane. Monuments at various points on the island commemorate Columbus and his discovery.

Cat Island

The country's highest elevation, Mount Alvernia, is found here at 206ft above sea level. In 1939, Father Jerome, an Anglican missionary turned Catholic priest, built a miniature monastery with steps and the Stations of the Cross hand-carved out of solid rock. St Francis of Assisi Catholic in Old Bight testifies to the Christian beliefs of islanders – surprising, considering Cat Islanders are known for their practice of Obeah, or witchcraft.

Deep-sea fishing offers visitors to Cat Islands' resorts a chance to enjoy the crystal clear waters. For those who prefer less energetic pursuits, shopping at one of the island's straw stalls, or basking in the sun at the country's only clothing-optional resort, might be in order.

Inagua

This nature-lover's paradise is home to Inagua National Park and the Western Hemisphere's largest flock of West Indian flamingos, as well as populations of wild donkeys, boars and birds, including the endangered Bahama Parrot and White-crowned pigeon. The Morton Salt Company produces mountains of salt, which are nicknamed the Bahamian Alps.

Exuma

The Exuma chain consists of 365 cays scattered throughout stunning turquoise seas with ample safe anchorage. Allan's Cays are inhabited by friendly iguanas you can hand feed. Highbourne Cay was once occupied by slaves taken from illegal trades between 1807 and 1883 and is now a common first point of entry to the Exumas.

The Exuma cays are among the most beautiful yachting areas in the world. Most of the cays are uninhabited and many, such as Saddleback Cay, are privately owned, the 176-sq mile Exuma Cays Land and Sea Park is the world's first land and sea reserve, and is a popular area for yachting and snorkeling, although fishing is prohibited.

Andros

This 2,300 square mile island the largest in The Bahamas, has exceptional scuba diving and bonefishing. The second largest barrier reef in the Western Hemisphere is just offshore, running along the mile-deep Tongue of the Ocean. Andros supplies much of New Providence's fresh water.

Long Island

Spectacular scenery on this long and narrow island includes a dramatic rocky shoreline on the Atlantic side and white sandy beaches on the Great Bahama Bank side. Caves at Cape Santa Maria provides a window to the ocean, while Long Island's many churches feed the soul. Archaeologists have found evidence that Long Island's magnificent caves were inhabited in pre Colombian times.

Berry Island

This group of cays, scattered over 40 miles of water along the edge of the Great Bahama Bank, is a top fishing, cruising and diving spot. Great Harbour Cay contains the largest settlement, Bullock's Harbour.

Acklins /Crooked Islands

Christopher Columbus noted Acklins, and its sister Crooked Island, as "fragrant islands." Today residents still use fish pots to catch their dinner.

Economy

The Bahamas is a stable, upper middle income-developing nation according to the US Department of Commerce report prepared by the US Embassy in Nassau.

Education

Bahamian education comes under the jurisdiction of the Ministry of Education, Youth and sports. There are approximately 214 schools in The Bahamas. Of these, 151 (74%) are fully maintained by Government and 53 (26%) independent. In New Providence, 39 are government-owned and 28 independent.

The Bahamas

School Population 1998-1999

	Government	Independent	Total
Primary			
New Providence	16,927	4,784	21,711
Family Islands	7,695	1,594	9,289
Primary			
New Providence	–	1,854	1,854
Family Islands	3,442	1,459	4,901
Primary			
New Providence	13,365	4,579	17,944
Family Islands	7,212	1,190	8,402
Special schools			
New Providence	340	–	340
Family Islands	139	–	139
Preschool /Nursery			
New Providence	347	1,037	1,364
Family Islands	196	358	554
Total	49,643	16,855	66,498

Figures are supplied by the Ministry of Education and Youth

Schools in The Bahamas are categorized as follows:

Preschool	age 4
Primary	ages 5-11
Secondary	age 11-16+
All Age	all ages

(for exceptional students or those with severe learning disabilities)

Free education is available in Ministry schools throughout The Bahamas. The Ministry of Education, in consultation with the University of Cambridge Local Examinations Syndicate, introduced The Bahamas General certificate of Secondary Education (BGCSE) in 1993. A wide range of subjects covering academic, technical and vocational areas are offered. Grades are on a seven-point scale, A-G. It is based on the UK General Certificate of Education (GCSE), and is targeted to a wider range of abilities than the former GCE O levels. Grade 9 students take nine subjects at The Bahamas Junior Certificate (BJC). Grades are on a seven-point scale, A-G.

Independent schools provide primary and secondary education. The term “college” connotes a fee-paying school rather than a university. The government –operated Princess Margaret Hospital offers a nursing course through the School of Nursing, at the College of to the Bahamas’ Oakes Field Campus.

Literacy

Eighty-five per cent of the Bahamian is literate: 15% cannot read or write, according to Let's Read Bahamas Secretariat. Literacy is based on the number of students completing sixth grade. While more than 95% of Bahamians complete six grade, they are not all functionally literate. The National Literacy Service Project – Let's Read Bahamas – was established in 1994. It is now expanded to include family literacy.

Higher Education

Four government-operated institutions in the Bahamas offer higher education:

- The College of The Bahamas
- The University of the West Indies (regional)
- The Bahamas Hotel Training College, sponsored by the Ministry Education and Hotel Industry
- The Bahamas Technical Institution (BTVI)

Every school must be registered with the Ministry of Education. There has been a marked increase in private institutions offering tertiary level education and degrees.

Culture

Junkanoo

Junkanoo is the most beautiful Bahamian “rush-out” which has been compared to Mardi Gras in New Orleans. It is characterized by colourful costumes made from crepe paper and card board, goatskin drums made by our own Bahamian son John “Chippie” Chipman, cowbells, horns and a brass section. Junkanoo is one example of a uniquely Bahamian culture. The celebrations are held in the early mornings of December 26 and January 1, New Year's Day. If either date fall on a Sunday, the celebrations are held on Monday morning.

Regular groups participating in the parade include the Fancy Dancers, One Family, Fox Hill Congos, Roots, Most Qualified, Saxons, Music Makers and Valley Boys, just to name a few. These groups can be heard and seen in New Providence and in Grand Bahama on a regular basis entertaining the public in mini Junkanoo “rush-outs”.

Social

People – to – People

The Bahamas Ministry of Tourism is designed to bring visitors and Bahamians together for cultural exchange. Ministry of Tourism personnel match volunteer and visitors according to age, interest and occupation. The highlight of the programme is the tea party at Government House, held on the last Friday of each month (January-August).

Other programmes include:

- Home - away – from-home. This programme encourages volunteers to act as foster parent and hosts foreign students attending Bahamian colleges.
- Spouse programme. This programme focuses on spouses while delegates are in conventions or on field trips.

Population Growth

Our population would double – or even triple! – While the earth we depend on for life remains unchanged. Today’s rapid population growth and highly populated communities are already contributing to the destruction of forest, misuse of agricultural land, spreading deserts, population and the depletion of non-renewal resources.

In the Bahamas, the facts are....

- *The 1990 Census estimated our population at 260,000.*
- *Our population has increased 20% since our last census in 1980.*
- *50% of our population is in the childbearing age.*
- *60% of our teenage birth (15-19 years) ratio is twice as high as the USA, 3 times higher than Canada and 11 times higher than the Netherlands.*
- *Bahamians are living longer. The average life span for males is 68 years and females are 74.*
- *At the rate our population is growing we will double our present population within the next 35 years.*

C. Health and Family Life Education Programme

1. History of Health and Family Life Education

In keeping with the goals of Education in The Bahamas, Family Life and Health Education was officially implemented in schools in 1991. Available data suggests that elements of Family Life and Health Education have been taught in most schools in The Bahamas at different levels as early as the 1970’s. Research also reveals that family life and drug abuse classes were taught at the Teachers Training College and high schools, while general health and hygiene classes were taught in primary schools.

Early in the 1980’s, officers in the Ministry of Education submitted a proposal to implement a Family Life and Health Education Curriculum in schools. However, the first formal discussion towards the actual implementation of the Family Life and Health Education Programme were held in February 1990 when the Director of Education asked officers to familiarize themselves with the document “**A Rationale for the Family Life and Health Education Programme**”. The document, which was dated 10th November 1989, was prepared by Mrs. Barbara Curtis, Health Education Officer and was submitted to the Ministry of Education for feedback.

A Steering Committee, which comprised of the following officers in the Ministry of Education, met to formulate plans for the implementation of Family Life and Health Education in schools:

Country Presentations

- Miss Edna Russell, Assistant Director of Education (Learning Resources Section, Curriculum Section) and Chairperson
- Dr. Caroline Hanna, Assistant Director of Education (Special Services Section) Mrs. Andrea Archer, Chief School Welfare Officer
- Mrs. Beverly Taylor, Senior Education Officer (Science and Technology)
- Mrs. Heloise Newbold, Education Officer (Home Economics)
- Mrs. Verdell Ferguson, Education Officer (Guidance and Counselling)
- Mrs. Caroline Major, Senior School Welfare Officer

Additional members from the Ministries of Education and Health and the general public also provided input and direction for the development of Family Life and Health Education over the years.

The Steering Committee spent much time reviewing the documents from The Bahamas and the Caribbean including the CARICOM Document: **Family Life Education: A Regional Workshop Final Report and Recommendation** Barbados, 23 – 27 November 1989. Supplementary documents reviewed included:

- **“Family Life Education in The Bahamas 1973 - 1982”** by Verdell Ferguson, 13 May 1980.
- **“Anti-Chemical Dependency Programme for Schools”** 1987 National Education Conference, compiled by Dr. C. Hanna.
- **“Proposed Approach for Incorporating Materials Related to Identified Social Ills into School Curriculum Programme,”** Beverly Taylor, 4th April 1990.
- **“Draft Handbook on Safety Rules for Schools”** produced by the National Education Committee and compiled by Andrea Archer, 1989.
- **“Family Life Education Curriculum K – Grade Eight”** compiled by the Catholic Board of Education, Bahamas
- **“Family Life Education Programme for the Post Primary Centres in Trinidad and Tobago,”** Curriculum Unit, Ministry of Education, Trinidad and Tobago, 1987
- **“CARICOM – Family Life Education – Regional Workshop – Family Life Education in the Formal Education System,”** Monserrat, November 1987

In reviewing the documents the Steering Committee attempted to do what all other Caribbean territories have done, which was to develop a draft programme in Family Life and Health Education that meets the needs of the Bahamian society.

During the opening of the 10th Annual Education Conference on the 11th July 1990, The then Minister of Education, the Hon. Paul A. Adderley delivered the following policy statement, which further laid the groundwork for the implementation of a Family Life and Health Education curriculum in the education system.

“... Students will be exposed to curriculum activities designed to foster a better understanding of their growth and development. Community living as well as topics in the areas of health will be covered in detail.”

(Pages 21 and 22 of Address of the Hon. Paul A. Adderley, Minister of Education and National Security at the official opening of the 10th Annual National Education Conference, 11th - 14th July, 1990 at Wyndham Ambassador Beach Hotel)

Family Life and Health Education was officially launched at the 11th Annual National Education Conference, 15th – 19th April 1991 under the theme “**Curriculum Development: Focus on Family Life and Health Education**”. The curriculum was implemented in schools in September of that year. In 1998, the subject’s name was changed to Health and Family life Education, as part of the initiative of the CARICOM Health and Family Life Education Multi Agency Project to strengthen Health and Family Life Education in Caribbean states.

The rationale to incorporate Health and Family Life Education as part of the school curricula was based on the high rate of teenage pregnancy along with other related physical, mental and social problems in the society at the time. Other issues identified included substance abuse (especially among adolescents), behavioural problems due to family crises, rising incidents of sexually transmitted infections and gang violence.

These issues are addressed in one or more of the three components of the curriculum, which is designed to holistically address the needs to students and to empower them to with the necessary knowledge, skills and attitudes required for personal development and for active participation in society.

Health and Family Life Education Programme Methodology

Family Life Education and Health Education Advisory Council, Family Life Association

In 1991, the Government of The Bahamas appointed a Family Life and Health Education Advisory Council to monitor the implementation of Health and Family Life Education in The Bahamas. The responsibilities of this Advisory Council include:

- Advising the Minister of Education on issues of national concern
- Providing discussion on and direction for the promotion of Health and Family Life Education in The Bahamas
- Acting as a resource body for training and sensitization of various target groups on topics relevant to Health and Family Life Education
- Assisting with community outreach programmes with particular emphasis on parenting education
- Developing and implementing positive public relations strategies for health promotion
- Reviewing the Health and Family Life Education Curriculum Guidelines and resource materials.

The Family Life and Health Education Advisory Council is appointed every two years and comprises of individuals from various sector of the society – education, health, civic and religious. The list of members of the present FLHE Advisory Council is as follows:

- Dr. Baldwin Carey, Department of Public Health, Chairman
- Mrs. Mary Ferguson, Catholic Arch Diocese

Country Presentations

- Miss Christine Campbell, the AIDS Secretariat
- Dr. Sandra Dean-Patterson, The Crisis Centre
- Ms. Audrey Deveaux, Ministry of Health
- Mrs. Thelma Grimes, C.V. Bethel High School
- Mrs. Carmen Gomez, Department of Statistics
- Mrs. Glenda Rolle, Department of Education
- Mrs. Philabertha Carter, Department of Public Health
- Bishop Elgarnet Rahming, Church of God of Prophecy
- Rev. Mitchell E. Jones, New Annex Baptist Church
- Rev. Terrance Morrison, Zion Baptist Church

The HFLE Programme was further strengthened with the formation of the Family Life Association in 1993. The goal of the Family Life Association is to provide support, through its membership, for the implementation of HFLE in schools and in the community. This organization is open to all health educators and persons interested in promoting health and family life in The Bahamas.

Health Promotion and Health Education

Over the past twenty years the Ministry of Health has launched a number of initiatives to promote health among the various population, namely:

- “Here’s to your Health, Bahamas”, which was launched in 1995 with a view to encouraging healthy lifestyles with special reference to nutrition and exercise
- The Nation Drug Council
- The AIDS Secretariat
- The Crisis Centre
- The Public Hospitals Authority

The Ministry of Health’s most recent initiative has been the development of a National Strategic Plan called “Healthy People”, having as its objective to increase healthy behaviours in school children and adolescents.

The general public has demonstrated significant interest in health and health matters. This increased interest in exercise and healthy eating practices have heralded the opening of a number of businesses catering to these special needs. The amount of Gyms and health Food stores and even health food restaurants have sky rocketed in the last decade. Insurance companies have also added preventive health services to their slate of coverage. Health Maintenance Organizations and Preferred Provider Organizations have emerged which are based on the premise of disease prevention and health promotion in the media profession. The media has also increased their interest in health issues and is covering more health on their shows.

Health and Family Life Education is a comprehensive life-skills based programme which is designed to empower students with the knowledge, skills and attitudes required for full personal development and for active participation in society.

Its objectives are to develop:

- positive attitudes towards self and others
- effective decision-making skills
- respect for personal and family values

The HFLE curriculum is divided into three major categories – **The Family, Health and Well Being and Community Living**. Topics addressed in these categories include family roles and responsibilities, growth and development, mental, physical, social and emotional health, nutrition, disease control and prevention, safety and first aid, consumer health human sexuality, and substance abuse prevention.

In HFLE classes students practice in the following life skills and behaviours:

- Being responsible for one's actions
- Building communication and cooperative skills
- Managing attitudes and emotions
- Resisting negative peer pressure and drug use
- Resolving conflicts
- Strengthening relationships with family and others
- Solving problems and making healthy choices
- Using higher order thinking skills
- Setting goals and following through
- Providing services to others

Character Education

A Character Education Programme has been implemented in primary schools to support the implementation of the Health and Family Life Education and Religious Studies curricula.

The objectives of this programme are as follows:

- To provide positive morals and foster good behaviour
- To promote pride in self and surroundings
- To reinforce the importance of values in developing the moral health of the nation.

The Ministry of Education, Youth and Sports in collaboration with other Government Ministries (Ministry of Health, Ministry of Housing and Social Development) and NGOs (Bahamas Family Planning Association - BFPA, Bahamas Association for Social Health – BASH) has implemented the following intervention programmes for students and individuals who influence them. These programmes are designed to provide students with knowledge and skills to make the right choices about their health.

Since 1991, the following self-esteem programmes have been implemented to promote positive self-esteem in students:

- *I'm Special Programme* for primary school level and Lead High Expectation Programme for secondary school level

Country Presentations

- Focus on youth – Pregnancy, HIV, STI prevention programme for preadolescents and adolescents in primary and junior high schools
- The Bahamas Family Planning Association Adolescent Reproductive Health Education Project for Grand Bahama and New Providence, Abaco and Eleuthera, 1997-2001
- Second Step: Violence Prevention Curriculum – Preschool –Grade eight
- National Drug Council Substance Abuse Prevention training workshops
- National Drug Council Summer Enrichment Programme, during July

Educators involved in the implementation of the Health and Family Life Education Programme have been afforded the opportunities to participate in In-service training both nationally and internationally in areas relevant to Health and Family Life Education. In-service sessions have addressed topics such as Human Sexuality, Teenage Pregnancy, Parenting Education and Curriculum Development.

During the period August 5th through 31st 1996, four representatives from the Ministries of Education and Health and The Bahamas Family planning Association participated in Phase 1 of the CARICOM Multi Agency Project Trainer of Trainers Course at the University of the West Indies, Mona Campus.

In an effort to fulfill the requirements of the Phase II of the Trainer of Trainers Project, twenty-five representatives from the Ministries of Education and Health and Civic groups in New Providence and Grand Bahama participated in a workshop held July 14th through August 1st 1997. The course was taught using the participatory methodology and the PAHO/Carnegie Core Curriculum Guide on Health and Family Life Education.

Healthy Environment

The focus of environmental health over the past five has been on the development, strengthening and maintenance of policy, standards, resources, communities and partnerships for protecting the people of The Bahamas from adverse and environmental impacts. Environmental awareness programmes such as Integrated Vector Control and Solid Waste Management have been designed to create an awareness about the importance of a clean and healthy environment and to empower communities to take charge of their environment.

As a result of the Integrated Vector Control and the Solid Waste Management programmes components on vector and pest control have been incorporated in various school curricula – Health and Family Education, Science, Agriculture Science, Home Economics and Mathematics. During 1996 through 1997, Officers from the Ministries of Health and Education along with representatives from the Pan American Health Organization, Bahamas, visited family islands to conduct training and sensitization for various family island communities on the importance of healthy environments.

The Department of Education seeks to ensure a safe and healthy school environment conducive to learning, personal growth and the overall success of the Bahamian children through the implementation programmes designed to prevent violence and substance abuse. In 2000 the Department of Education developed a Manual of rules and procedures for creating a safe school environment. The manuals for students and teachers are designed to teach responsible

student behaviour that will result in effective citizenship and to support the implementation of preventive programmes in violence and substance abuse prevention.

Nutrition and Health Services

Heart disease is presently the number one cause of mortality in the Bahamas. Research has shown that Bahamians tend to consume high levels of processed food with high sugar and salt content and low in fiber. As a result, there is a high correlation between diet and non-communicable disorders such as obesity, cardiovascular disease, type II hypertension, stroke and various forms of cancers. These diet-related diseases are included among the leading causes of immobility among adults.

A number of studies conducted among the school population have also shown that the diets of children place them at risk for coronary heart disease. Recommendations have been made for nutrition education programme for both children and adults who care for them.

A component on Nutrition is included in the Health and Family Life Education and Home Economics curricula. The Ministry of Health also provides services in meal planning and counselling for students and adults who are overweight or obsessed.

The Ministry of Education, Youth and Sports provides daily lunches for those students who have been found eligible. This service is primarily organized and provided for by the Department of Social Services with the assistance of the Department Education. This lunch programme is implemented in school districts throughout The Bahamas. The lunches comprise of hot and /or cold dishes.

The Department of Public Health provides the following services for the Ministry of Education, Youth and Sports school population:

- Physical and dental examinations
- Adolescent Reproductive Health Education services
- Counselling Services
- Health Talks

School Health Services were first implemented in The Bahamas during the 1950's. Some of the actions and plans currently in place:

- At registration, 4–4 year olds must present up-to-date Immunization Records. They must have received required immunization by the time they enter school in September.
- In-school medical examinations are conducted annually at grades one, six and ten in Ministry of Education schools in The Bahamas
- On-site or visiting school nurses provide follow-up care to “at risk” students, present health education lectures, and conduct minor ailment clinics
- School social workers are assigned to visit schools weekly
- There is a school oral health programme implemented for students in primary and high schools

Country Presentations

- A Mobile Health Clinic is used to conduct examinations and carry out lab work at New Providence schools
- All new schools and recently remodeled school buildings have a Sick Bay to facilitate students who become ill

There is a Hospital School for sick children, which provides an instructional programme for children who are hospitalized. Additionally there are programmes/provisions for students who are challenged – physically, mentally, deaf, blind and autistic. Other special services with the education and health sectors include speech therapy, psychological services, guidance, counseling, and behaviour modification.

In an effort to address the needs of all students, the Government of The Bahamas has implemented programmes to cater to those students who are “at risk.”

The Providing Access for Continued Education (PACE) Programme for teen mothers is a programme designed to prepare student/teen mothers to prepare themselves academically and socially for re-entry into the school system or entry into the job market.

Current Situation of Health and Family Life Education Programme

Policy Decision by the Department of Education

Health and Family Life Education is taught as a separate subject in grades one through twelve. Some primary schools, however, have integrated the subject with Social Studies and Religious Studies. Aspects of the HFLE Curriculum are integrated in the pre-school curriculum.

The Department of Education made the decision that the curriculum should be given two periods per week at primary and high school levels and that the homeroom teacher should teach the curriculum. This decision was later negated in favour of a careful selection of teachers to teach the course at the high school level. At the primary level, HFLE is taught by all grade-level teachers.

Coordination of Health and Family Life Education

The Health and Family Life Education Curriculum falls under the auspices of the Health and Family Life Education Unit of the Department of Education. In addition to the supervision of the Health and Family Life Education curriculum in schools, Officers in the Health and Family Life Education Unit coordinate and conduct training and sensitization for target groups, supervise the loan of resource materials, liaise with GOs and NGOs to implement health intervention programmes in schools and the community.

Officers involved in the administration of Health and Family Life Education are as follows:

- Mrs. Glenda Rolle, Senior Education Officer for Primary School HFLE
- Mrs. Sabrina Skinner, Education Officer for High School HFLE
- Mrs. Ruth Mae Young, Acting Education Officer for Primary School HFLE
- Mrs. Joyce Pinder, Coordinator for the Adolescent Health Education Programme, Grand Bahama District

- Miss Sandy Walker, Coordinator for the Adolescent Health Education Project, Abaco District
- Mrs. Theresa Burrows, Coordinator for the Adolescent Health Education Programme, Eleuthera District

Implementation of HFLE Activities

1. Supervision of Health and Family Life Education in primary and high schools in The Bahamas
2. Curriculum Development and production of resource materials to support the HFLE curriculum
 - Development of HFLE Standard and Benchmarks for grades one through nine
 - Development of Health and Life skills Education Curriculum for grades ten through twelve
 - Production of Audio tapes utilizing HFLE content for listening and speaking classes
 - Production of brochures, newsletters, and HFLE resource materials
3. Coordination of Programmes e.g. health intervention, peer leadership
4. Coordination of Professional Development in Adolescent Reproductive Health Education
 - School-based training for teachers, guidance counselors, peer leaders
 - Sensitization and/or training for community groups
5. Liaison with Government Agencies and Non-Government Organizations.

Health and Family Life Education Materials

Since 1991, the Health and Family life Education Unit has procured resource materials to support the implementation of the HFLE curriculum in schools. These materials have included textbooks, audio and videotapes, posters and charts. In addition the HFLE Unit operates a small resource centre in the Humanities Section, Department of Education. Books, charts, audio and videotapes containing information on health and family life are available for loan to the public.

As a result of the collaboration with The Bahamas Family Planning Association, the following resource materials have been developed by a team of Health Educators to support the HFLE curriculum:

- **Helpful Hints for Adolescents** – Distribution to the wider community
- **Helpful Hints for Adults**
- **Resource Guide for Teachers: Adolescent Reproductive Health Education Series** – Distribution as part of the training in Adolescent Reproductive Health Education
- **Pauline and Tommy's Puzzles and Games** – Distribution to schools to be utilized by students of low ability high interest level
- **Posters** – Distribution to schools and community groups
- **Audio tape for Creole Community** – Distribution to the Haitian community

Participation in School Health Networks

The Healthy Schools Initiative is scheduled to be implemented in schools in The Bahamas during the 2001/2002 academic year. A Draft Concept Paper for the promotion of the Healthy Schools has been developed. The areas of health promotion for the Healthy Schools Initiative include:

- Nutrition and Physical Activity
- Sexuality-physiology and anatomy
- Violence Prevention
- Substance Abuse Prevention

These components are addressed in a number of the Ministry of Education Curriculum Guidelines – HFLE, Home Economics, Physical Education, Science and Agricultural Science. The promotion of the Healthy Schools Initiative would ensure that these critical areas are addressed in the school/community programmes as well.

Training of Teaching Staff

Training for teachers involved in the implementation of Health and Family Life Education is on-going. Presently, Officers in the Ministries of Education and Health are in dialogue with representatives from the College of The Bahamas to implement a Health and Family Life Education programme at that institution for high school teachers, and to strengthen the HFLE programme for primary teachers.

Community Participation

Since the implementation of HFLE in 1991, efforts have been made to sensitize the public to the importance of HFLE. Activities have included education exhibition radio programmes on health promotion and training workshops. These efforts should be sustained to ensure that the public is sensitized and knowledgeable about the importance of health and family life.

Surveillance and Monitoring of HFLE

Supervision of the Adolescent Reproductive Health Education is an integral part of HFLE activities. The During the next phase of the programme more emphasis should be placed on reduction of STIs in adolescents, reduction in teen pregnancy in adolescents, and education of persons who influence adolescents.

Evaluation

Because the primary focus of Health and Family Life Education is to assist in combating the negative influences that are aimed at our youth, the subject is not viewed as one that lends itself to structured examinations. Instead, students and educators are afforded the opportunity to explore life together in an environment, which does not pose the threat of major examination stress. Teachers, however, are expected to evaluate students' progress throughout the year. The instrument of evaluation takes the form of homework assignments, projects, portfolios, post- and pre- tests, etc.

Presently, no formal evaluation instrument is in place to assess the impact of the Health and Family Life Education Programme in The Bahamas. Assessment of the programme is based on feedback from various target groups and observation of student behaviours. Efforts are being made to develop an evaluation to assess HFLE for the next five years.

A Mid-term evaluation for the Adolescent Reproductive Health Education Project was conducted in May, 2000. A Final evaluation was conducted in June, 2001. The evaluation report is forth coming.

Lessons Learned / Future Plans and Felt Needs

Health and Family Life Education has been implemented in The Bahamas for ten years. While progress has been made in a number of areas, there have been challenges to the promotion of Health and Family Life Education. As the programmes move into another decade, the following activities have been developed to promote Health and Family Life Education in schools and in the community:

- Development of a Strategic Plan for the implementation of HFLE in The Bahamas for the next five years
- Training and sensitization for target groups (teachers, guidance counselors, students, out of school youth, parents, Haitian community)
- Implementation of a HFLE Programme at the College of The Bahamas
- Curriculum revision
- Implementation of peer leadership programmes in primary and high schools
- Implementation of the Healthy Schools Initiative
- Production of materials to support the implementation of HFLE in schools
- Development of evaluation to assess the impact of HFLE in The Bahamas.

Health and Family Life Education is among the most important subjects students can learn in school. Many of the problems and issues that adolescents face e.g. teenage pregnancy, STDs, eating disorders and peer pressure are addressed through the implementation of Health and Family Life Education. This programme will ultimately affect the ability of young people to perform at school, at home and in the community.

Health and Family Life Education will also benefit educators by providing a supportive framework and environment within which they can develop and pass on life sustaining skills.

The successful implementation of Health and Family Life Education will depend on the support of and collaboration among institutions of society – home, school, community and government, all which are concerned with the well being of young people.



British Virgin Islands

Ivy George, Manager, Health Education Unit, Health Department, Ministry of Health and Welfare

Abigail Daniel, Education Officer, British Virgin Islands Department of Education and Culture

History of Family Life Education Programme

In 1983, British Virgin Islands' Health Education Unit initiated a formal health education programme. In 1984, the BVI was one of the three Eastern Caribbean countries to participate in the School Health and Family Life Education Project, jointly sponsored by the Carnegie Corporation of New York and PAHO/CPC. In November 2001, the proposal was revisited and was presently being modified when the information arrived about this meeting to form the Caribbean Network of Health-Promoting Schools.

Curriculum Development

A Six-unit curriculum for the Family Life Education Programmed was developed and implemented in the primary schools. The curriculum includes the following units:

1. Community and Environmental Health
2. Disease Prevention and Control
3. Family Life
4. Food and Nutrition
5. Mental Health
6. Personal Health

Planning

A Planning Team was set up by the Ministry of Health and Welfare. The members of the team include representatives from PAHO and senior members of the Departments of Health Education. The planning team uses reference materials developed by the CDC as well as materials from the Caribbean.

Teacher Training

Hull University contracted to conduct Health Education training for teachers working on a BA in Education. A series of in-service workshops have been conducted during the summer vacation for teachers not participating in Hull's programme for three years.

Methodology/Management

After the completion of the project, the committee was disbanded and the implementation of the programme rested with the Department of Education and Culture.

Health Education is one of the subjects time-tabled in all government primary schools. The subject is taught once per week by class teachers. Health personnel are used as resource persons.

Health Education and Health Promotion

Health Education and Health Promotion include the following components:

- Parenting Programmes
- Drug prevention
- AIDS prevention
- Peer Education Programme for High Schools

Health Environment

The Health Department conducts inspection of schools and does water quality testing. There is no formal programme in place.

Nutrition and Health Services

School Health Services are provided through health centres located in many of the schools. The BVI maintains active immunisation, asthma education and control, and hearing screening programmes. Physical examinations are required of all students entering school at ages 4 1/2 and 11.

CFNI's Healthy Lifestyle's Project is being piloted in three primary schools.

The BVI also runs a multi-faceted Dental Health Programme, which includes dental health education, screening and cleaning, fluoride rinses, and extraction and filling of teeth.

Current Situation

The BVI's School Health Programme is ongoing but needs upgrading and strengthening to ensure maximum benefit to the school population. In 1998, Guidance Services, Department of Education and Culture, and the Health Education Unit, Health Department, prepared a proposal for upgrading and strengthening the school health programme. The proposal was developed following the US Comprehensive School Health Model. An interim working group, the School Health and Safety Advisory Committee, was established and consists of persons from the departments of health and education, as well as school personnel and parents.

Lessons Learned: Positive

- The prepared curriculum guide provides teachers with a guide as to what to teach.
- Many teachers have a keen interest in School Health.
- Health and Family Education is now part of the Teacher Training Programme at the Community College.

Lessons Learned: Negative

- Inadequate understanding and acceptance of school health programmes at the national level.
- Inadequate collaboration among the agencies.
- Lack of a coordinated effort to school health.
- Lack of coordinating body.
- Lack of a national comprehensive approach to school health policy or programme.
- Lack of research and evaluation of existing programme.

**Health and Family Life
Education Programmes /
School Health in the
British Virgin Islands**

1980 - 2000

**HISTORY OF FAMILY LIFE
EDUCATION PROGRAMME**

- 1983 – Formal Health Education Programme initiated by the Health Education Unit, Health Department.
- 1984 – The BVI was one of the three Eastern Caribbean countries to participate in School Health and Family Life Education Project, jointly sponsored by Carnegie Corporation of New York and PAHO/CPC.
- In November 2001, the proposal was revisited and was presently being modified when the information of this workshop came.

COMPONENTS

- **Curriculum Development**
Six-unit guide was developed and implemented in the primary schools.
 1. Community and Environmental Health
 2. Disease Prevention and Control
 3. Family Life
 4. Food and Nutrition
 5. Mental Health
 6. Personal Health

PLANNING

- Planning Team was set up by the Ministry of Health and Welfare.
Members
 - PAHO
 - Senior Members of the Departments of Health EducationReference Materials
CDC, Atlanta, Caribbean

TEACHER TRAINING

- Hull University contracted to conduct Health Education training for teachers participating in BA in Education.
- Series of in-service workshops conducted for teachers not participating in Hall's programme during the summer vacation for three years.

METHODOLOGY

Management

- After the completion of the project, the committee was disbanded and the implementation of the programme rested with the Department of Education and Culture.
- Health Education is one of the subjects time-tabled in all government primary school. The subject is taught once per week by class teachers. Health personnel are used as resource persons.

HEALTH EDUCATION AND HEALTH PROMOTION

- Parenting Programmes
- Drugs
- AIDS
- Peer Education Programme for High Schools

HEALTH ENVIRONMENT

- Environmental Health, Health Department conducts inspection of schools and do water quality testing [no formal programme in place]

NUTRITION AND HEALTH SERVICES

- School Health Services conducted through Health Centres
- Active Immunisation Programmes
- Physical Examinations – students entering school at 4½ and at 11 years
- Asthma Education and Control Programme
- Hearing Screening -

HEALTH AND NUTRITIONAL SERVICES

- CFNI Healthy Lifestyle's Project being piloted in three primary schools
- Multi-faceted Dental Health Programme
 - Education
 - Screening and Cleaning
 - Fluoride Rinse Project
 - Extraction and Filling of Teeth

CURRENT SITUATION

- School Health – Ongoing but needs upgrading and strengthening to ensure maximum benefit to school population.
- 1998 – Guidance Services, Department of Education and Culture and the Health Education Unit, Health Department, prepared a proposal for upgrading and strengthening the school programme. The proposal was developed following the US Comprehensive School Health Model.
- An interim working group – School Health and Safety Advisory Committee was established and was comprised of persons from Health, Education, school personnel and parents.

LESSONS LEARNED - POSITIVE

- The prepared curriculum guide provides teachers with a guide as to what to teach.
- Many teachers has a keen interest in School Health.
- Health and Family Education is now part of the Teacher Training Programme at the Community College.

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- Inadequate understanding and acceptance of school health programmes at the national level.
- Inadequate collaboration among the agencies.
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- Lack of research and evaluation of existing programme.



Dominica

Joan Henry, Coordinator of Health Promotion, Ministry of Health and Social Security

Myrtle Prevost, Health and Family Life Education Coordinator, Ministry of Education, Sports and Youth Affairs

Overview

The purpose of this paper is to highlight issues and activities relating to Health and Family Life Education (HFLE) in the formal and non-formal education systems in Dominica. It makes reference to the status of Health Education in schools before the introduction of HFLE and provides statistical information to demonstrate trends and substantiate claims made in reference to teenage pregnancy and other socially related issues.

Introduction

This paper focuses on the Delivery of Health and Family Life Education within the formal and non-formal education systems in the Commonwealth of Dominica. The information is organized in five sections: the background and general context of the country, Health and Family Life Education, HFLE programme methodology, current situation of the HFLE programme, lessons learned and future plans and felt needs.

General Context of the Country

The island of Dominica in latitude 15° N and longitude 61° W, lies between the French Departments of Martinique and Guadeloupe, and is approximately 29 miles in length and 16 in breadth. Viewed from the sea, the island has a singularly bold and magnificent appearance. A dark, irregular mass of lofty mountains rises abruptly from the ocean, as if suddenly upheaved from the deep by some mighty convulsion of nature. Dominica is of volcanic origin and many volcanic openings can be found in different parts of the island.

There exist many fissures and hot springs in the Roseau Valley and the southern extremity of the island. The second largest boiling lake in the world is found in the Roseau Valley.

Dominica boasts of a pristine environment and unsurpassed beauty. Given the mountainous nature of the island there is an abundance of rain, 365 rivers, cascading waterfalls, 500 different species of birds, 2,500 species of flowers, an abundance of fruits, vegetables and wildlife. Towards the end of the 20th century, bananas have become the major crop grown on the island.

Though the temperature at some seasons is high during the day and the atmosphere close and sultry, the nights are invariably cool. The mean average temperature in Roseau is 79.88° F (26.3° C). The average maximum is 83.93 degrees F (28.9° C) and the minimum 74.88° F (23.9° C).

Country Presentations

Dominica has a rich history and is the home of the indigenous people, the Caribs. It is the only island that has an area set aside as a settlement for the indigenous people – 3000 acres. The land is held in common and is accessible to all local Caribs.

A recent publication from the Central Statistical Office (2001) has revealed that the island's population is approximately 73, of which there are 22 centenarians, five of these being male. Elizabeth "Ma Pampo" Israel, at 126 years old, is among these centenarians and is believed to be the oldest living person in the world. Considering the size and population of this island state and the number of centenarians alive suggests that our health care system is, by and large, addressing the needs of its people.

The Commonwealth of Dominica Constitution Order (1978) declared that the island is a Sovereign Democratic Republic within the Commonwealth. Its Parliament consists of the President and the House of Assembly. The 21 representatives of the House correspond to the number of constituencies in the island. Each term of office lasts for a period of five years.

The Education Act II of 1997 governs the administration of the island's education system. The system consists of 4 levels: Early Childhood Education, Primary, Secondary, and Tertiary. The following is a summary of the relevant data:

- Early Childhood Education Centres – 81 centres, 2,069 students, 162 teachers
- Primary Education System – 66 schools, 12,389 students, 608 teachers
- Secondary Education System – 15 schools (7 Government-supported, 7 Government-assisted, and 1 private), 6,535 students, 305 teachers
- Tertiary Education System – there are several targeted groups for this level:
 - The Clifton Dupigny Community College – 601 students, 52 teachers – comprises Academic and Technical sections for students who have completed the secondary programme.
 - Dominica Teachers Training College – 91 students, 24 teachers
 - Department of Continuing Studies for adult students

Table 1. Socioeconomic Indicators

GNP per capita (US\$) (1998)	5885
Annual GDP growth rate (1998)	7.1
Literacy rate	81.2
National health expenditure per capita (1988)	411.4
Total health expenditure as % GDP (1995-98)	4.5 %
Total education expenditure as %GDP (1999)	5.58%

Accordingly, this paper seeks to outline the Health and Family Life Education programme that is jointly supervised by the Ministry of Health and Social Security and the Ministry of Education, Sports and Youth Affairs.

Health and Family Life Education Programme in the Country History

Prior to the 1980s, hygiene was taught in the schools. Health Education, which was taught by visiting nurses and environmental health officers, replaced this. In the early 1980s, Health and Family Life Education (HFLE) was introduced in Dominica, but due to the lack of public awareness regarding the definition of HFLE, there was resistance to the idea, even on the part of some school principals. The problem stemmed mainly from the fact that Family Life Education was interpreted to be synonymous with family planning or sex education.

Workshops were conducted at the school, community and church levels to sensitize the public about the importance of Family Life Education. Subsequently, curriculum guides were prepared for both primary and secondary school pupils, with funding provided by international agencies.

Besides the Ministry of Education, other agencies and institutions played their part in disseminating information on HFLE as follows:

- The DPPA provided materials and technical assistance for conducting district workshops.
- The Caribbean Association of Catholic Teachers provided a series of guides for the primary school level entitled, “Wonderfully Made.” Copies of these guides were bought by DPPA and presented to the Ministry of Education for the benefit of 3 to 12 year olds in selected schools.
- The Ministry of Health, in collaboration with the Fertility Management Unit of the University of the West Indies, Mona, Jamaica and the UWI Centre in Dominica, conducted training in Health and Family Life Education, counseling, and family planning for health care workers, teachers, and social workers.
- The Women’s Bureau produced a manual for Family Life Education.
- The Social Center also provided Family Life Education as part of its teaching/learning programmes, i.e., from pre-schools to its adult education courses. The recently introduced parenting programme had also been integrated into the Center’s HFLE programme.
- HFLE was taught at the Teacher’s College as part of teachers’ in-service training.

Justification

In 1990 Dominica’s Minister of Education made these observations:

“The 1990s pose new challenges for Family Life Educators. We live in an age that is characterized by an apparent breakdown in the moral fabric of society: Abandonment of the traditional family values, increasing incidence of child abuse and family violence, drug abuse, sexual promiscuity and the nightmare of HIV/AIDS, paralleled by the rise in materialism fueled by our increasing exposure to foreign influences. As our world keeps shrinking and the physical and artificial barriers evaporate, packaged menus of foreign values and behavioral norms on the television screen are fed to a public that is too frequently unable to discriminate good from bad, separate myth from reality, and readily accepts the standards portrayed on the soap operas and other escapist TV series.”

Country Presentations

The then Minister at a meeting of Ministers of Education held in February 1991 mentioned the further deterioration of the socioeconomic situation as evidenced in the BDD-financed, “Drafts Poverty Assessment for the Government of Dominica” and the UNICEF-supported, “Situation Analysis of Women and Children (1991-96).” The BDD report estimates that 27.6 percent of households are unable to meet their basic needs. This had implications for the welfare of children. The Situation Analysis outlined some areas where the impact of an unsatisfactory socioeconomic situation was evident.

Teenage Pregnancy

Table 2. Births to teen mothers as percent of total births, 1987, 1990, and 1994

Year	1987	1990	1994
% Total Births	25.8	24.3	14.3

The Analysis pointed out that the contributors to teenage pregnancy are:

- Lack of knowledge of human sexuality, family planning, and reproduction
- Belief in myths and misinformation
- Unemployment and dependence
- Improper use of too much leisure time
- Desire to have a child to boost self image
- Lack of control and a “do and dare” attitude

HIV/AIDS

Table 3. Number of HIV Positive by Age and Sex, 1987 – (July) 1995

Age	F	M	Total
1	1	2	3
1-5	2	1	3
5-14	1	0	1
15-19	3	0	3
20-24	2	6	8
25-34	11	37	48
35-44	5	19	24
55+	2	5	7
Total	28	79	108

Source: Ministry of Health, Dominica, 1995

The incidence of HIV-positive cases by age and sex is shown above in Table 3. A total of 79 male and 28 female seropositive cases were recorded for the period of 1987-(July) 1995. There were 6 HIV positive in the 0-5 age group and 4 cases among teenagers. Data indicated that women were increasingly at risk of infection and raised questions about the AIDS awareness programmes.

Obesity

Obesity was another lifestyle condition affecting the Dominican society in the 1990s. The Situation Analysis also mentioned the fact that 26 percent of the adult population, as well as 10 percent of 0-5 age group, were obese. Reasons for obesity included insufficient breast-feeding, too much sugar and fat in the diet, consumption of low-fiber food, and TV promotion of “junk” food.

Drug Abuse and Juvenile Delinquency

The National Report in Preparation for the International Conference on Population and Development held in September 5-13, 1994 declared that:

“Drug abuse ranked as one of the most common and critical problems facing the nation’s youth. It resulted in increased deviant behaviour, crime, and decline in the participation of youth in productive activities. This was especially true of the young male. Trafficking and use of these drugs (mainly marijuana and more recently crack cocaine and “coke”) had infiltrated the secondary schools and might have been even in the primary schools.”

The multifaceted social problems, impacting negatively on the home, school, and community, gave rise to the need for a National Health and Family Life Education (HFLE) Policy and Plan of Action.

Health and Family Life Education Programme Methodology

The national Health and Family Life Education (HFLE) programme is coordinated jointly by the Ministry of Education, Sport and Youth Affairs and the Ministry of Health and Social Security. The programme forms part of the education curriculum at the pre-primary, primary, and secondary levels of education and at the Dominica Teachers Training College. Several Non-Government Agencies manage HFLE programmes in collaboration with both Ministries. There is a National Coordinating Committee that comprises 12 representatives from various governmental and non-governmental agencies and includes parents, teachers, students, and the clergy. This committee operates at the national level and is functional. The committee reviewed the HFLE Primary School Curriculum and the National Draft Policy on HFLE. Both documents were upgraded and finalized. The policy document is presently with the Minister for Education to be presented to the Cabinet for approval and the reviewed curriculum is being printed. The programme is facilitated and monitored by personnel from both Ministries and the Dominica Planned Parenthood.

The curriculum consists of health promotion concepts and principles, environmental health, human sexuality (which addresses domestic violence and abuse), and life skills for drug abuse prevention.

Food and Nutrition represents a large component of the HFLE curriculum. The school health service is managed by the Department of Community Health, the Family Nurse Practitioner and the Community Health Nurse, who are jointly responsible for conducting physical assess-

Country Presentations

ments, treatment of minor ailments, immunization and student referral for new school entrants, grade 4 and school leavers. Referrals are made to and also received from teachers, parents, school guidance counselors, and other social support network systems.

A School Feeding Programme is administered at 7 schools on the island. This programme provides one daily meal to students, and is subsidized by the students who pay a minimal fee of \$1.00 for a meal. Parents voluntarily prepare the meals. The School Feeding Programme Coordinator monitors the programme.

Current Situation of the Health and Family Life Education Programme

Currently the Draft Policy on HFLE is not yet endorsed. The new Minister of Education, Sports and Youth Affairs indicated that he needed some time to familiarize himself with the HFLE programmed before presenting the document to Cabinet for approval.

The development of HFLE materials by the Curriculum Development Unit of the Ministry of Education, in collaboration with the Ministry of Health and Social Security, was drawn from CARICOM HFLE Guidelines. The materials were field-tested at eight schools and modified for use.

Since 1997, Curriculum Guides for secondary school have been developed. These materials were reviewed in 2000 for structured sessions within the first to third forms of the secondary schools.

Presently, Dominica is not participating in the Latin American Network of Health-Promoting Schools; however, Dominica hopes to do so in the future. In the meantime, the Health-Promoting Schools concept is being piloted at one primary school, which was recently adopted by the national radio station. The results of this initiative will be used to further develop the Health-Promoting Schools concept island-wide.

Resource materials from CARICOM Multi-Agency HFLE Project and the Core Curriculum Guide for Strengthening HFLE are used in the conduct of yearly teacher training.

Parents are kept informed through Parent Teachers Association (PTA) meetings and HFLE awareness campaigns.

The HFLE programme is monitored by school visits, discussion with teachers and principals, teacher observation, and medical assessment of students.

Some evaluation of the HFLE programme has taken place and an instrument was developed to determine attitudes towards HFLE in schools. In 1999 a structured questionnaire was used to conduct a needs assessment among teachers from 20 schools. The results are highlighted under the heading "Lessons Learned."

Several materials such as school curriculum guides, a manual on Human Sexuality, the Draft National Policy on HFLE and lesson plans for use in the HFLE programme have been developed and printed locally.

Lessons Learned

- Some teachers were uncomfortable with certain sensitive aspects of the curriculum.
- HFLE became entrenched in the schools where the principal had a favorable attitude toward the subject.

- In schools where HFLE was taught, the children were able to talk about their problems openly.
- Incidences of abuse were picked up during HFLE sessions at schools.
- Support from key personnel of the Ministry of Education may not always be forthcoming (due to choices made in the distribution of scarce resources).
- HFLE was not formally taught in pre-schools.
- Teachers who have not been to Teachers College have limited formal training in HFLE.
- Collaborative work among the various governmental departments and nongovernmental agencies facilitated the implementation of the process.
- For the HFLE programme to be a success, it must be made a core subject of the school curriculum.
- HFLE was implemented at the tertiary level, but the strategies and approaches to the subject needed to be revised to include skills such as communication, relationship building, friendship-making, counseling, and appropriate attitudes towards work.
- There was a lack of parenting skills at upper secondary and tertiary schools to help bridge the gap between the homes and schools.
- Students who participate in community outreach HFLE programmes exhibit higher self-esteem, and good leadership skills. Most of them volunteer to become peer educators for the youth division summer camp programme.

Future Plans and Felt Needs

- Further teacher training for HFLE to become mandatory
- Motivational workshops with assistance from officials of the Ministry of Education, Sports and Youth Affairs to encourage principals—several principals are not committed to including the topic on the daily schedule because the subject is not a core subject and students are not graded
- Review of the secondary curriculum guide needs to be completed to enable a more structured programme to be implemented
- Greater awareness of the Health-Promoting Schools concept to be fostered so as to create opportunities for wider sensitization among all schools island-wide
- The necessary administrative arrangements to be made to all for other teachers with greater competence and interest to teach HFLE

The programme's vision is that by the year 2003, 100 percent of children and youth at pre-primary, primary, and secondary levels of education will have effective exposure to HFLE so as to promote positive behaviors and lifestyles. Similar programmes will have been developed for teachers at the tertiary levels as well as youth in the non-formal sector. It is anticipated that persons including parents, community representatives, health workers, and NGOs will be trained to deliver the programme in a health-promoting and supportive environment.

UPDATE OF HEALTH SITUATION - DOMINICA

Dr. Paul Ricketts
Chief Medical Officer (Ag.)

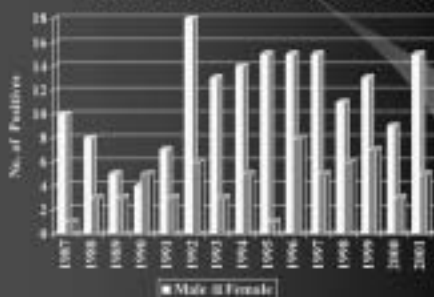
GENERAL SITUATION

Demographic and Socioeconomic Overview

- Preliminary figures from census May 2001 indicates population of 71, 000
- Current census includes more information related to health than previous censuses but results not yet available
- Economy in difficulty – worsened with Sept 11 events in the US

SPECIFIC HEALTH PROBLEMS

HIV POSITIVES BY SEX & YEAR DOMINICA 1987 - SEPT 2001



HIV/AIDS

- Major challenge for the MoHSS
- 20 new cases of HIV in 2001 to date
 - 15 male, 5 female incl 4 pregnant
- AIDS surveillance needs strengthening
- National Strategic Plan being developed
 - Situational analysis needs to be done
 - World Bank team expected end of Nov 2001
 - Local leadership

Child Health (<5 years)

- Remains a priority group
- No further outbreaks of sepsis in the NNU since

Child Health (5-9 years)

- School health programme continues to screen primary school entrants

Adolescents

- Remains a challenge for the Ministry to develop a focused programme
- Drug Prevention Unit survey of schools due to be undertaken

Health of Adults (15-60 years)

- Good access to antenatal services
- Maternal mortality low
- Sensitization campaign and survey on prostate cancer undertaken by Grandbay Health Team October 2001

Health of Older Persons (60+ years)

- Dominica Council on Aging looking for new Executive Director following the passing of Ms. Hyacinth Elwin

Family Health

- MoHSS represented on HFLE Committee of the Min of Education
- Upcoming launch of Caribbean Health Promoting School initiative in Barbados this month

Health of the Indigenous Population

- TB appears to be on the decline. No new cases 2000

Vaccine Preventable Diseases

- Immunization coverage remains high
- Pentavalent vaccine - ? affordable

Vector Bourne Diseases

Biological Warfare Diseases

- Anthrax threats reported in Trinidad and the Bahamas triggered a response from CAREC
 - Local intersectoral meeting held and response mechanisms agreed upon
 - Updates held for medical staff
 - Physician and public educational materials developed and distributed

Respiratory Conditions

- The Common cold continues to be the leading cause of new episodes of respiratory illnesses
- Asthma continues to be a significant cause of visits to the A&E department

Nutrition

Chronic NonCommunicable Diseases

- Diabetes is a major public health challenge - 2.7% of total population registered at primary health care clinics. World Diabetes Day 14 Nov
- Cardiovascular disease responsible for

Cancer

- Cancer was the leading cause of death in 2000
 - In men
 - In women

Accidents and Violence

- Continue to take a toll on the health services especially at the Princess Margaret Hospital

Oral Health

- Clinical services continue in the seven health districts
- School oral health education needs to be strengthened
- Oral health epidemiological survey is due

Mental Health

- Community mental health continues to be the focus
- 20 level II nurses trained in mental health to graduate in January 2002
- Training of primary health care workers in the detection and mrx of common mental health disorders to be undertaken soon – needs assessment undertaken in Aug 2001, proposal to be submitted to PAHO by Nov 15

RESPONSE OF THE HEALTH SYSTEM

National Strategic Health Plan

- Draft National Health Plan (based on CCH II priorities) completed but not yet submitted to Cabinet for approval

Hospital Management Project

- CBD, PAHO and MoHSS funded
- Canadian consultant selected with the assistance of PAHO expected to take up duties later this month
- Among other things it is hoped that improved revenue collection will be realised

Human Resources

- Unprecedented turnover/shortage of senior level staff – Hon. Minister, CMO, Epidemiologist, HMD, AS, SEO (Accounts), HSC
- Staffing - Health Information Unit, A&E Department, Health Promotion Unit, Nursing
- Formal Establishment of Units – HIU, DPU
- Neurologist employed since Sept 2001
- Nigerian pathologist arrived last week

Health Promotion

- Head of Health Promotion Resource Unit formally established
- One additional staff member allocated by MoH to unit to assist with PMTCT programme
- Analysis of community consultations on health conditions, needs and perceptions being completed by local consultant

Health Sector Reform

- PAHO Workshop on assessing essential health functions held in Jamaica attended by AS and Ag. CMO
 - Hope to conduct evaluation with PAHO assistance before end 2001 or early 2002
 - Evaluation will assist MoHSS to identify weaknesses and strengths and monitor same
- AS and Health Planner attended PAHO workshop on National Health Accounts in Sept 2001

Environmental Health

- CEHO Mr. Boniface Xavier has returned from studies as of October 2001
- US \$20m water and sewerage improvement project is underway in the capital (DOWASCO)
- Need for pit latrines esp in rural areas continues
- Surveillance of foodborne illness is poor at present but efforts will be taken to strengthen same in 2002 following attendance at Epi-Eta meeting in Buenos Aires Sept 2001

Health Systems Development

- PMH IT/IS Plan completed and launched October 2001.
- MoHSS keen on developing integrated plan for the Ministry
- Staff shortage – Statistical Officer on sick leave

Essential Drugs and Medical Supplies

- Essential drugs and medical supplies being maintained at present but major budgetary difficulties with debt at EC \$1.4 m
- 33% of PMH medical supplies budget spent on haemodialysis
- Items accounting for highest expenditure are insulin, anti-hypertensive drugs, oral hypoglycaemic agents and Lactated Ringer's solution

External Health Technical Cooperation and Financing

- 28 Dominicans expected to graduate from Cuban universities in medicine over the next 3 years
- Donation of CT scan (Ms Deikel – installation expected early 2002)
- Brenda Strafford Foundation to assist in construction of Eye Care Centre and the repair of at least one health centre
- 2 vehicles donated by Taiwan – to be purchased soon

External Health Technical Cooperation and Financing

- Donations from Dominicans overseas
- PAHO continues to be the most significant partner in the provision of health care in Dominica
 - We look forward to the discussion of the 2002-2003 HPB

DOMINICA'S HEALTH & FAMILY LIFE EDUCATION EXPERIENCE

INTRODUCTION

- This presentation focuses on Health and Family Life Education (HFLE) in the formal and non-formal education systems in the Commonwealth of Dominica

GENERAL CONTEXT OF THE COUNTRY

- Located in the windward Islands Dominica lies between the 2 French Departments of Martinique and Guadeloupe
- Population 70,444
- Main language English
- Other spoken dialects- patois & kohkoy

- The island is a sovereign democratic republic within the commonwealth
- The government functions at 2 levels- central and local
- Its Parliament consists of the President and the House of Assembly
- The duration of each term of office is five years.

Economics

- GNP per capita (US\$) (1998) 5885
- Annual GDP growth rate (1998) 7.1
- literacy rate 81.2
- National health expenditure per capita (1988) 411.40
- Total health expenditure as % GDP (1995-998) 4.5%
- Total education expenditure as % GDP 1999 5.58%

Education System

- The Education Act II of 1997 governs the administration the 4 levels of island's formal education system:
- Early Childhood Education
- Primary
- Secondary
- Tertiary

HFLE HISTORY

- Prior to the 1980's, hygiene was taught in the schools.
- Early 80 HFLE was introduced in Dominica

WHY HFLE

- Break down in the moral fabric of society
- Deterioration of socio-economic situation with implication for the welfare of children
 - Teenage Pregnancy
 - Drug abuse & Juvenile delinquency
 - Obesity among 0-5 year olds
 - HIV Infection among young people

Planning & Reference Materials

- The following agencies participated in the planning:
- Ministry of Health collaborated with the fertility management unit of UWI, Mona
 - Dominica Planned Parenthood
 - Women's Bureau
- The Caribbean Association of Catholic Teachers

HFLE PROGRAM METHODOLOGY

- The national Health and Family Life Education program is coordinated jointly by the Ministries of Education.
- The program forms part of the education curriculum at pre- primary, primary, secondary and tertiary and teachers training college.
- Several Non-Governmental Agencies manage HFLE program in collaboration with both Ministries.

- There is a National Coordinating Committee that comprises 12 representatives from various governmental and non-governmental agencies.
- This committee functions at national level.
- The program is monitored by the committee

Health Promotion&HFLE

- The HFLE Curriculum consists of: Health promotion concepts and principles; environmental health; Human sexuality that addresses domestic violence and abuse; life skills for drug abuse prevention.
- Food and Nutrition represents a large component of the curriculum.
- A School Feeding Program is being implemented in 7 schools.

- School health services is managed by the department of community health.
- The Family Nurse Practitioner and the Community Health Nurse are jointly responsible
- The dental therapist is responsible for oral health
- Health Promoting School concept is piloted at 1 primary school

Current Situation

- Draft National HFLE Policy not yet endorsed
- National Coordinating committee fosters the development of alliances among HFLE agencies.
- HFLE is mandatory in primary schools, it is required for teacher's certification

- Curriculum review, field tested and is about to be printed
- Manual for teaching Human Sexuality to be field tested
- Resource materials for UNICEF, PAHO, CARICOM and other agencies are used to develop curriculum
- Parents are informed at PTA meetings, HFLE awareness campaigns

EVALUATION

- An evaluation instrument was developed and used to determine students' attitude towards HFLE
- 1999 a structured questionnaire was used to conduct a needs assessment among teachers from 20 primary schools

LESSONS LEARNED

- Some teachers were uncomfortable with certain sensitive aspects of the curriculum.
- HFLE became entrenched in the schools where the principal had a favourable attitude to the subject.
- In schools where HFLE was taught the children were able to talk about their problems openly.

- Incidences of "abuse" were picked up during HFLE sessions at schools.
- collaborative work among the various governmental departments and non-governmental agencies facilitated the implementation of the process

HFLE was currently implemented at the tertiary level, but, the strategies and approaches to the subject needed to be revised to include skills such as counseling, and appropriate attitudes to work.

There was a lack of parenting skills at upper secondary and tertiary schools to help bridge the gap between the homes and schools; and community

FUTURE PLANS

- To make further training for teacher in HFLE mandatory.
- Review of the secondary curriculum guide to be completed to enable the implementation of a more structured program
- To have 2 health promoting schools by 2003 to create opportunities for higher level of sensitization among all schools

- To conduct more motivational Workshop for Principals
- To make necessary administrative arrangements for more teachers with greater competence and interest to teach HFLE



Grenada

*Cecilia Peters, Health and Family Life Education Coordinator/Curriculum Officer,
Ministry of Education*

Alma Smith, Consultant, Community Health Services, Ministry of Health

Health and Family Life Education in Grenada

Background

- Initiated by Ministry of Health (MOH) in 1985
- Ministry of Health held discussions with Conference of Churches, Ministry of Education (MOE) etc. Re: addressing social problems affecting young persons
- Social Trends:
 - Drug use/abuse – STDs – HIV/AIDS – Child abuse
 - Poor parenting – Teen pregnancy
- Several meetings with stake-holders led to a draft syllabus (Primary and Secondary Schools) in Family Life Education (FLE)
- A United Nations Consultant facilitated the development of the draft syllabus which was sent to all Schools and PTA's for feedback and review
- The Syllabus as well as CARICOM Guide For FLE Documents were used to guide the development of a curriculum in FLE schools
- Family Life Education (FLE) Curriculum was piloted in fifteen (15) schools for the year 1989
- 1986 to 1989 - Training done in batches with primary and secondary teachers in FLE (two teachers from each school).

NB. The first batch of trained teachers was used as a writing team to produce the Family Life Education (FLE) Curriculum. Topics are:

- Communication – Counseling – Family and Culture
 - Concepts of HFLE – Crisis Issues – Family Planning
 - Human Reproduction – Human Sexuality – Human Growth and Development
 - Male Responsibility – Myths – Interpersonal Relationship
 - Population Education – Value Issues – Sexually Transmitted Diseases
 - Self-understanding
- A Health Education Syllabus was developed for primary schools at the same time
 - Both Family Life Education and Health Education were taught as separate subjects until the advent of Health and Family Life Education.

1. Health and Family Life Education Program Methodology

a) Management

- An HFLE Coordinator was appointed in 1997
- Subject Coordinators at each school
- A National HFLE Policy endorsed by Cabinet 1998
- An HFLE eighteen (18) member committee established in 1998
- Committee comprises:
 - HFLE Coordinator
 - Health Educators (2)
 - Community Representative
 - Grenada Union of Teachers
 - NGOs (3)
 - T.A. Marryshow Community College
 - Department of Teacher Education
 - Early Childhood Education Department
 - Ministry of Social Services
 - Church Representatives (2)
 - Youth Representatives (2)
 - Food and Nutrition (1)
 - National Parent Teacher Representative
- Terms of Reference in National Policy

b) Health Promotion and Health Education

- Media Awareness Programmes:
 - Radio jingles
 - TV spots
 - TV interviews
 - Radio call-in programmes
- Billboards posted in each parish
- All Primary and Secondary Schools
- PTA Sessions
- In-service Training
 - Staff sessions
 - Workshops for subject leaders
 - NGOs training at community level
 - Community/School linkage (pilot)
 - Teachers' College

c) Nutrition and Health Services

PAM	Programme for Adolescence Mothers
NDRS	National Drug Resistance Secretariat
GFN	Grenada Food and Nutrition
MOH	Ministry of Health (Health Education)
GBS	Grenada Bureau of Standards

Carlton Home

**Ministry of Health & Environment
Grenada**

**Implementing a School Health
Programme**

**Developing the School Health
Programme in Grenada**

Need identified by Community Nursing

**Funding obtained through UNICEF for
implementation**

**Developing a School Health
Programme in Grenada**

The Ministry of Health responded to the need
to implement the programme

Health Education took the lead because of the
Health Educator's training in school health.

Developing the School Health Programme in
Grenada

The programme was piloted for one year in St
Andrew's parish, and an evaluation report
was produced in September 1999.



Guyana

Lorna McPherson, Senior Education Officer, Ministry of Education

Bhagwandai Giddings, Health Education Officer, Ministry of Health

General Context of the Country

Guyana covers 214,970 square kilometers and has an estimated population of 770,000. With a population density of 3.4 persons per square kilometer, it is one of the least densely populated countries in the world. In the 3 major population centers – Georgetown, Linden and New Amsterdam, population density can rise to about 5,000 persons per km². On the other hand, in areas such as the Rupununi, density could be lower than one person per 10 km². The reason for this is that over 90% of the population live on the small coastal area, which comprises less than 10% of the landmass.

In addition 10% of Guyana is natural waterways. The 3 main rivers (Berbice, Demerara and Essequibo) and the network of secondary rivers, creeks, canals and streams together with the extensive and dense forests and mountains have a profound impact on the volume and speed of movement around the country and hence the distribution of population.

For purposes of administration the country is divided into ten administrative regions with a chairman as the local head of each region.

Guyana's DC Sugar is used in many parts of the world, and along with Rice and Bauxite is our main foreign exchange earner. Our gold and tasty fresh water fish, and our durable hardwoods such as Greenheart are among the best in the world and contribute to bringing in some portion of our earnings.

Culturally, Guyana is rich in heritage with six ethnic groups making up the populace, the two largest groups being those of East Indian and African origins. The cuisine is therefore varied and rich with contributions from all the ethnic groups, these ranges from the indigenous pepper pot and cassava bread, to Indian roti and curry, Chinese fried rice and chowmein, and African conky and cook-up rice which dates back to days of slavery.

Education

Guyana's Education system is divided into eleven administrative education districts, ten of these correspond with the 10 administrative regions of Guyana while Georgetown the capital is treated as a separate education district. The education system comprise institutions of the following levels and type: - nursery, primary, secondary, technical and vocational, Teacher Training and University, in addition to special schools for children who are disabled and those living in difficult circumstances. The Adult Education Association and the Institute of Distance and continuing education (an arm of the University of Guyana) provide continuing education.

The total number of Schools for the year 2000 stands at one thousand, three hundred and thirty one spread out over the entire country and varying from a primary grade A+ school in Georgetown with over one thousand students to a grade E school in Region 8 with under one hundred.

The Education system is plagued with numerous difficulties, the attrition rate of teachers is high, and schools find themselves in crises at the beginning of every term. Usually it is the better-trained teacher who leaves to more lucrative positions. The social and economic conditions under which many children live present major challenges for the school system with resources limited as they are. Former support mechanisms such as the church and the extended family are not functioning as they used to while new and old threats such as HIV/AIDS and Drug Abuse leave children vulnerable and victims.

1. Health and Family Life Education Program in Guyana

Introduction

Taking the lead from the experts at the global and regional levels, the prevailing social, economic conditions, layman and professional views about the state and future of our children Guyana embarked, albeit slowly on the path of the Regional HFLE Process. The process of sensitizing, convincing stakeholders of the benefits of this approach was an uphill battle and even now persons are still unsure about the “how” and if indeed it will work.

For those of us who visualize HFLE operating in our schools, homes, and communities we see it as eventually replacing the growing number of vertical programs which overload our system and do not work. Despite all efforts, many of our children and youth are still poor problem solvers, fail to relate well with parents and teachers (in fact the generation gap is widening), fall prey to negative peer pressure and are unable to resolve conflicts in amicable ways. Then there is HIV/AIDS.

History

A number of organizations came together in 1997 and launched a series of activities that resulted in heightened awareness of stakeholders and brought modest successes to the program.

Activities such as the National Consultation (97) Policy Formulation Forum ('98); and the Seminar/Workshop for Decision Makers ('99) provided awareness of the CARICOM Multi-Agency HFLE Project; involved agencies working in and in support of HFLE which increased participation; provided opportunity to discuss issues of import to our nation and gave recommendations for and discussions about the value of having a policy for HFLE.

Committees and Teams were formed ('98) to move the process of Policy formulation and Training of facilitators. Policy formulation committee members remember fondly the many breakfast meetings at 6:30 in the morning at which time many issues were dealt with resulting in a Draft Policy Document. The committee also assumed an advisory role and provided guidance on how to proceed with the country program.

The HFLE Country Team of facilitators and the National Team of Facilitators were formed after two representatives participated in the Teacher Training Strategy Phase 1 &2 in Jamaica and Guyana. These teams total fifty functionaries from five of the more populated regions of the country and the four participating sectors.

The Country Team of Facilitators produced a program which detailed activities relating to sensitizing key policy and other officials, teacher training (including life skills training for teachers) and development of Curriculum guides and other materials for schools. They also organize sensitization activities for head teachers and other stakeholders in their respective regions.

A Working Group was established (2000) with the intention of developing a “handbook” for teachers but this group evolved into a coordinating body for developing curriculum guides for schools. Membership for this group includes; a representative from MOH, Human Rights Association, Moral Education Committee, Secondary Schools Reform Project and Spear-headed by the Curriculum Development Unit. The group having reviewed all available materials and related programs recommended that Citizenship be included in the content and to be now named “*Life-Skills Based: HFLE/Citizenship Program*” The group also pulled together the modules of all related programs (an attempt to present a single comprehensive life-skills based program), eliminated repetitions and prepared an outline to guide curriculum writers.

2. Health and Family Life Education Program Methodology

Collaboration between the Ministry of Health and Ministry of Education has been a hallmark of the HFLE program in Guyana. The program was first introduced and coordinated by the MOH. Membership for committees and teams came from the four participating sectors and NGO'S. Training was done by the multiplier method.

3. Nutrition and Health Services

- School Health monitoring and education in the mandate of Health Clinics
- Immunization cards are required for entry into all nursery, primary and secondary schools and teachers trained to recognize when a child lacks coverage
- A School feeding programme operates in some schools and in its absence low cost meals are provided in canteen services at the schools. Milk and biscuits are supplied to children daily at all primary and nursery schools.
- The MOH supported by PAHO recently launched another healthy nutrition program as part of the health-promoting schools venture. The program is being piloted from November 2001 to April 2002 in the Matthews Ridge Primary and Nursery Schools. 340 Children are given nutritious meals twice weekly. Meals are prepared by volunteers. Efforts are also being made to ensure that the school-feeding programme becomes self-sustainable and that meals can be provided everyday.
- Adolescent Health Initiatives: The MOH have Adolescent Health programs in various regions. The aim of these programs is to provide support out of school youth and provide opportunities to develop life coping skills.

A pilot project to establish wellness centres in the less developed parts of the country is also underway. One such centre is located in New Amsterdam, Barbice. It aims to provide a safe place where young people can go to develop skills, access health information and services, Remedial education; Career Guidance; Opportunity for personal growth through Life skills Courses and fitness based activities.

4. Current Situation and Future Plans of the Health and Family Life Education Program

- a. **Policy:** The policy document is under review after which it will be submitted to the Minister of Education to present to Parliament. Parts of the document will also be published in the widely circulated Sunday's Newspapers.
- b. **School Level Teacher Training:** The whole school approach to training will commence in august 2002.
- c. **Pre- and In-Service Teacher Training:** Two tutors participated in training program at the school of Education in Barbados earlier this year. Orientation sessions have since been held for tutors of the pre and in service colleges, including those operating in the outlying areas. The HFLE Curriculum module is now under review to make it more comprehensive.
- d. **Establishment of Regional Teams:** Teams will be established in regions 2, 3, 4, 6 and 10. These were identified as the regions to receive training in the first phase of the program. These teams will function to plan community and school level activities
- e. **Curriculum:** Curriculum writers have been identified and the writing of the guides will be launched earlier this month. A series of workshops each month will bring the writers together to confer on units written. Curriculum guides are expected to be completed and accepted in the system in time to be used in the training of the school staff.
- f. **Health-promoting Schools:** Twelve pilot schools in the Secondary Schools Reform Project have been totally refurbished, and the school program reviewed in an effort to upgrade and provide schooling to meet the needs of the children. As part of this general improvement, collaboration between MOH and the SSRP will provide information and guidance to schools. A Healthy Schools competition is planned from January to April 2002;
- g. Career Guidance
- h. Student Government:
- i. Non-Academic Norms
- j. Environmental Clubs

HEALTH AND FAMILY LIFE EDUCATION

SCHOOL HEALTH IN GUYANA
COUNTRY EXPERIENCES
(Ministry of Education and
Ministry of Health)

Introduction - General Description of the Country

- Size: 214,970 Square kilometers
- Estimated Population: Year 2000 - 770, 000
- Population Density: Coastal- 5, 000 persons per sq. km Hinterland –Lower than one person per sq. km
- Problems of size and distance, transportation.

Education

- Eleven (11) School Districts
- Total no. Schools- 1, 331
- Nursery – 462 *Tech/Voc- 21
- Primary – 433 *Special- 7
- Secondary Dept. Primary- 305
- Community High- 33
- General Secondary- 70

Health and Family Life /Citizenship Education

- National Consultation ('97)
- Policy Formulation Forum ('98)
- Sensitization of Education Systems Committee
- Seminar Workshop for Decision-Makers

Committee/Teams working in HFLE

- Policy Formulation Committee
- Country Team of Facilitators (12)Nat. level
- National Team of Facilitators (40)Reg. Level from five regions
- Curriculum Working Group (6)
- Curriculum Writers (30)

Nutrition and Health Services

- School Health Monitoring
- Immunization
- School Feeding
- Adolescent Health
- Student Government
- Career Guidance

Current Situation and Future Plans

- Policy
- Teacher Training
- Establish Regional Teams
- Curriculum Guides / Learning Materials
- Health Promoting Schools
- Career Guidance and Student Government



Jamaica

Monica Holness, Senior Education Officer, Ministry of Education, Youth and Culture

Overview

This paper highlights issues and activities relating to the history and status of Health and Family Life Education (HFLE) in Jamaica against the social and economic realities of the island. It also addresses our present situation with respect to HFLE, the lessons learned from our experience and our vision of the way forward in achieving our set goals.

General Context of Jamaica

Jamaica, the largest English-speaking Caribbean Island and the third largest island of the Greater Antilles of the West Indies, is situated south of Cuba with an area of 4411 sq. miles (10,991 sq. km.). Kingston, the capital, is the largest city and is also a large commercial seaport.

Land and Resources

The terrain is mountainous, except for several tracts of low land in the south. The principal mountain range is the Blue Mountain in the east, (noted for its famous Blue Mountain Coffee), with its highest point at 7,402 feet/2,256 metres). The 1,020 km of coastline is irregular, particularly in the south and there are a number of excellent natural harbours, including Montego Bay, St. Ann's Bay and Lucea.

Tropical climatic conditions prevail in the coastal lowlands of Jamaica. The mean annual temperature in this region is 27° C but on the plateau and mountain areas, the temperature averages 22° C and below. The annual precipitation is characterized by wide regional variations. More than 5,100 mm of rain is deposited annually in the mountainous areas of the northeast while in the vicinity of Kingston, the annual average is 810 mm. The months of maximum precipitation are May, June, October and November.

Mineral deposits in Jamaica include gypsum, lead and salt. The bauxite deposits in the central section of the island are among the richest in the world. Jamaica has a high degree of biodiversity. Over 3,000 species of plants grow on the island and 27% of them are found nowhere else on Earth. Among indigenous trees are the cedar, blue mahoe (national tree), mahogany, logwood, rosewood, ebony palmetto palm and pimento (allspice). The animal life includes a highly diversified bird life including an abundance of parrots, hummingbirds and cuckoos.

With respect to environmental issues, Jamaica has a protected area comprised of forest reserves, nature protection areas and parks. However, the monitoring agency is sometimes plagued with lack of resources leading to undetected violations of these protected areas. Also the absence of a clear environmental policy coupled with a growing population has brought

Country Presentations

about an ecological deterioration of the island. Soil erosion is common and some coastal waters are polluted with industrial waste, sewage and oil spills. Safe drinking water is generally available and automobile traffic in Kingston causes air pollution. Government policy encourages conversion of 'idle' land into fields and pastures.

Jamaica is party to several regional agreements on conservation of marine resources and combating oil pollution in the Caribbean Sea. It ratified the World Heritage Convention in 1983.

Population Issues

The population of Jamaica is primarily of African or mixed African-European origin, descended from slaves brought to the island between the 17th and 19th centuries. Among the established minorities are East Indians, Europeans and Chinese. About half the population lives in rural areas. The population of Jamaica (2001 estimate) was 2,665,636, giving the country an overall population density of 243 persons per sq. km.

Jamaica is divided into 14 parishes. Of these, 12 parishes are administered by popularly elected councils, and the remaining parishes are administered by elected commissions. The major cities/towns are Kingston, Montego Bay, Mandeville and Spanish Town.

English is the official language, although many Jamaicans speak a local dialect of English that incorporates African, Spanish and French elements. Among the Christian majority, the major denominations are Catholics, Anglican, Church of God, Seventh-day Adventists and Pentecostals. Several well-established Jewish, Muslim and Hindu communities exist. A number of popular sects such as Rastafarians are a significant and famous feature of the national religious life.

School attendance by children between the ages of 6 and 11 is nearly universal, and 70.9 percent of all 12 – 18 year olds attend secondary institutions. In 1996, the enrollment in primary schools was 293,900. A major institution of higher learning for the Caribbean Region is the University of the West Indies, Mona Campus located in Kingston. There are two other universities, Northern Caribbean University and the University of Technology, together with a number of vocational and technical schools, and teacher-training colleges offering tertiary level education.

Economy

The economy of Jamaica is primarily agricultural, but gains in mining, manufacturing and tourism have diversified the economy. In 1999, GDP was \$6.89 billion, or about \$2,650 per capita. Some 21% of the total Jamaican labour force are engaged in agricultural production. The chief crop is sugarcane; the harvest in 2000 was 2.5 million metric tons. Other leading agricultural products are bananas, citrus fruits, tobacco, cocoa, coffee, coconuts, corn, peppers, ginger, mangoes, potatoes and arrow root. Jamaica grows nearly the entire world supply of allspice.

The main foreign exchange earners are alumina, bauxite, sugar, rum, clothing and coffee and music (Reggae). Presently, international events and disasters have affected our foreign exchange earnings, bringing pressure on the local currency. The unit of currency is the dollar, consisting of 100 cents (46.00 dollars equal U.S.\$1 – 2001 average).

In 1998, Jamaica had 19,000 km of roads. Numerous international airlines and Air Jamaica serve the island, and internal flights are provided by Trans-Jamaican Airlines.

Government

The Jamaican constitution, promulgated in 1962, established a parliamentary system of government patterned after that of Britain. The Prime Minister is head of government. The British monarch is the head of state and is represented by a governor-general, who is appointed on the advice of the Prime Minister.

Executive power in Jamaica is vested in a cabinet consisting of 20 ministers and is headed by the Prime Minister. The Prime Minister is the leader of the majority party and is appointed from the House of Representatives by the governor-general. The Prime Minister appoints the ministers of the cabinet.

Jamaica has a two-party political system. The People's National Party (PNP) is socialist in orientation, and the Jamaica Labour Party (JLP) supports free enterprise in a mixed economy.

Legislative authority is vested in the bicameral Parliament. The 60 members of the House of Representatives are popularly elected to terms of up to five years. The 21 members of the Senate are appointed by the governor-general, 13 in accordance with suggestions by the Prime Minister, and the remaining 8 on the advice of the leader of the minority party.

The legal and judicial system is based on English common law and practice. The judicature comprises the Supreme Court, a court of appeals, resident magistrate courts and petty session courts.

History

Members of the Tainos (previously called Arawaks) tribe, a group of Native North American Indians, were the aboriginal inhabitants of Jamaica (the Arawakan word Xaymaca, meaning "isle of springs"). Christopher Columbus sighted the island during his second voyage, and it became a Spanish colony in 1509. Saint Jago de la Vega (now Spanish Town), the first settlement and, for the ensuing 350 years, the capital, was founded about 1523. Colonization was slow under Spanish rule. The Tainos quickly died out as a result of harsh treatment and diseases. African slaves were imported to overcome the resultant labour shortage. Jamaica was captured by the English naval force in 1655 and the ensuing rapid expansion of the sugar industry led to large-scale importation of black slaves from Africa.

After abolition of slavery in 1834, large numbers of freed blacks abandoned the plantations following emancipation and took possession of unoccupied lands in the interior, gravely disrupting the economy. After many insurrections and rebellions and struggles, Jamaica gained independence from Britain in 1962 and Sir Alexander Bustamante (JLP) became the first Prime Minister. The present Prime Minister is Percival James Patterson (PNP) who won a third term in the 1997 elections.

Family Life (FLE) Programme Developed by the Ministry of Education Youth & Culture in Jamaica

Between 1983 and 1987, the Ministry of Education, Youth and Culture (MOEY&C) in collaboration with the National Family Planning Board and the USAID, developed and piloted a Family Life Education Project in the public schools in Jamaica. The project targeted grades 1-6 and grades 7-11.

Activities of the Project:

The project activities included the development of resource materials such as:

- FLE source books for teachers
- FLE Curriculum for grades 1-6
- FLE curriculum for grades 7-11
- FLE handbook of lesson plans
- The Facts of Life (Student material)
- My Body and Me (Student material)
- The Family

HFLE Curriculum - Grades 1-6

The curriculum guide was designed to assist teachers in dealing with some of the concepts, themes, objectives and content in Family Life Education at the primary level of the school system. The material was not intended to be used slavishly by the teacher, but was intended as a guide in the preparation of instructions in FLE. The material was developed in scope and sequence format, which provided for more depth in the treatment of the topics as the lessons are taught at the different grade levels.

Topics addressed for grades 1-3 were as follows:

- The family
- Self awareness/self realization
- Social skills
- Personal and family health
- Safety
- Human sexuality
- Reproduction

Topics addressed for grades 4-6 were:

- The family
- Self realization

- Communication
- Social skills
- Health
- Safety
- Human sexuality
- Reproduction
- Nutritional health
- Consumer education
- Substance/drug abuse
- Disaster preparedness

Grades 7-11 Curriculum

The grades 7-11 curriculum manual was designed to assist teachers in dealing with some of the main objectives, concepts and generalizations in FLE at the secondary school level. Implicit in the teaching is the concept of helping students by stimulating and guiding their efforts, thereby helping them to clarify their values and develop positive attitudes towards themselves, their families and their society. Topics included:

- The family
- Communication
- Social development
- Personal development
- Physical development
- Emotional development
- Preparation for family life
- Health and nutrition
- Contraceptive education
- Population education
- Consumer education
- Cancer education

The Child Health Education & Development (CHED) Project

This began in 1991 and was a major HFLE initiative for grades 1-6 in the primary schools. This was a collaborative effort among the Ministries of Health and Education and UNICEF, the sponsor. This project utilized the entry points in the existing curriculum to develop health education themes and issues. Thirty-two (32) schools in five parishes were included in the introductory phase of the programme.

Country Presentations

The CHED programme was knowledge-based and revolved around five core areas:

- Personal Health and Hygiene (disease prevention)
- Food and Nutrition
- Environmental Health
- Accident Prevention and Safety
- Growth and Development

The CHED curriculum was supported by teacher's manuals for each grade, student's workbooks (grades 1-6) and a "Health Jamboree" which was a resource book with health related songs, poems, cartoons and stories.

Some skills development was encouraged in children, namely; hand washing, making water safe and personal health and safety. Some positive spin-offs from the CHED programme included school gardens, breakfast and lunch programmes, clean-up campaigns and sanitation clubs.

Teachers were trained at workshops conducted by the Ministry of Health to infuse health information and skills into the lessons and also how to use non-formal settings like exhibitions and contests to facilitate the dissemination of the health message. At least one classroom in 508 schools (70% of the 799 primary and junior high schools) participated in the programme and the project ended in 1999.

Final evaluation of the CHED programme revealed that there were gaps in the programme, that the environment was not supportive, that some skills could not be practiced (due to absence of water, poor latrines, no feeding programme, etc.) and that CHED only addressed the needs of grades 1-6. It was therefore recommended that instead of trying to extend CHED to 100% of primary and junior high schools, the MOEY&C should adopt the programme and fully integrate it into the curriculum and also to extend it to grades 7-11.

GOJ/USAID – Family Life Education Curriculum Development Sub-Project

While CHED was being implemented, other HFLE programmes or related projects were being implemented concurrently. In 1996, the MOEY&C, through funding from USAID, initiated the FLE Curriculum Development Sub-project as part of the Family Planning Initiative Project (FPIP). The project was committed to the following:

1. The development and conduct of baseline research in FLE in Primary & All-Age schools.
2. Development of a scope and sequence and a revised curriculum for grades 1-6 and grades 7-9 respectively.
3. Development of prototype materials for students & teachers in support of the scope and sequence and the revised curriculum.

The goals of the programme were:

1. The development of the kind of person who sees him/herself as worthy, responsible members of society, who plan their lives and take decisions that contribute to their well-being and that of their families.
2. The development among persons an understanding of the implications of population changes for themselves as individuals, as members of a family and the society. He/she

should understand the effect of these changes on sectors such as health, education, agriculture and labour.

3. The fostering of conditions that strengthen the family's socialization function, especially in the transmission of values, attitudes and cultural identity, highlighting the importance of affection, a sense of belonging and respect of family members for one another.
4. The reduction of the susceptibility of adolescents to sexual abuse and exploitation.

Objectives

The objectives were to:

1. Develop among children, their parents and other members of the community a better understanding of the contribution of HFLE to the attainment of the goals of the Jamaican society.
2. Assist individuals to develop a more complete understanding of themselves in relation to their families, communities and their environment.
3. Enable persons to understand themselves as socially and sexually responsible beings.
4. Expose persons of all development stages and all life conditions to the values, attitudes and skills, which will help them to develop as individuals.

The Revised Scope and Sequence (Grades 1-6)

The broadened Health and Family Life Education Scope and Sequences for grades 1-6 is designed to assist the teacher to understand the process for the delivery of HFLE in the normal teaching/learning situation. The aim therefore is to include these social and health issues in the curriculum at the primary level. This will be facilitated through the training of teachers in the infusion and integration methodologies and to reinforce the linkages between the home, school and community.

The Themes:

Five themes are used throughout the grades 1-6 with appropriate objectives. These are:

1. Self-development – a Goal in Life (objective to introduce self development as a goal in life.)
2. Values for Growth and Development (objective to help students become aware of the importance of values for growth and development)
3. Interaction for Social Development (objective to enable students to understand the importance of interaction for social growth and development)
4. Positive Choices for Growth & Development (objective to enable students to develop skills necessary for making positive choices.
5. Healthy Lifestyle for Growth and Development (objective to encourage the students to develop healthy lifestyles for growth and development).

Country Presentations

The Child Health and Education materials (CHED) were used extensively in the revision of the grades 1-6 Scope and Sequence. Students' and teacher's materials from the 'Jamboree' series were recommended as resource materials for use in the delivery of the subject.

HFLE Curriculum Grades 7-9

In keeping with the agreement achieved at a meeting of Health Ministers of the CARICOM region in 1993 as well as the global approach, the focus of the grades 7-9 curriculum has been broadened to include benefits of health promotion, with the understanding that health relates to social, cultural, mental, physical, psychological, economic and environmental aspects of the individual. This is reflected in the name of the curriculum "**Health and Family Life Curriculum.**" It was recognized that health promotion cannot be the sole responsibility of the school; there must be greater collaboration between, home, school and community. The inclusion of activities that encourage the child to do research at home and in the community will facilitate this collaboration.

Then seven themes addressed by the grades 7-9 curriculum are as follows:

1. Family – The Ties That Binds
2. Relationship – Bridging The Gap
3. Community Service – In Service of Others
4. Personal Development – Realizing Potential
5. Gender Issues and Human Sexuality – Harmonization of The Sexes
6. Career – The World of Work
7. Parents – The Society's Building Blocks

Core Curriculum Guide – Grades 1-6

The recent revision of the core curriculum guides for the school system embraced the infusion of HFLE content into the various curricula areas. This will facilitate the teaching of the subject by the classroom teacher.

Other Ministry of Education Youth & Culture projects which provided specific areas of the HFLE delivery include:

- **Prevention Education Programme (PEP)** – This is a substance/drug abuse programme in collaboration with National Council on Drug Abuse.
- **HIV/AIDS Education** (WHO/UNESCO – 1991 – 93)
- **HIV/AIDS Education** (GOJ/UNDP – 1994 – 97)
- **Reduction of Teenage Pregnancy** (1995 – 97)
- **Parenting Education** (UNICEF 1995 – 97)
- **Peace and Love in Schools (PALS)** – A private sector initiative focusing on conflict resolution/prevention of violence.

- **National Guidance Curriculum** (Grades 7 – 9) 2001
- **The New Horizon for Primary Schools (GOJ/USAID)** – This is an innumeracy and literacy programme with a health component. Out of this programme five schools in Kingston established breakfast programmes where parents come in to cook the meal and also participate in raising funds to sustain the school programme.
- **The Jamaica All-Age Schools Project (JAASP)** – GOJ/DFID
- **Teen Camps** – Annual ‘Teens are Terrific’ camps are held to equip youngsters with life skills and prepare them to be peer counselors and role models in their secondary schools.
- **Environmental Health Education spearheaded by the Ministry of Health** – This utilizes a video produced by the Environmental Health Unit in collaboration with P.A.H.O. The video focuses on the various aspects of the healthy school environment, for example, excrta disposal, refuse management and food hygiene and through skits and poster competitions impress on the young minds the importance of practicing good personal and environmental hygiene.
- **YOUTH NOW** – A Future’s project addressing the mental, physical, social and emotional issues of adolescents. A magazine, Youth Rising, which can serve as resource materials for teenagers, was also produced.

School Environmental Health programmes

1. Ministry of Health and PAHO have worked together on a number of projects to improve water supply and improve sanitary facilities in a number of schools islandwide.
2. Private Sector Agencies and NGOs, e.g., Food For The Poor, providing desks and chairs for students.
3. Community Health Committees initiated by Health education Officers and Environmental Health Officers, address various environmental health problems in schools, for example, painting of buildings, repairs and erection of buildings, building and repairing toilets, improving canteen facilities, planning and implementing refuse cleanup campaigns and beautification projects.
4. School garden projects undertaken by some schools, which in some cases, provide vegetables for the canteen and excess produce is sold as a means of sustaining the project.

School Health Services

1. School dental health programme – implemented by the dental auxiliaries. Dental clinics are present in every parish and dental nurses visit these schools annually to do dental examinations. Students are referred for treatment to the nearest dental clinic for fillings, extractions and any other intervention that may be required.
2. Immunization – this is carried out by the nursing staff at the health centers. All students entering pre-primary, primary, secondary and some tertiary institutions are mandated to be fully immunized before registration. Students go to the health center for this service but nurses visit schools to do checks and to immunize during campaigns, e.g. measles campaign.

Country Presentations

3. Environmental Health services – All schools are inspected annually by the public health department officials and recommendations for improvements are made to the school's administration.
4. School Feeding Programme in Pre-Primary and Primary Schools – government provides nutribuns and milk for each child daily, to all schools participating in the programme.
5. Blue Cross of Jamaica does health screening in some secondary schools
6. Some schools have school nurses and those that are without refer students to the nearest health center or hospital.

Current Situation, Lessons Learned, Future Plans, and Felt Needs

This section of the presentation will address the current situation of HFLE programmes in Jamaica, including lessons learnt, future plans and felt needs.

The Development of a National HFLE Policy Document

The Ministry of Education, Youth and Culture recognized the need for standardized delivery modes in the teaching of Health and Family Life Education, coupled with a duplication of effort among the various interest groups competing to teach the subject. From all indications, the articulation of a national policy was necessary and timely. Hence, in 1994, a policy formulating committee was named and assigned the task of developing a Statement of National Policy for Health and Family Life in Jamaica. The several interest groups competing for slots in the curriculum, and the various claims on the available resources provided reasons to document a policy to guide future developments.

Goal of the Policy

The goal of the policy is to ensure a more systematic and effective development and implementation of HFLE by institutionalizing the mechanisms for strengthening and facilitating HFLE in the formal and non-formal sectors.

The Objectives of the Policy

1. Promote among children, their parents and other members of the community a better understanding of the contribution of HFLE to the attainment of our social goals.
2. Promote HFLE as a proactive concept, capable of empowering individuals to regard themselves as worthwhile and responsible, capable of contributing to the development of self, community and country.
3. Provide guidelines for the standard delivery of HFLE in the formal system.
4. Provide guidelines for the revision and development of HFLE materials for the formal and non-formal sectors.
5. Suggest mechanisms for strengthening collaboration between the government and non-government agencies, which traditionally participate in HFLE programmes and encourage new players in the field.

Procedure for Formulating the Policy

1. Formulation of the policy has been approached in a systematic manner. The steps included:
2. Establishing the HFLE Coordinating Committee. This was an inter-agency committee representing both government and non-government organizations.
3. Gathering information on the perceptions and status of HFLE in government and non-government organizations.
4. Establishing terms of reference for the policy by the committee.
5. Drafting the policy, informed by a situational analysis, made possible by technical assistance available to the NFPB, using USAID funds.
6. Presentation by the consultant of the draft to representatives of key agencies such as National Family Planning Board (NFPB), The Fertility Management Unit, Planning Institute of Jamaica, Epidemiology Unit, Coalition for Better Parenting, USAID, UNESCO, and UNFPA in a round table discussion.
7. Amendments by consultant, informed by the outcomes of the discussion.
8. Presentation by National Family Planning Board of draft to the Ministry of Education, Youth and Culture and other key representatives of the committee for approval.
9. Refinement of the policy by MOEY&C, as agreed with the NFPB and other committee representatives.

Coordinating Mechanism

The activities of the HFLE programme in both the formal and informal sectors would be monitored at three levels; the Interagency Committee and two sub-committees, one each to monitor the formal and non-formal sectors.

Interagency Committee – This committee would monitor the implementation of the national policy and advise the respective agencies on the development and delivery of HFLE in the formal and non-formal sectors.

Sub-committee for the formal sector – This committee will be chaired by Deputy Chief Education Officer of the Ministry of Education Youth and Culture and seeks to:

- Collaborate with the Joint Board of Teacher Education to devise a strategy to co-ordinate the sector.
- Inform the programme by a current research base
- Promote the use of innovative strategies to foster positive, healthy and responsible behaviour among students

Membership to this committee include:

- MOEY&C
- JTA
- Teacher College
- The Nursing Council

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- Coalition for Better Parenting
- PIOJ
- UWI Department

Sub-Committee for the Non-formal Sector – This committee is chaired by the NFPB and consists of the following agencies:

- NFPB
- Joint Trade Union Research Development Council
- Health Promotion and Education
- Bureau of Women Affairs
- Parent Groups
- Male Groups
- NGOs
- Churches
- Planning Institute of Jamaica
- Private Sector

Elaboration of Educational Material

Several educational materials to support the HFLE programme were developed and distributed in schools. Some of these include:

- The Facts of Life
- My Body and Me
- The Family
- Source Book for Teachers
- Handbook of Lesson Plans
- Curriculum – Grades 1-6
- Curriculum – Grades 7-11

Other supporting materials developed by the unit since 1983 include:

- Prevention Education Programme Booklets
- HIV/AIDS Education Material
- Parenting Education
- PALS
- Revitalization of Parent Teachers' Association
- Baseline Research
- Revised Scope and Sequence

- Revised HFLE Curriculum
- Prototype HFLE Student material
- The National Guidance and Counseling Curriculum
- Career Education Material (Reform of Secondary Education Programme)

Distribution

Distribution and adequate recording of materials given to schools can present a challenge. Material distribution is done via four routes:

1. Presentations made to participants at workshops
2. Requests made at Regional Offices
3. Walk-in distribution at Central Office
4. Packages mailed to schools.

Surveillance and Monitoring

The HFLE programme is monitored at four levels. This provides very useful information as to the deficiencies in delivery and strengths of the programme. Monitoring is done through:

1. Feedback /checks done by Territorial Officers
2. Monitoring and clinical visits done by Unit Officers and other officers in Health Education
3. Monthly case conferences held in-house
4. Collaborative visits done with external interest groups.

Training of Teaching Staff

The training of personnel to teach HFLE can take several routes, resulting in various levels of preparation:

1. Several institutions are now engaged in counselor preparation at the certificate and degree levels, e.g., Mico & Sam Sharpe Teachers Colleges and the Jamaica Theological Seminary.
2. In most teachers training institutions, the personal development slot in the timetable is used to teach HFLE.
3. The Fertility Management Unit in collaboration with the CARICOM Multi-Agency Project is committed to the strengthening of HFLE in Teachers colleges.
4. The Guidance and Counseling Unit continues to offer in-service training of teachers in HFLE. These workshops are conducted island wide.

Evaluation

A baseline study of the HFLE programme was conducted in 1998, targeting the following areas:

1. Delivery status of HFLE

Country Presentations

2. Adequacy (quality/quantity) of materials
3. Delivery personnel for HFLE
4. Institutional Organization (delivery, effectiveness)

The study consisted of three components:

1. A survey (modified version of the CARICOM multi-agency HFLE Needs Assessment Instrument))
2. Focus group discussions
3. Interviews

The following findings were reported from the study:

1. HFLE was being delivered by teachers and guidance counselors
2. Guidance counselors and teachers reported deficiency in dealing with sexuality
3. Infusion strategy was the methodology most widely used.


Lessons Learned

1. Programme must be sustained to ensure continued success.
2. Efforts are fragmented, so there is need for co-ordination and integration to avoid duplication of efforts and resources.
3. There is need for more community involvement to protect schools from vandalism.
4. The National HFLE policy needs to be fully implemented and embraced by all concerned.
5. There needs to be strengthening of the National Advisory (Interagency) Committee.

Future Plans and Felt Needs

1. Guidance and counseling services should be provided to all schools.
2. The HFLE programme should be extended to the Early Childhood level of the education system.
3. A creative strategy for teaching sexuality should be embraced (ASHE – performing arts group)
4. HFLE student materials should be reproduced and made available to all schools.
5. A National Advisory Committee should be established with members from the Ministry of Health.
6. The programme at the Teacher's college level should be supported and strengthened.
7. The in-service training of teachers and counselors to be strengthened.

CURRENT SITUATION OF HFLE PROGRAMME IN JAMAICA



- To include:
 - Lessons Learned
 - Future plans & Felt Needs

Presented by: Maxica Helms
Senior Education Officer
Guidance & Counselling Unit
Ministry of Education, Y & C.

CURRENT SITUATION OF HFLE PROGRAMME



POLICY DEVELOPMENT

- A Statement of National Policy for Health & Family Life Education was developed in Jamaica in 1994

GOAL OF THE POLICY

- To ensure more systematic and effective development and implementation of HFLE by institutionalizing the mechanisms for strengthening and facilitating HFLE in the formal and non-formal sectors

OBJECTIVES

1. To promote among children their parents and the community a better understanding of the contribution of HFLE to attainment of our social goals
2. To promote HFLE as a proactive concept capable of empowering individuals to regard themselves as worthwhile and responsible capable of contributing to the development of self
3. To provide guidelines for revision and development of HFLE materials for the formal and non-formal sectors.
4. To suggest mechanism for strengthening collaboration between the government and non-government agencies and to encourage new players in the field.

PROCEDURE FOR POLICY DEVELOPMENT

STEPS :

1. Establishment of HFLE Policy Formulating Committee: 1992 (Government & Non-government organizations)
2. Information gathering - perception and status of HFLE in Jamaica
3. Establishing Terms of Reference
4. Drafting Policy
5. Presentation of draft in round-table discussion

CONT'D

6. Amendment by consultant
7. Presentation by NFPB to MOEY&C
8. Refinement of Policy
9. Printing and distribution

Country Presentations



- ### Agencies in the Formal Sector
1. MOEY&C
 2. JTA
 3. Teachers Colleges
 4. The Nursing Council
 5. Coalition for Better Parenting
 6. PIOJ - Education Desk
 7. UWI - Department

- ### Agencies in the Non-formal sector
8. NFFB
 9. Bureau of Health Education
 10. Bureau of Women's Affairs
 11. Churches
 12. Youth Groups
 13. Parent Groups
 14. NGO's
 15. Media
 16. Private Sector
 17. Jamaica Constabulary Force
 18. Male Groups
 19. PIOJ

- ### IMPLEMENTATION OF ACTIVITIES
- At the school level:
- workshops planned & conducted by MOEY&C
 - workshop participants ensure that HFLC is infused in the relevant subject areas
 - Health educators conduct training of teachers in the infusion of HFLC into the curriculum
 - CHED provides for the reproduction of educational materials at the parish level. These supplement the MOEY&C programme
 - monitoring visits done to determine the status of the programme in schools (MOEY&C and MCH)

- ### ELABORATION OF EDUCATIONAL MATERIAL
- HFLC MATERIALS DEVELOPED: 1983-87
- The Facts of Life
 - My body & Me
 - The Family
 - Source Books for Teachers
 - Handbook of Lesson Plans
 - Curriculum (Grades 1-6)
 - Curriculum (Grades 7 - 11)

- ### HFLC MATERIALS DEVELOPED THROUGH OTHER PROJECTS:
- Prevention Education Programme (1985-87)
 - HIV/AIDS Education (WHO/UNESCO:1991-1993)
 - HIV/AIDS Education (GOJ/UNDP:1994-1997)
 - Reduction of Teenage Pregnancy (1994-1996)
 - Parenting Education (UNICEF: 1995-1997)
 - Peace And Love in Schools (PALIS)

HFLE MATERIALS DEVELOPED (1998):

- Baseline Research
- Scope and Sequence -Grades 1-6
- Scope and Sequence -Grades 7-9
- Prototype material to support curriculum

CONT'D

Distribution is done via one of four (4) routes:

- Presentation to workshop participants
- Sent to regional offices for distribution
- Walk-in distribution at central office
- Packages mailed to schools

SURVEILLANCE AND MONITORING

The programme is monitored at four levels:

- Feedback/checks done by Territorial Officers
- Monitoring & clinical visits done by Unit Officers & Health Educators
- Monthly Case Conferences held in- house
- Collaborative visits done with external interest groups

TRAINING OF TEACHING STAFF:

- FNU/UWI (Certificate, Diploma, Degree)
- Institutions in Counselor preparation (Mico, San Shupe)
- Other Teacher Training Institutions -through PD sessions
- Caricom Multi-agency Project to strength HFLE in Teachers Colleges (Mico)
- In-service Training (MOEY & C, MOH)

EVALUATION

Components of HFLE baseline study (1998)

- Survey (modified version of CARICOM multi-agency HFLE Needs Assessment Instrument)
- Focus group discussion
- Interviews

RESEARCH TARGET:

1. Delivery status of HFLE
2. FLE Material (adequacy - quality & quantity)
3. FLE Delivery Personnel
4. Institutional Organization (delivery effectiveness)

Country Presentations

FINDINGS:

- HFLE being taught in most schools
- Infusion strategy was widely used
- Some teachers experienced difficulty teaching sensitive areas
- Some find infusion challenging
- Subject mainly taught at upper grades(4 -6) and infused at grades 1-3
- Students reported HFLE beneficial
- HFLE making a difference in some schools

IN-HOUSE STATUS SURVEY

Indicated that:

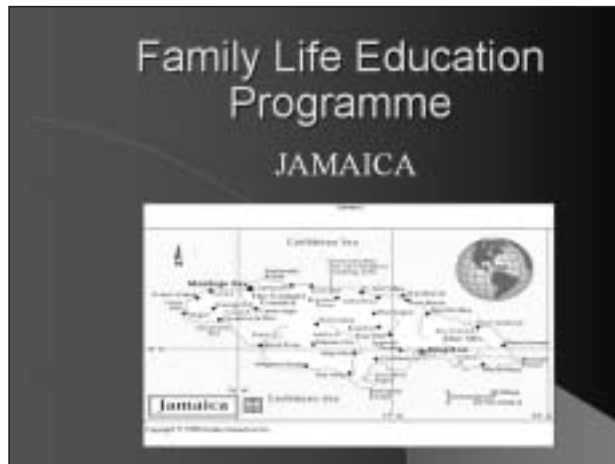
- Most schools are teaching HFLE (85% sample)
- Most preferred strategies - Infusion & Discrete Subject
- Equal number of schools have/da not have revised HFLE curriculum

LESSONS LEARNED

- Programs must be sustained to ensure continued success
- Efforts are fragmented - need for co-ordination & integration to avoid duplication of efforts & resources
- Need for more community involvement to protect schools from vandalism
- National HFLE policy needs to be fully implemented and enforced
- HFLE National Advisory (Interagency) Committee to be strengthened

FUTURE PLANS AND FELT NEEDS:

- Guidance & Counselling Services to be available to all schools
- Extend HFLE at the Early Childhood level of the system
- To embrace a creative strategy for teaching sexuality (ABHE performing Arts)
- Reproduce HFLE student materials and make available to schools
- Set up a National Advisory Committee (MOU)
- Support and strengthen programme at Teachers College Level
- Strengthen the in-service training of teachers and counsellors

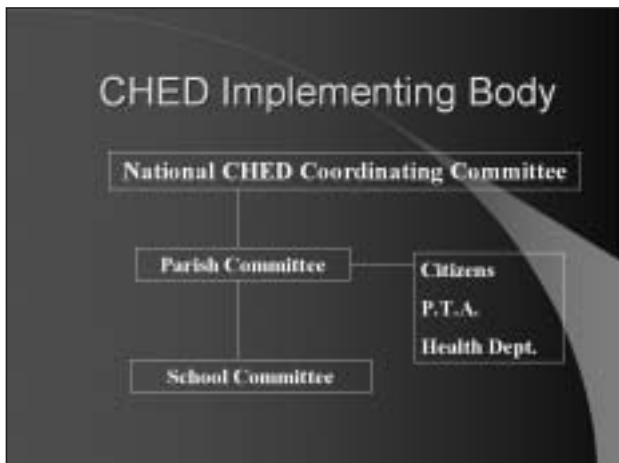


HISTORY of FLE

- Sex and Family Life Education in Jamaica spanned over six decades.
- **Prior to 1980's**
 - Health topics were included in the curriculum of primary and secondary schools
 - Health personnel visited schools, inspected, screened and immunized school children.
 - The Public Health Nurse was responsible for the monitoring of the health of the school children.
 - Guidance & Counselling established in the formal education system.

FLE - Early 1980's

- The Child Health Education & Development (CHED) project commenced.
- Collaboration with the Ministries of Health and Education and UNICEF.
- Utilized the entry point in the existing curriculum to develop health education themes and issues.



CHED Programme

- Was knowledge based
- Included Information such as:
 - Personal & Environmental Hygiene
 - Disease Prevention
 - Nutrition
 - Accident Prevention & Safety
 - Growth & Development
 - Human Sexuality & Interpersonal Relationships
 - Life Skills

CHED Programme

- Encouraged skills development in children
 - Handwashing
 - Making Water safe
 - Personal Health and Safety

CHED Programme Initiatives

- School gardens
- Breakfast & Lunch Programmes
- Cleanup Campaigns
- School Sanitation Clubs

IMPLEMENTATION

- Teachers were trained at workshops
- Health information and skills infused into lessons
- Exhibition and Contests
- Over 500 schools participated in the programme
- Project ended in 1999

CHED Evaluation

- Done at the end of the programme
- Gaps identified:
 - ✓ Environment was not supportive
 - ✓ Some skills could not be practiced e.g., no running water, poor toilets, no feeding programme.
 - ✓ CHED only addressed the needs of grades 1-6.

Other HFLE Programmes

- **USAID Funded Project**
 - Teachers & Guidance counsellors taught to infuse FLE into school's curriculum
 - Development of syllabi (Grades 1-6 & 7-11) with other resource materials

Other FLE Programmes (Cont)

- **CARICOM Initiative**
 - Provision of and use of Curriculum Guidelines for Family Life Education in the Caribbean

Other HFLE Related Projects

- **HIV/AIDS Education**
 - 1991-1993 (WHO/UNESCO) Grades 6-9
 - 1994-1997 (GOJ/UNDP) Grades 1-11
- **Reduction of Teenage Pregnancy Project**
1994 – 1996 (UNICEF)

Other Projects (Cont.)

- Parenting Education 1995-1997 (UNICEF)
- PALS – Peace and Love in Schools (A private sector initiative focussing on conflict resolution/prevention of violence.
- New Horizon Project - Innumeracy and literacy programme with a health component
- YOUTH NOW – a Future’s Project focussing on adolescent health (MOH)
- PEP – Preventive Education Programme dealing with substance abuse education

School Environmental Health Programmes

- Ministry of Health & P.A.H.O. – addressed excreta management and water problems in a number of schools islandwide.
- Private Sector Agencies e.g., Food For The Poor – providing desks and chairs
- Community Health Committees (H.E.O.s and P.H.I.s) addressing environmental health problems e.g. excreta and refuse management problems.

School Health Services

- School Dental Health Programme – implemented by dental auxiliaries
- Immunization – Public Health Department
- Environmental health services – Inspection & recommendations
- Blue Cross – Health Screening in some secondary schools
- School Feeding programme in primary schools – provides nutribuns & milk at a minimal cost (government funded).

Why NEW HFLE Programme?

- Fragmentation of HFLE in schools
- Teachers frustrated & confused with the number of projects and initiatives
- Discontinuation of funding for some projects
- Ministries of Health and Education thought that it was time for a comprehensive policy on health promotion in schools.



St. Kitts and Nevis

Sharon Rattan, HFLE Coordinator, Ministry of Foreign Affairs and Education

Petronella Edwards, Ministry of Health

Introduction

This paper examines the history and status of **Health and Family Life Education (HFLE)** programmes in St. Kitts-Nevis. Forces hindering and helping the implementation of HFLE activities are outlined. An assessment of our present situation raises the question: are the systems and structures producing the desired outcomes?

Efforts to ensure that meaningful and far-reaching HFLE programmes are implemented and sustained throughout St. Kitts-Nevis are described in our future plans.

General Background

St. Kitts and Nevis are located in the northern Leeward Islands of the Caribbean archipelago. St. Kitts covers an area of 68 square miles. Separated by the Narrows channel lies our sister island Nevis, which is 36 square miles. The population of this twin-island federation is approximately 40,000. Travel between the islands is easily accessed by sea and air. The official language is English.

St. Kitts-Nevis became independent from Great Britain in September 1983. This sovereign nation functions as a federation: the Federal parliament, the highest decision-making institution, is located in St. Kitts. Nevis has its own Island Assembly, which gives the Premier an extensive range of local authority. The Prime Minister is generally responsible for all aspects of the nation's business.

The Ministries of Health and Environment and Foreign Affairs and Education are the executive arms of the government. The government of St. Kitts-Nevis is the key provider of health and education. The public is assured of access to the best available health care and the government promotes healthy lifestyles and maintenance of well being through its organized health and environment programmes. The Nevis Island assembly governs the internal affairs on Nevis and there is a ministry of Health that organizes for the residents of Nevis.

Schooling is compulsory for children from age 5. Children in St. Kitts-Nevis enjoy equal opportunity to attend secondary school. Hence, all children obtain a secondary education. There are 31 primary schools (24 public and 7 private), and 9 secondary schools (7 public and 2 private).

The leading contributions to the gross domestic product have been government service, wholesale and retail trade, construction, agriculture, communications, informatics and tourism. Tourism is the strongest economic sector.

Country Presentations

Health and Family Life Education has always been a component of the national core curriculum from the pre-primary to the tertiary level. The Health and Family Life Education Programme was initiated in schools in the 1970s at the basic level and was referred to as “health”. Its main focus then was good grooming and eating right. In the early 1980s, human sexuality was introduced as a result of concerns that arose about increase in teenage pregnancy and sexually transmitted illnesses. Teachers were involved in a trainer of trainers’ workshop done by the Caribbean Family Planning Association. Since then follow-up workshops were held with a view to improve counseling skills of participants.

From its inception, the Ministry of Health was involved in the HFLE program. The Health Educator contributed to the curriculum development, but the implementation of the program rested with the Ministry of Education—that is, taught by class teachers and guidance counselors. The aim was to start HFLE at the primary schools and later have it included in the high school curriculum. A primary HFLE curriculum guide was introduced in the 1980s with assistance from PAHO. Principals and teachers were involved in this curriculum exercise.

Status of HFLE in Schools

Pre-Primary	Primary	Secondary	Tertiary
Health promotion activities are integrated into all activities Main Focus: Personal Hygiene Cleanliness	HFLE is timetabled once per week	No standardized curriculum exists. Guidance Counsellors deliver the programme	HFLE is part of Teacher Training Programme

School Health Programme

A structured health program exists in the community-based health services with 3 areas of focus: Health Services, Health Education, and Promotion of healthful school living. School health has been in the region for years but has always emphasized services. Developmental screening of school entrants is done for each child at the beginning of each school year (September - October). Health services include visual and auditory check-ups and/or medical and dental examination. Delinquent attendees to child health clinics are traced and immunized.

Nurses make presentations to children on a class-by-class basis, with individual counseling where needed. Focus of discussion is usually about personal hygiene, nutrition and healthful living, prevention of accidents, promotion of safety and sanitation. Special sessions are organized periodically for teachers during staff development.

High school entrants 11+ and 15 years old are assessed between February - March. DT and Polio booster doses are given, health education exercises continue with the emphasis during this given period placed on human sexuality, child abuse and some other adolescent health issues—related to lifestyle and behaviour patterns. Although there is not a standardized HFLE curriculum in the high schools, health education continues in a sometimes ad hoc manner, such as when invited by the Guidance Counsellors and on occasions when there is a health campaign as for World AIDS Day or dengue awareness.

Promotion of healthful school living examines the needs of the school-based population: school meals, physical environment, and school surroundings. An assessment of the schools feeding program was recently done. The ministries are awaiting the final report. Periodically, public health nurses and environment health officers visit the schools, and inspection of the surroundings is done.

Collaborative efforts continue into the tertiary level teacher-training program - HFLE is presented by health educators and practitioners. Health promotion activities coordinated by the Health Promotion Unit often include the participation of the students at the schools and at the College. Students access information for SBA projects every school year. Cooperation between the Unit, Community Affairs and Education ensures that health education reaches Parent-teachers Associations, Fathers Groups and school clubs/groups. Currently, the Unit is doing preparation for a school-based Global Youth Tobacco Survey among the 13-15 years old in St. Kitts and Nevis.

In 1998, the Curriculum Development Unit was established. The staff consists of five coordinators with responsibility for the core areas: Language, Mathematics, Social Studies, Science and Learning Support. It has certainly been a formidable task for the Curriculum Development Unit to undertake curriculum review, monitor and evaluate HFLE programmes. However, the CDU acknowledges that rapidly changing socio-economic conditions demand that there is a need to review the HFLE curriculum to reflect a life skills component. The present strategy involves:

- A – Identifying common themes, topics and objectives in Social Studies for Integration.
- The inclusion of life skills in the Social Studies curriculum

Examples:

- i) a spirit of cooperation and respect for others
- ii) personal responsibility for choices
- iii) developing self-awareness and self-esteem
- iv) displaying positive patterns of behaviours

These examples are spiraled through the K-6 Social Studies curriculum and are reflected in the following topics:

- My Family
- My School
- My Community
- Safety
- Responsible Citizenship
- Building Relationships
- Helping The Elderly
- The Environment
- Consumer Rights and Responsibilities

- B The responsibility of HFLE curriculum and programmes have recently been assigned to the Social Studies Coordinator.

The realization that there is an urgent need for St. Kitts-Nevis to delineate, document and intensify their commitment to the holistic development of children and youth requires an analysis of our present situation.

Country Presentations

Hindering Forces	Helping Forces
No policy exists	Available personnel who can prepare policy
Uneven implementation of HFLE curricula within schools	Recognition of the need for adequate instruction time for HFLE and teacher training in this field
Primary curriculum lacks life-skills component	Recognition of the need to craft life-skills based curriculum for HFLE from pre-primary to tertiary level
An HFLE coordinator is not an established post in the MOE	Social Studies coordinator is assisting with HFLE curriculum and programmes
Health-promoting activities, resources and materials are used in an ad hoc fashion	Recognition of the need for cooperation and networking
Lack of coordinated leadership in HFLE programmes	Decision by MOE to spearhead the formation of a National Task Force for HFLE support for HFLE at the regional and international level

Forces Amenable to Change

- inter-sectoral avenues identified for strengthening HFLE
- strengthening the commitment of ALL stakeholders
- available primary school curriculum
- availability of resources and materials
- public awareness
- can influence funding agencies

Lessons Learned

- The major barrier to HFLE programmes is the absence of leadership, coordination and collaboration.
- Territorial attitudes exist among Ministries responsible for executing HFLE programmes.
- Available resources personnel
- Regional and international support for HFLE programmes e.g. CARICOM, UNICEF and PAHO.

Recommended Action

The Ministry of Education will spearhead the formation of the St. Kitts-Nevis Task Force for Health and Family Life Education. This body will provide effective leadership and manage-

ment in order to provide strong administrative support and broad-based involvement of relevant persons, agencies and sectors.

Composition of the St. Kitts-Nevis Task Force for HFLE

Chairperson: Social Studies and HFLE Coordinator

Ministry of Foreign Affairs and Education

Ministry of Information, Culture Youth and Sports

- Youth Coordinator
- Director of Sports
- 1 Representative from the media

Ministry of Health and Environment

2 representatives from Health Promotion Unit

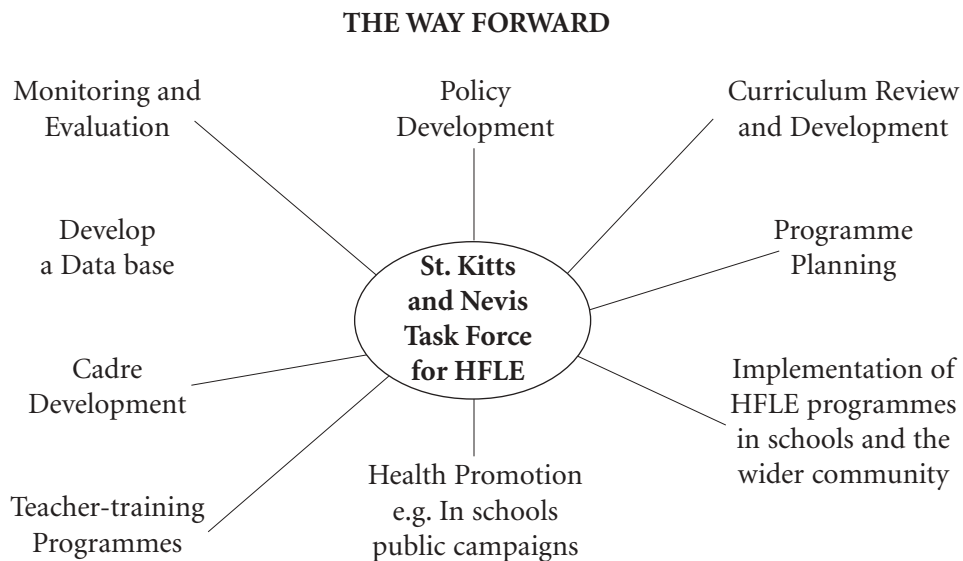
Ministry of Community and Social Development

2 Representatives

- 1 Representative from the Teachers' Union
- 1 Representative from the Church and Evangelical Association
- 1 Representative of Parent Teachers' Association
- 1 Representative of the DARE program

Nevis Representation

- 1 Education Officer
- 1 Health Educator



Country Presentations

Establishment of a Task Force for the HFLE program is timely and appropriate. This will ensure that a comprehensive program, with a multi-disciplinary approach, is put in place to prevent health-damaging behaviour patterns before they are established. Some factors that are pressing priorities include:

- Improving networking between sports, health and education ministries for physical activity.
- Supporting networks for healthy and safe psychosocial surroundings i.e. health promotion for teachers and administrative staff, PTAs, and community organizations involved in youth activities.
- Creation of supportive environment for promoting healthy dietary behaviours, e.g. support for small productive projects such as school gardens.
- Training in health promotion strategies and health communication for health and education officers.
- Establishing school-based life skills training program to reduce high risk behaviours: i.e. activities that help young people develop the skills they need to avoid tobacco, alcohol use, sexual behaviours resulting in HIV and other STDs and unwanted pregnancy, and unintentional injuries
- Building alliances with the private sector in addressing health among school-age-population.

INTRODUCTION

This paper examines the history and status of **Health and Family Life Education (HFLE)** programmes in St. Kitts-Nevis. Forces hindering and helping the implementation of HFLE activities are outlined. An assessment of our present situation raises the question: are the systems and structures producing the desired outcomes?

Efforts to ensure that meaningful and far-reaching HFLE programmes are implemented and sustained throughout St. Kitts-Nevis are described in our future plans.

GENERAL BACKGROUND



LOCATION: Northern Leeward Islands of the Caribbean archipelago.
SIZE: St. Kitts covers an area of 68 square miles. Separated by the Narrows channel lies our sister island Nevis, which is 36 square miles.

OFFICIAL LANGUAGE: English

POPULATION: Approximately 40,000

GOVERNMENT: St. Kitts-Nevis became independent from Great Britain in September 1983. This sovereign nation functions as a federation: the Federal parliament, the highest decision-making institution, is located in St. Kitts. Nevis has its own Island Assembly which gives the Premier an extensive range of local authority. The Prime Minister is generally responsible for all aspects of the nation's business.

ECONOMY: The leading contributions to the gross domestic product have been government service, wholesale and retail trade, construction, agriculture, communications, informatics and tourism. Tourism is the strongest economic sector.

OVERVIEW OF HFLE

- ❑ The Health and Family Life Education Programme was initiated in schools in the 1970s at the basic level and was referred to as "health". Its main focus then was good grooming and eating right.
- ❑ In the early 1980s, human sexuality was introduced as a result of concerns which arose about increase in teenage pregnancy and sexually transmitted illnesses. A primary HFLE curriculum guide was also introduced in the 1980s with assistance from PAHO.
- ❑ Teachers were involved in a trainer of trainers' workshop done by the Caribbean Family Planning Association.
- ❑ From this inception, the Ministry of Health was involved in the HFLE program. The Health Educator contributed to the curriculum development, but the implementation of the program rested with the Ministry of Education.

CURRENT STATUS OF HFLE

Status of HFLE in Schools

Pre-Primary	Primary	Secondary	Tertiary
Health promotion activities are integrated into all activities Main Focus: Personal Hygiene Cleanliness	HFLE is timetabled once per week	No standardized curriculum exists. Guidance Counsellors deliver the programme	HFLE is part of Teacher Training Programme

The CDU acknowledges that rapidly changing socio-economic conditions demand that there is a need to review the HFLE curriculum to reflect life skills component. The present strategy involves:

- A - Identifying common themes, topics and objectives in Social Studies for integration.
 - The inclusion of life skills in the Social Studies curriculum

Examples:

- - a spirit of cooperation and respect for others
- i) - personal responsibility for choices
- iii) - developing self-awareness and self-esteem
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Country Presentations

These examples are spiraled through the K-6 Social Studies curriculum and are reflected in the following topics:

My Family	Building Relationships
My School	Helping The Elderly
My Community	The Environment
Safety	Consumer Rights and Responsibilities
Responsible Citizenship	

B The responsibility of HFLE curriculum and programmes have recently been assigned to the Social Studies Coordinator.

SCHOOL HEALTH PROGRAMMES

- Provision of community-based health services with 3 areas of focus – Health Services, Health Education, and Promotion of healthful school living.
- Presentations made by Nurses and health personnel to students and periodically to teachers during staff development.
- Student participation in health promotion activities coordinated by the Health Promotion Unit.
- Health and Community personnel serve as resource persons for the school programmes and community-based activities.

Hindering Forces	Helping Forces
No policy exists	Available personnel who can prepare policy
Uneven implementation of HFLE curricula within schools	Recognition of the need for adequate instruction time for HFLE and teacher training in this field
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FORCES AMENABLE TO CHANGE

- ❖ Inter-sectoral avenues identified for strengthening HFLE
- ❖ Strengthening the commitment of ALL stakeholders
- ❖ Available primary school curriculum
- ❖ Availability of resources and materials
- ❖ Public awareness
- ❖ Can influence funding agencies

Lessons Learned

- ✓ The major barrier to HFLE programmes is the absence of leadership, coordination and collaboration.
- ✓ Territorial attitudes exist among Ministries responsible for executing HFLE programmes.

RECOMMENDED ACTION

The Ministry of Education will spearhead the formation of the St. Kitts-Nevis Task Force for Health and Family Life Education. This body will provide effective leadership and management in order to provide strong administrative support and broad-based involvement of relevant persons, agencies and sectors.

Force for HFLE

- Chairperson:** Social Studies and HFLE Coordinator
Ministry of Foreign Affairs and Education
- Ministry of Information, Culture Youth and Sports**
- Youth Coordinator
 - Director of Sports
 - 1 Representative from the media
- Ministry of Health and Environment**
- 2 representatives from Health Promotion Unit

Ministry of Community and Social Development
2 representatives

1 Representative from the Teachers' Union
1 Representative from the Church and Evangelical Association
1 Representative of Parent Teachers' Association
1 Representative of the DARE program

Nevis Representation
1 Education Officer
1 Health Educator



Thanks for Viewing

Sharon Rattan : Ministry of Foreign Affairs and Education
Petronella Edwards: Ministry of Health and Environment.

St. Kitts Nevis



St. Lucia

Arthusa Semei, Ministry of Education CAMDU

Anne Henry, Assistant Principal Nursing Officer, Ministry of Health

Situation Analysis

St. Lucia is a small island state in the Eastern Caribbean with a population of 155596 people. Of this number, 18060 fall within the 0-4 age group, 15795 are within the 5-9 age group, 16162 fall within the 10-14 age group, and 16457 are within the 16-19 age group. It has a GDP of 1171.90 million Eastern Caribbean Dollars and a per capita income of 0.0075. The main thrust of the economy is tourism and agriculture. St. Lucia has made significant strides in the advancement of its people, both in education and other spheres of life. For example, St. Lucia is the only island in the Caribbean which can boast of having two Nobel Laureates. However, in recent times, there has been much concern over the response of the youth in St. Lucia and the rest of the Caribbean to the social problems which impact on their lives. The emergence of unrest, crime, gang violence, increased suicide, coupled with disgruntled youth, dysfunctional families and unhealthy lifestyles stop the youth from maximizing their potential. It was felt that a Health and Family Life Education (HFLE) Programme could help in addressing the problems of that critical mass of nearly fifty percent of the population. To this end, St. Lucia responded to the CARICOM Multi Agency HFLE Project for the implementation of Health and Family Life Education in the education system and the wider society. The overall aim of this project is to introduce a comprehensive Life skills-based Health and Family Life Education Programme in the Education, Health and Community Development/Services Sectors. The implementation plan comprises four components: Policy Development, Curriculum Development, Training, and Materials Development.

A Historical Perspective

Prior to 1991 Health in the school system was focused mainly on nutrition and hygiene and was not all-inclusive of all the health issues that confront the youth of the nation. As such the response of St. Lucia to HFLE saw the emergence of a Curriculum Specialist for HFLE and the development and implementation of an all-encompassing new curriculum. The implementation of this curriculum took place at all levels in the education system to include primary and secondary levels of education, and the Teachers' College. At the same time, efforts were made to raise the consciousness of the wider population as to the problems that plague the youth of the nation. This sensitization took the form of radio and television call-in programmes, Parent Teacher Association meetings all across the island and Public Speaking Competitions among students in the school system on issues that impact on the youth.

Needs Assessment

In 1997 St. Lucia participated in a UWI Multi Agency Needs Assessment conducted among selected CARICOM member states. The target population included policy makers, parents, students, teachers, and principals. This needs assessment revealed the following:

- St. Lucia was the only country which had made significant strides in HFLE at the school level.
- Students who were exposed to HFLE wanted to have more periods.
- Those who were not exposed did not want any.

Curricular Reform

Under the Curricular Reform Project of the Ministry of Education in 1997, the HFLE curriculum was revised. The PAHO Curriculum Framework to include the five themes was adopted under the new revision. The curriculum review team was intersectoral in composition and included representatives from the Ministry of Health, PAHO, The Teachers' College, practicing teachers and parents. The curriculum is life-skills based, adopts an integrated approach, through the use of interactive and participatory methodologies.

Intersectoral Training

Training for the delivery of the curriculum both at the school and community level was and is still a critical need. To this end, in 1998, The Fertility Management Unit of the University of The West Indies spear-headed a series of Trainer of Trainers Programme to fill that need. This provided St. Lucia with a critical mass of trained persons in Education, Health, and Community Development. These persons were mandated to carry our further training in-country to bring about a multiplier effect. St. Lucia has just fulfilled this mandate and to date there is a total of twenty-five additional trainers. This training has now positioned St. Lucia to bring the HFLE programme into the community. Additionally, St. Lucia has benefited from a series of invaluable training activities conducted by UNICEF to support the delivery of HFLE at the classroom level.

Policy Development

In keeping with the four components of the Health and Family Education Project, St. Lucia embarked on the following actions in the development of a policy for Health and Family Life.

- An intersectoral National Team was put together. The team consisted of representatives from Ministry of Planning, Ministry of Health, Ministry of Community Development, Ministry of Legal Affairs, St. Lucia Planned Parenthood, The St. Lucia Crisis Centre, The Church, Mothers and Fathers Groups, and Students.
- Focus Group discussion were conducted across eight health regions in the island with a view to soliciting the views of a cross-section of the wider population.

- Call-in radio and television programmes were also conducted with the further aim of allowing the wider population to contribute to the policy.
- The first draft of the policy was put together under the guidance of the National Team.
- The first draft of the policy was distributed to all stakeholders in preparation for a proposed National Consultation
- A National Consultation was held with the participation of a wide cross section of the population. During the consultation, presentations were made by key stakeholders to include PAHO in the person of Patricia Brandon, Elaine King of UNICEF, Representatives of Family Court, Gender Relations, and Legal Affairs. Before the document was finalized, a working committee with the support of PAHO expanded on the Situation Analysis for promoting Health in Schools. Final work to be done on the policy includes the application of a time frame to programme objectives, printing, and the development of a Programme Plan of Action.

Future Plans and Felt Needs

Future plans and felt needs are as follows:

- There is need for massive teacher training.
- The secondary school curriculum needs to be revised with a matter of urgency.
- Materials must be developed to support the delivery of the curriculum at the school level.
- There is a dire need for human resource both at the school level and to take the programme into the community.
- The Teachers' College and Secondary School Curriculum should be modularized.
- The Curriculum Unit is presently collaborating with the Adult Education Unit of the Ministry of Education to include HFLE as part of the Adult Enrichment Programme.

Lessons Learned

- The success of this programme thus far can be attributed to the invaluable financial support provided by UN Agencies especially UNICEF.
- There is a critical need for human resource to offer support at the classroom level and to bring the programme into the community.
- It is difficult to get schools to buy programmes that are not examinable.
- Pioneering work requires total commitment.

HEALTH AND FAMILY LIFE - A HISTORICAL PERSPECTIVE

The Way We Were

1. Prior to 1991

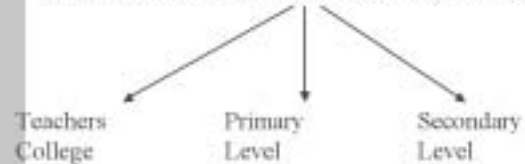
HFLE: Not as all inclusive – we taught only Health and Nutrition

The Way We Were [Cont.]

2. 1990 – Curriculum Development
3. 1991 – Appointment of Curriculum Specialist / Health and Family Life

1991 - 1992

CURRICULUM IMPLEMENTATION



1991- 1992 [Cont.]

Curriculum Implementation

Sensitization of Public

- Radio
- P.T.A Meetings
- Public Speaking Competition among schools

1995 - 1997

Endorsement of HFLE by

- ❖ CARICOM Ministers of Education
- ❖ CARICOM Ministers of Health
- ❖ Heads of Government Respectively

1997

Participated in UWI, CARICOM MULTI AGENCY Needs Assessment

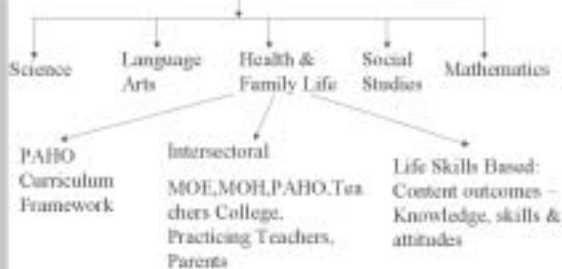
Target Groups

Policy Makers	Parents
Students	Teachers
Principals	

Significant Statements

1. St. Lucia was the one country where things were happening at the school level in HFLE.
2. Students who were receiving HFLE wanted more periods
3. Those who were not receiving HFLE did not want

Curricula Reform - 1997 Revision at Primary Level



Approach

- ❖ Integrative
- ❖ Methodology – participatory and interactive

1998 Onwards Trainer of Trainers

- ❖ Fertility Management Unit of U.W.I
 - > Provided training for a critical mass of educators, health workers and community workers
 - > Caused a trickle down effect
- ❖ St. Lucia in country intersectoral training completed in 2001

UNICEF Support



Policy Development Process

- Qualitative Survey in the form of focus groups
- Call in Radio and Television Programmes
- First draft of policy under the guidance of National Team (MOE, MOH, MCD, MOP, PPA, Crisis Centre, Church, Mothers & Fathers Groups, Students,
- Distribution of draft Policy to stake holders prior to National Consultation

Policy Development Process

- National Consultation
Presentation by Key Stakeholders
 - (a) PAHO
 - (b) UNICEF
 - (c) Family Court, Ministry of Health, Legal Affairs
 - (d) Wider audience
- Final Working Committee With PAHO Support / Expanding the Situation Analysis for Promoting Health in Schools

Policy Development Process

- Final Document
Need to Apply Time Frame to Policy Objectives and Develop Programme Plan of Action
- Print Policy

Future Plans and Felt Needs

- ◇ Teacher Training
- ◇ Revision of Secondary School Curriculum
- ◇ Modularization of Curriculum of Secondary Schools and Teachers College
- ◇ Development of Teaching Support Material
- ◇ Implementation of HFLE at the Community Level
- ◇ Human Resource Support

Lessons Learned

- ◇ Pioneering work is hard, intense and requires total commitment
- ◇ Requires massive financial support
- ◇ Requires involvement and commitment of all stakeholders

PRIMARY HEALTH CARE SERVICES

INTRODUCTION

The Primary Health Care Services has the following components:

- > Community Nursing
- > Environmental Health
- > Health Education/Family Life
- > Nutrition
- > Pharmacy
- > Dental

The above services are being provided to individuals, families and communities utilizing the health team approach.

COMMUNITY HEALTH NURSING SERVICE

This organization provides Primary Health Care Services in Maternal and Child Health/Family Planning, Control of Communicable Diseases, Screening/Monitoring of Chronic Non-Communicable Diseases, School Health, Home Visits and visits to Institutions eg. Daycare and Preschool.

These services are provided throughout the island at thirty two (32) Health Centres, one (1) Polyclinic and two (2) District Hospitals on a weekly to twice weekly basis.

MATERNAL & CHILD HEALTH (MCH)/FAMILY PLANNING (FP)

Special sessions are held at the clinics which include health education/health promotion, counselling and demonstrations.

These activities include team members from the other sectors in Primary Health Care.

COMMUNICABLE & NON COMMUNICABLE DISEASE

Activities include surveillance, health education, prevention, promotion, screening and control.

Country Presentations

SCHOOL HEALTH

Health Education and Family Life Education is conducted at the Schools islandwide. Health assessment are conducted for children at five (5), eleven+ (11) and fifteen (15) years.

This programme includes complete physical examination, eye, ear and dental screening, weight and height. Health talks on personal hygiene, growth and development are also part of this programme. Immunization is administered routinely.

HOME VISITS/VISIT TO INSTITUTIONS

Follow up care, counselling and anticipatory guidance are provided at home visits, and visits to institutions.

There is linkage with special schools eg. Mentally Challenge, School for the Deaf, etc. where we participate in health maintenance and health promotion programmes.

COMMUNITY PROJECTS

There are special projects involving mass community screening focusing on health promotion and early identification of problems eg. Cancer Screening, Hypertensive/Diabetic and Prevention of Blindness among others.

Primary Health Care Team also participates in even sessions with community groups.

ENVIRONMENTAL HEALTH PROGRAM

This programme includes water, Food Sanitation and Vector Control.

WATER:

Activities such as residual water testing done on a weekly basis. There is also microbiological testing of water done as deemed necessary, e.g. in drought and where there is reported diarrhoea cases.

FOOD

Enforcement of food regulation through inspection of food establishment. Training for food handlers in food safety and hygiene, and also Hazard Analysis Critical Control Point (HACCP), assist in the training and education of students in the hospitality programme.

VECTOR CONTROL

Environmental Health Officers do field visits assessing sanitation of environment for vector and other hazards. They do lavyceiding and fogging of environments as needed.

LESSONS LEARNED

- Health and Family Life Education is now taught at all levels throughout the school system.
- Multisectoral approach to Health and Family Life.
- Lack of resources – human, material and finance.

FUTURE PLANS AND FELT NEEDS

1. Closer collaboration between Health Education and Community Development.
2. Maternal and Child Health (MCH) needs to be expanded to incorporate male gender.
3. Health facilities needs to be more adolescent friendly.
4. Educational drive on meat hygiene.



St. Vincent and the Grenadines

Beverly Neptune, Education Officer, Ministry of Education

This presentation focuses mainly on the development of and current status of Health and Family Life Programmes in St. Vincent and the Grenadines. The information is divided into four main headings:

- General Context of the Country
- Health and Family Life Education Programme in the Country
- Health and Family Life Education Methodology
- Current Situation of the Health and Family Life Education Programme, Lessons Learned, and Future Plans and Felt Needs

General Context of St. Vincent and the Grenadines:

St. Vincent and the Grenadines forms part of the group of islands known as the Windward Islands. They are called Windward Islands because of their more direct exposure to the well-known winds that blow through the area in a north-easterly direction, the Trade Winds.

Our country is in the east of the Caribbean Region. It comprises mainland St. Vincent to the north, with some 32 islands and cays scattered around the south-west known as the Grenadines. Bequia, Mustique, Union Island, Myreau, Palm Island, and Petit St Vincent are the larger Grenadine islands.

St. Vincent and the Grenadines have an array of hills and mountains, especially in the interior of mainland St. Vincent. The Soufriere mountain is the highest mountain peak at 1,230 metres, with Mourn Garu, the second highest, rising to 1,070 metres.

According to the 1999 census, our population was estimated at 111,200. Our main economic activities are agriculture and tourism.

History and Culture

Our fore-parents came from various parts of the world- Africa, India, South America, England and Europe. Some families have been here for so long, we do not know exactly when they came. These are known as indigenous people. In St. Vincent, the group of indigenous people most known are the Caribs. However, the Arawaks inhabited the country before them and earlier the Ciboneys. Another set of indigenous people are the Black Caribs who came into existence from the union of African men and Carib women.

Our fore-parents brought with them different customs, sayings and methods of doing things. They interacted with the indigenous peoples and other Caribbean people helping to influence them and in turn be influenced. From this mixture came a Vincentian and West Indian culture.

Country Presentations

Parts of our culture, that is, our festivals and celebrations, food, art, literature and music are shared with outsiders, while some remain special to us.

Government

The system of government in St. Vincent and the Grenadines is based on the Westminster system of Parliamentary democracy practised in the United Kingdom.

The official head of state is the British monarch currently Queen Elizabeth II. The Governor General – Sir Charles Antrobus is the Queen’s representative in St. Vincent and the Grenadines.

The parliament is the legislative arm of government and is made up of persons who have won their seats in national elections and others who have been nominated as Senators.

The Cabinet, made up of ministers of government, is the executive arm of government. The Prime Minister – Dr. the Hon. Ralph Gonsalves heads Cabinet and the government.

The Attorney General heads the judicial aspect of government. Our system of government also includes an opposition.

QUEEN

GOVERNOR GENERAL

PARLIAMENT

ELECTED REPRESENTATIVES AND NOMINATED SENATORS

Education

The mission of the Ministry of Education is to provide all the persons of the state, singularly or co-operatively, with learning opportunities appropriate to their learning needs and to ensure a quality of education that will equip them with the required values, skills, attitudes, and knowledge necessary for creating and maintaining a productive, innovative, innovative and harmonious society.

This mission is accomplished mainly through the subsystems, which comprise the formal-education system:

1. Preschools
2. Primary schools
3. All-Age schools
4. Secondary schools
5. Special Schools
6. Tertiary Institutions
7. Special Programmes
8. Special Services e.g. juvenile care
9. Social Welfare Services
10. Support Unit
11. Multi-Purpose centres
12. Curriculum Development
13. Testing and Evaluation
14. Non-Formal Adult and Continuing Ed
15. School Supervision

PROCEEDINGS

First Meeting and
Creation of the
Caribbean
Network of
Health-Promoting
Schools

Health and Family Life Education in St. Vincent and the Grenadines

Prior to 1990, two separate health related programmes existed in the Primary Schools- One was called Health Education and addressed issues of Personal Hygiene and Body Systems. The other was called Family Education and addressed Human Sexuality and related issues. However, Educators and other StakeHolders realised the need for one comprehensive programme to help address many of the social ills, which threaten the very foundation of our society. These social ills included: school and domestic violence, poverty, drug abuse, disintegration of family life, negative peer pressure, teenage pregnancy, and debilitating sexually transmitted infections including HIV/AIDS.

The Current Status of HFLE

Currently, HFLE is taught at all Primary and All Age Schools in St. Vincent and the Grenadines. All schools at these levels have been supplied with HFLE curriculum guides to facilitate the teaching of HFLE in these schools. HFLE is tested:

- (a) as a separate subject in the annual School Leaving Examination and
- (b) in combination with Science and Social Studies as a General Paper Test in the Common Entrance Examination which selects pupils for entry into secondary schools.

At the Secondary level some amount of HFLE is also taught mainly in the lower forms (1-3), but most schools lack a well-developed HFLE curriculum. Generally, Secondary Schools use the primary programme to guide their teaching.

Each week students benefit from a special radio programme known as the “schools’ broadcast” where topics in HFLE are aired.

Students at the primary level benefit from a “school feeding” programme.

In an effort to help educate parents, some schools are conducting programmes for parents after regular school hours. One such programme is FAST: Family And School Together.

Another school has established a programme called PEACE. Students in this programme have extensive training in areas such as conflict resolution, interpersonal communication, and they wear special clothing carrying the words PEACE at intervals in the school week. Their special responsibilities include spreading the word of peace and acting as mediators in and around their school.

Students in one private school are presently working on a project to have a ‘soda free’ tuck shop and have advocated that only healthy snacks be served.

The police department conducts a programme known as DARE (Drug Abuse Resistance Education) in many Primary and All Age Schools.

An Education Officer has been appointed at the Ministry of Education to coordinate HFLE programmes in both Primary and Secondary Schools. In addition the officer functions as resource person, conducts in-service teacher training, tutors at the Teachers’ College and works in collaboration with the Ministry of Health and Community Development.

Country Presentations

With the appointment of the HFLE Education Officer, Schools will once again benefit from 'Schools Health Day- This HFLE experience allows children opportunities to be more health conscious on this Special Day (1st Friday in May). Their activities will include making posters, dramatizing of health workers, focusing on healthy eating habits and the cleaning of the surrounding.

The Education Officer {HFLE} in-collaboration with St. Vincent and the Grenadines Family Planning Association works with parents through PTA on a programme called 'How to talk to your children on things that are not easy to talk about.'(sex. puberty, relationships).

Health and Family Life Education has been reintroduced into the Teachers' College. Unfortunately it has not been made mandatory thus there are only seventeen (17) of approximately one hundred and fifty (150) student teachers taking the course.

A national HFLE team for St. Vincent and the Grenadines has been established. This team is an intersectoral body comprising personnel from the Ministry of Education, the Ministry of Health and the Ministry of Community Development.

UNESCO has completed phase 1 of a project for HIV/AIDS prevention and drug prevention and intervention through Health and Family Life Education. The project targets approximately 10,000 primary school students nationwide.

Ministry of Health- School Health Programmes

Complete assessment of children at the Pre-school level (age 4+), which includes immunization shots and another complete assessment at age 10+.

Regular free dental service, which includes cleaning, filling, extracting and brushing.

Follow up care at school and at home.

Programmes for adolescent groups in Health Centres.

The Health Education Unit conducts Youth Guidance Centre programmes across the country for in school and out of school youth.

Lessons Learned

Health and Family Life Education classes are affording students opportunities to share many sensitive issues, which are otherwise lost.

All teachers at all levels need to have comprehensive training in HFLE so that HFLE becomes a whole school community affair.

There is willingness on the part of Health and Education personnel to work in-collaboration with each other. However, there needs to be more advocacy in getting other stakeholders more committed.

The Core Curriculum Guide for Strengthening Health & Family Life Education in Teacher Training Colleges allows the teacher a holistic view of health and helps him /her to practice healthier habits. However, the guide appears to be inadequate in preparing the teacher for the

actual teaching of HFLE using the existing guides in the primary schools. Therefore there is need for teaching methodologies.

Teachers are not always prepared to teach some aspects of HFLE especially those who have not had formal training in the area.

Future Plans

- Review of existing guides
- Writing materials to meet the needs of students beyond the third form level,
- Proposal for making HFLE mandatory in the Teachers' College
- Training for teachers at the pre-school level
- Conduct a Life- skills base programme in the prisons



Puerto Rico

Ms. Rosa Magaly Aleman, School Health Program Director, Department of Education

Puerto Rico is a Caribbean Island that has a population of 3.8 million of persons in 3500 square miles. The Puerto Rico Department of Education has 612,330 students in 1,543 community schools distributed in 84 schools districts known as centers for professional development. The School Health Program, which attends all the students from kindergarten through twelfth grade, has 23 school health supervisors and 625 health teachers. About 300 teachers are certified as school health teachers. We will continue with this issue until all the teachers are certified.

The School Health Program has a curriculum framework that establishes philosophy, goals, objectives, and curricular areas like: physical, mental, social, cultural and spiritual. This curriculum framework is based on the six (6) categories of risk behaviors and contains the competencies that the students will develop throughout the elementary and secondary school. This is a comprehensive school health education curriculum, which includes 11 components. Besides, our Program is legally supported by two laws, which establish the mandatory commitment of the health education throughout all the schools. (Law No. 70, June 1990) and Law 7, May 1991, which states the annually assignment of money for the implementation of the Law 70.

With regard to public policy, the School Health Program has two circular letters related to sex education and HIV.

HIV Circular Letter: Norms and Procedures Related to HIV/AIDS emphasizes the following aspects:

1. The rights of HIV/AIDS infected students.
2. General dispositions for HIV/AIDS student's record management.
3. Universal norms safety.
4. HIV/AIDS education for the student population

Also the Program has a Circular Letter, which has a mandatory effect like a law, to establish public policy by means of "Norms for Teaching and Functioning of the School Health Program at Elementary and Secondary Levels in Public Schools of Puerto Rico."

This document establishes the following, among other things:

1. In the Junior high school level (7th – 9th) it will be a requirement to take a school health course of half credit/hour (1/2) during a semester. The same requirement holds for the high school (10th.-12th).
2. In the secondary level (7th.-12th) there are other courses to be taken as elective.

The curriculum is being reorganized in several courses just to make the educational offering more attractive and pertinent to students. Some of the courses are:

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- **Arquitecto de Paz (Peace Architect)**. This course assists students to develop communications, problem solving, decision-making skills. Besides, the course encourages students to know themselves to enable them to develop these skills. Students identify a community problem to work out its solution. In this way they practice what they have learned. Working with the solution of the problem, they behave like builders in search of the solutions for problem the community faces. Being part of the solutions makes students feel good about themselves and useful to others.
- **Sex@educa.com** is another course to be taught in high school.
- **Mano a Mano con los viejos** is another course to be taught in junior high school. (In progress) This course helps students to develop positive attitudes toward elderly people.
- **Atrévete a estar en control**—to be taught in junior high school. It deals with tobacco prevention.

The School Health Program works with different educational strategies to attain our goals. Peer Groups work with folic acid, HIV, Sexual Abstinence and others.

As part of our goals, we will continue training teachers. Our emphasis is elementary teachers, who need sexual education training. Besides, we are training peer students through social theater strategy

The School Health Program works in close collaboration with different organizations, community based organizations, private organizations, and governmental agencies in order to reach its educational goal. All the efforts would be to enhance the curriculum through the comprehensive school health program. So, that's why we have a close collaboration with CDC.

According to the last High Risk Behavior Survey conducted in 1997:

- 36.8% of the participants were sexually active
- 22.9% of the sexually active have had 4 or more sexual partners
- 59.7% of the sexually active did not use condoms during their last sexual intercourse.
- 8.6% of the sexually active have used alcohol or other drugs during the sexual intercourse
- 40.8% of the participants drink alcohol always.
- 15.8% of the participants use marihuana always.
- 4.4% of the participants use cocaine always
- 3.1% of the participants use steroids always
- 2.0% of the participants use intravenous drugs always.

In May 2001 the High Risk Behavior Survey was conducted. We are waiting for the results.

This information permits us to work with the necessities of the youth population and to look for the strategies that better goes with the reality of the youth. Educational experiences have to make sense to the needs of our youth.

Suriname

Maaltie Sardjoe-Ashim, Director of Regional Health Services, Ministry of Education

Hildegard Illes, Ministry of Education

Adrianus Vlugman, Environmental Health Advisor, PAHO

Basic Life Skills Education and School Health in Suriname¹

By: Mrs. M. S. Sardjoe-Ashim², Mrs. H. Illes³, and Ir. A. Vlugman⁴

1. General Information

1.1 Geography, Population and Culture (1)

Suriname is located in the northern coast of South America between 2° and 6° N latitude and 54° and 58° W longitude. The neighboring countries are French Guyana in the east, Guyana in the west and Brazil in the south. The country covers an area of 163,820 sq. km. Topographically there is a subdivision of the country into the coastal lowlands (an area of an average 10 km parallel along the whole of the coastline), the savanna (a band between 10 to 50 km from the coastline) and the highlands in the south with their tropical rain forest. Suriname is divided into 10 districts (see map 1). These districts are subdivided into 62 “ressorten.” The capital city is Paramaribo, located in the northern coastal area.

Main economic activities are: gold and bauxite mining, timber logging and agriculture. The decade of 1983 to 1993 witnessed some political instability and a bloody guerrilla war in the hinterland which ended by a cease fire agreement signed in 1991 by the newly elected government.

GDP growth rates showed a decrease from 7% in 1995 to 2% in 1998(2). Due to huge increases in the inflation rates during the nineties, the percentage of the population living below the poverty line dramatically increased. It is estimated that between 50-75% of the population lives below the poverty line(3). The socio-economic decline that occurred over the past 10-15 years has adversely affected all segments of society including the health sector.

1.2 Population

According to official sources the population was estimated 422,000 in 1997 (based on the last census that was held in 1980), while unofficial sources estimate the population at 460,000 in 1999. More than 80% of the population lives in the coastal lowland bordering the Atlantic Ocean consisting of sandy soil, fertile agricultural land and swamps. The remaining 80% of the country consists of bush and mountains rain forests. The population density of 2.5 p/km² is

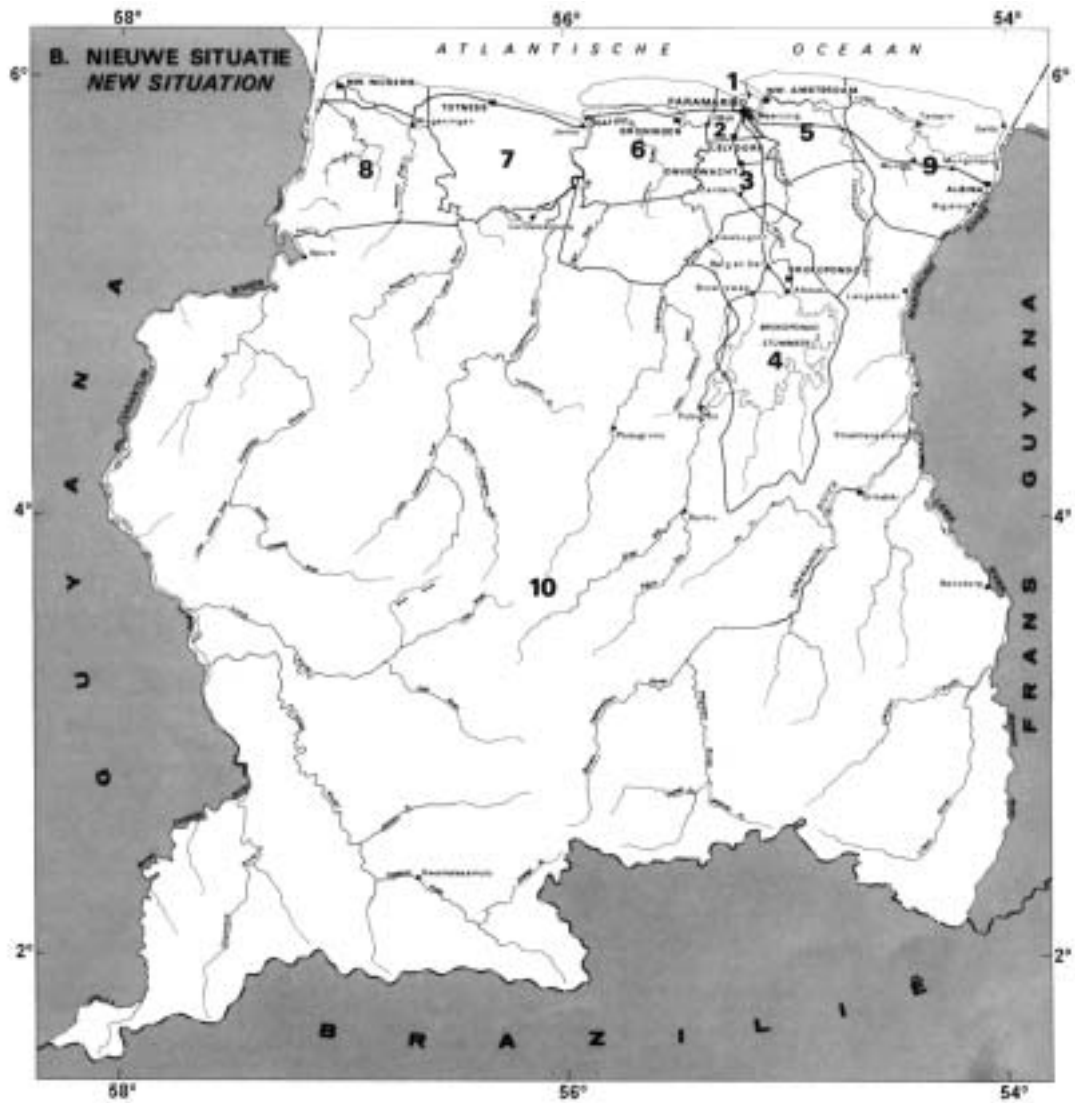
1 Presented at the First Meeting of the Caribbean Network of Health-Promoting Schools, Barbados, 27 November 2001.

2 Director Regional Health Services, Ministry of Health, Suriname

3 Basic Life Skill Officer, Ministry of Education, Suriname

4 Environmental Health Advisor, PAHO, Suriname

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Map 1: Suriname: Political boundaries (as per January, 1985)

No:	District	Area (km ²)	No	District	Area (km ²)
1.	Paramaribo	183	6.	Saramacca	3,636
2.	Wanica	443	7.	Coronie	3,902
3.	Para	5,393	8.	Nickerie	5,353
4.	Brokopondo	7,364	9.	Marowijne	4,627
5.	Commewijne	2,353	10.	Sipaliwini	130,566

among the lowest in South America. There are vast differences in population density in the country. About 70% of the population lives in the mainly urban districts of Paramaribo and Wanica, which occupy only 0.4% of the total land area (General Bureau of Statistics 1997). The Sipaliwini district is situated in the interior, a southern region with a vast rain forest. This district occupies 80% of the land area with a density of only 0.2 inhabitants per square kilometer.

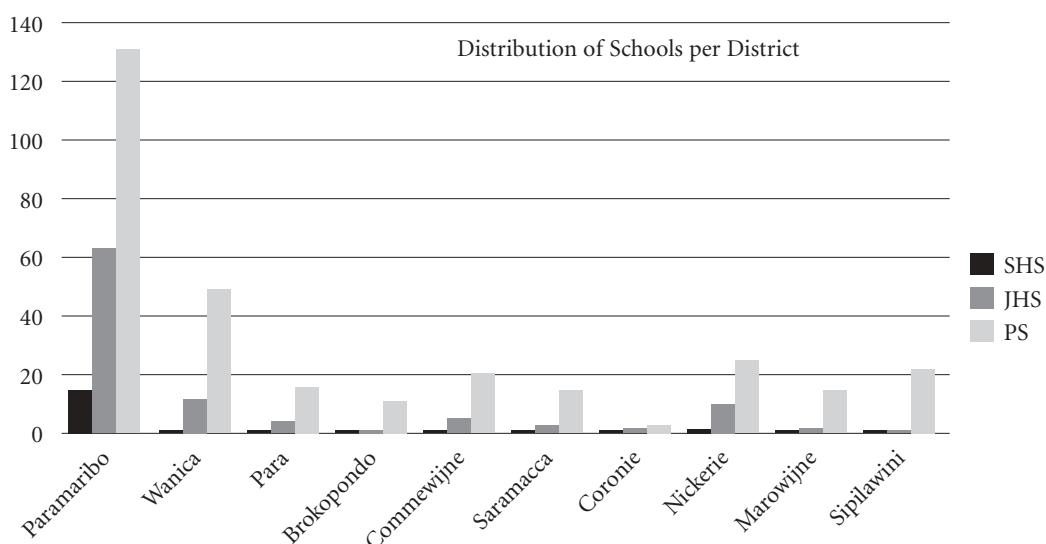
1.3 Ethnicity and culture

The population is multi-ethnic with 16 ethno-linguistic groups. The major groups in the urban and rural areas are the Hindustanis, who are descendant of people from India making up about 37% of the population, the Creoles 31%, the Indonesian (Javanese) 15%, the Maroons 10%, the Amerindians 2%, the Chinese 2% and others 3%. The population in the interior consists predominantly of maroons and indigenous people with a variety of ethno-linguistic groups. The multi-ethnic composition of the population has significantly influenced many aspects of culture and religion in Suriname as well as architecture, cuisine, arts and crafts. The many religions of the world live in close harmony in Suriname, where churches, mosques, synagogues, and temples are built next to each other. The religious buildings, together with old colonial architecture placed the City of Paramaribo on UNESCO's World Heritage List. Suriname also offers a wide variety of ethnic dishes, woodcraft, paintings, indigenous artisan crafts, gold and silver jewelry, etc.

2. School Health Programs and Basic Life Skills in Suriname

Approximately 78% of the children of primary school age in Suriname are attending primary school (4). School attendance in the interior is significantly lower at 61.2%. At the national level there is virtually no difference between male and female attendance. Almost 84% of the population over 15 years is literate, while the literacy rate of the age group 15-24 is 91.7%. The distribution of Primary and Secondary schools per district is shown in Graph 1 below.

Graph 1: Distribution of Primary and secondary schools per district, Suriname, 1997



2.1 Ministry of Education and Community Development

In support of its motto: “Education for All” the Ministry of Education and Community Development (MINOV) developed a new policy document (5) indicating the direction and specific action for the development of the educational system in Suriname. This document describes the introduction of the Basic Life Skills program in the curricula in the coming years.

Tertiary education includes:

1. Anton de Kom University
 - Higher Vocational Education which includes 7 institutions, e.g. the nurses school (COVAB) and Advanced Teachers College (IOL)
 - Vocational Education.
2. Secondary Education
 - Senior High School
 - Junior High School
3. Primary Education

Furthermore the document discusses Special Education, Education in the Interior, Adult Education/Literacy and Private Educational Institutions, which are accredited by the Ministry.

A Basic Life Skills Committee was established in 1997 with support from UNICEF and PAHO and a Basic Life Skills Needs Assessment was executed and published in 2000 (6). This document provides recommendations for the implementation of BLS into the curricula. The first phase included the development of BLS curriculum in the curricula of the pedagogic institutions. In the second phase, which is now being carried out, the teachers are being trained in the incorporation of the materials of the BLS curricula in the different subjects. It is intended that as of October 2002 BLS will be a specific subject at the pedagogic institutions for a period of two years. During this period, the teacher-students will adapt and develop from the materials of the pedagogic institutions, BLS materials for the students of the Secondary schools. In a later phase materials for primary schools will be developed. The BLS materials are based on five themes (7):

1. Responsible Environment maintenance and control
2. Dealing with ethnicity
3. Responsible sexual behavior and sexuality
4. Healthy nutrition and exercise
5. Socio-emotional development

For these five themes 10 basic life skills were written

1. to make decisions;
2. to solve problems;
3. enter into and maintain interpersonal relations;
4. communication skill;
5. empathy;

6. creative thinking;
7. critical thinking;
8. confidence;
9. dealing with emotions;
10. dealing with stress.

At the primary school level, the curriculum includes Nature Education. In this subject first graders learn about the diversity of food, derived from plants or animals and how organisms originate. They make acquaintance with various levels of hygiene, such as body care, dental care and taking care of excreta and waste.

In the second grade they learn the food pyramid and the four-color meal, dangerous materials in the house, pregnancy and the growth of the unborn child in the womb of the mother. A school garden program discusses the choice of crops, diseases and pests.

In the higher grades, the curriculum includes reproduction, safety, environment, diseases as malaria and dengue and drugs. There is no specific subject at junior high dealing with health, but at senior high school the curriculum includes Health Education.

Differences between Nature Education and Basic Life Skills—Nature education is based on intellectual skills in which some life skills were incorporated. In practice it appeared that the life skills aren't learned. BLS is a character building activity. It is directed to change the attitude of the person who is given these skills. Also there are more themes.

2.2 Ministry of Health, School and Health Program

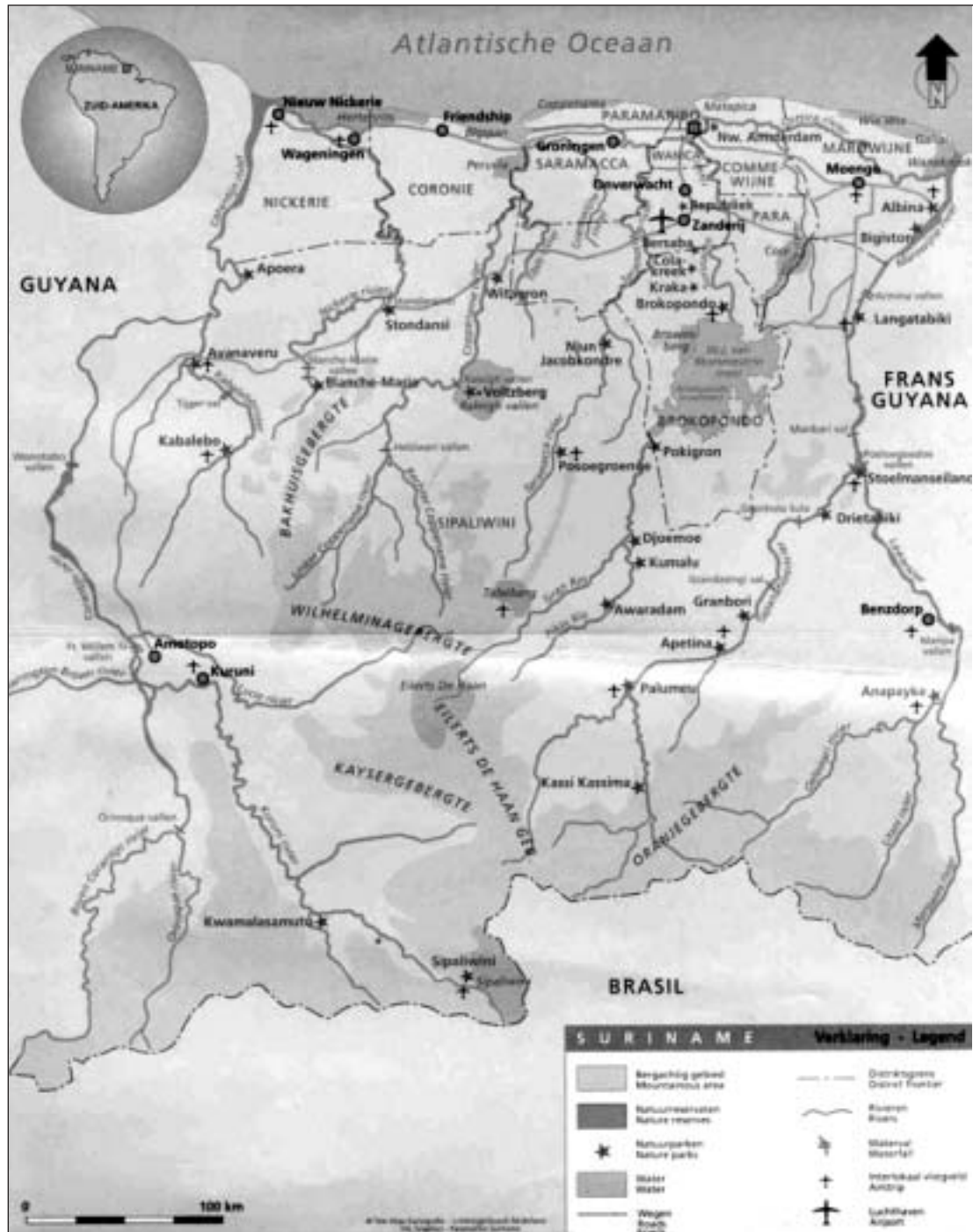
2.2.1 *The Bureau of Public Health (BOG)*

The Health Education Department of the Bureau of Public Health (Bureau van Openbare Gezondheidszorg, BOG/GVO) of the Ministry of Health carries out a School Health Project (SHP). However, after 1990 the BOG/GVO only carried out vaccination campaigns. After consultation with PAHO the Regional Health Services (RGD) became involved in the School Health Program for the coastal area as this organization already provided health services in this region. At the present time the BOG attends to 37 schools in the City of Paramaribo, as the RGD could not take over these schools because of lack of resources.

2.2.2 *The Regional Health Services (8)*

The Foundation for Regional Health Services is responsible for the primary health care in the districts 1, 2, 3, 5, 6, 7, 8, and 9 in the coastal zone of Suriname (see map 2). This zone is subdivided into 8 rayons. RGD's health services include:

1. Prenatal care
2. Postnatal care
3. Under five clinics (consultation bureaus)
4. Papsmear
5. Breast cancer surveys
6. Vaccination programs



Map 2: Suriname: Geographic

Suriname

The RGD also implements a school health program for the target population of 6-15 year olds attending school. Two hundred thirty six schools are included in this program with a total of 135,000 youth in the 6-15 year old category. Initially only curative health care was available for this age group, but since 1960 the first part of the school health program was implemented, i.e. vaccination. Since 1996 the RGD re-instituted the school health program (SHP). With support from PAHO, 23 school nurses were trained and a pilot project started in the school year 1997/1998. In 1999 another 19 school nurses were trained with support from UNICEF.

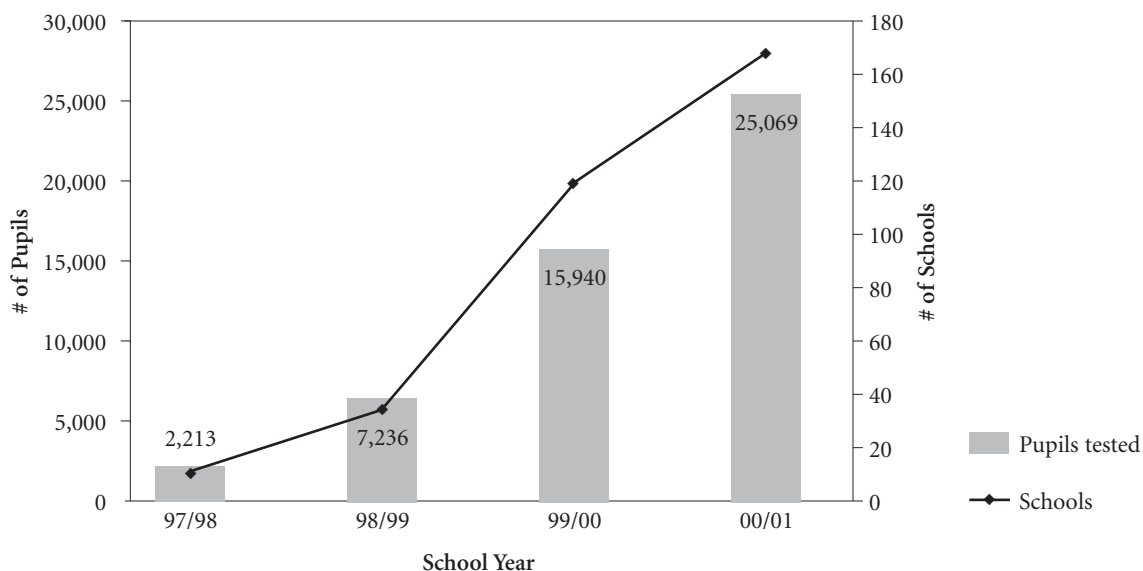
The objectives of the School Health Program are:

- Identify disorders and illnesses which could reduce learning capability
- Surveillance of communicable diseases
- Health promotion

The following aspects are included in the School Health Program:

- Nutritional status
- Hearing and vision
- Respiratory infections
- Dental disorders
- Orthopedic disorders
- Skin infections
- Poor school performance
- School hygiene

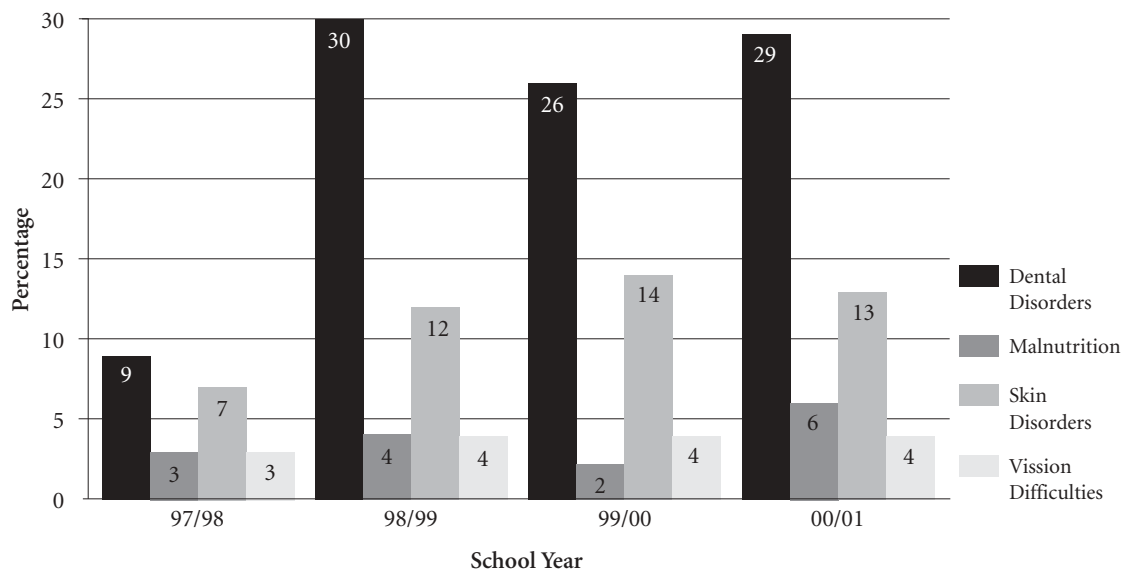
Graph 2: Suriname, Progress in School Health Program 1996-2001



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The survey included the 1st, 3rd, and 5th grades of the school and the program is executed in collaboration with the teachers. The number of schools and pupils surveyed over the period 1996-2001 is indicated in Graph 2. The results from these school surveys of the last four years indicated that most deficiencies with respect to school health are malnutrition, dental, vision and skin infections (see Graph 3).

Graph 3: Suriname RGD School Health Program, Main Disorders 1996-2001



From the data collected it is obvious that the SHP plays a key role in the primary health care. Early detection will prevent worse conditions at a later age and will increase conditions for improved learning. At this moment the problems encountered are dealt with on an ad hoc basis. There is little coordination between the health care workers and other agencies involved. The SHP is mainly medically oriented, while a broader approach is required considering the socio-economic environment of the pupil.

There is no SHP in the Interior of Suriname, where the Medical Mission (MM) provides primary health care. Health care providers of the MM provide health education, nutrition, breast feeding, and basic sanitation to the community at their clinics and on request by the community.

The RGD identified the following obstacles in the execution of its SHP:

1. Lack of information and collaboration between health care workers (doctors, nurses, specialists)
2. Lack of collaboration between different agencies and departments
3. Insufficient skill of school nurses in detecting socio-economic problems
4. Shortage of school nurses
5. Not all rayons are provided with school nurses

6. Insufficient logistical support for the work of the school nurses
7. Lack of equipment (scales, otoscopes, measuring tapes)
8. Lack of continuity in the education process (many strikes)
9. No standardized data collection and analyses, making intervention impossible.

2.3 School Feeding Programs

Nearly 16% of the cohort of children entering primary school are underweight, nearly 1 in 10 stunted and 6.5 % wasted (9). Children whose mothers have secondary or higher education are least likely to be underweight and stunted compared to children of mothers with less education.

Since 1940 the Ministry of Social Affairs has (MISOZA) implemented a youth feeding program for 0-12 year olds, including schools, nurseries, and boarding houses. The management of the institutions, schools etc. observes and selects those children who should receive nutritious complements and submits a request accordingly to the Department of Community Services. Some institutions request support for all pupils as to avoid stigmatization of children. The program collapsed after the commencement of the civil war in 1986. There were only intermittent private sector initiatives providing school feeding until 1996. The Ministries of Health and Education of the newly elected government in 2000 established the Foundation School Feeding and re-implemented the program. At present some 1800 children at 15 schools get a sub-sandwich. For example, at the Public School OS Latour (see previous chapter) 231 children out of 800 pupils receive a sub-sandwich each school day. A task group “School Feeding” of the Ministry of Health and the University provide quality control with regards to nutritional values. The Minister of Education recently submitted a request for funding of a school-feeding program to the IDB. There is also some level of school feeding by private initiatives at a small number of schools.

2.4 School Dental Health

The School Dental Health Program services consist of 71 youth dental health hygienists (3 yr. education in Suriname) to which students can subscribe on a payment basis and are registered at schools. Eleven clinics of the RGD have a dental room used for this school program, while 18 dental clinics are established at schools, either in a classroom or in a separate building. A total of 15,000 pupils in Paramaribo, Commewijne, Nickerie and Saramacca have subscribed to this service. There is also a special unit for handicapped children.

The services provided are preventative and curative dental health care:

Preventative

- weekly fluoride rinsing
- dental health education
- nutrition education

Curative

- removal of plaque
- polishing and removal of stains
- extraction of milk teeth
- x-rays
- conservation of teeth (filling and extraction)

3. School Watersupply, Sanitation and Hygiene Projects in Suriname (10)

This project's aims were to improve the physical condition of the watersupply and sanitation facilities in two selected public schools in Suriname and to improve the personal hygiene education. Furthermore this project served as a pilot for the introduction of the Global Healthy Schools Initiative.

The idea to improve watersupply and sanitary facilities at schools arose during the evaluation of the Inter American Water Day (IAWD) in 1999 and the IAWD Committee decided to focus on school watersupply, sanitation (and later added drainage and waste management), combined with personal hygiene education. Milestones of this project were highlighted at World Water Day in 2000 and 2001 and on Inter American Water Day in 2000 with collaboration of the whole school community (song, dance, poems, plays, drawings and art exhibitions, games, etc.)

The physical improvements included drinking water supply points in the schools yard, improved drainage of the schoolyard to reduce puddles and the subsequent worm and mosquito infestation, renovated bathrooms with flush toilets, trough urinals and wash basins. Different self-closing taps were used to reduce water demand and spillage. Waste issues were addressed through community clean-up campaigns and collaboration of the school in the national PET recycling competition.

At these schools special attention was paid to improve the skills of the teachers on sanitation and hygiene education for the students and the community to highlight the link between safe drinking water, good sanitation and personal and public health. Special workshops with follow up visits were conducted to increase not only the awareness and teaching skills in relation to water supply, sanitation, personal hygiene and health, but more so to change attitudes towards the sanitary facilities. Bathroom places were to be avoided, but the bathroom now becomes the place for personal hygiene training.

This project also fostered an improved cooperation between the community of the school, the relevant government departments of the Ministries of Health and Education, service clubs, private enterprises and NGOs. Broad participation from the schools and wider community was ensured from the beginning, strengthening the ownership of and pride in the renovated facilities and improved proper use, good caretaking and maintenance. The project was coordinated by PAHO and executed in collaboration with the Ministry of Education, Maintenance Department and BLS, Ministry of Health BOG/GVO, the Suriname Water Authority (SWM), the RGD, and Rotary Paramaribo Central. Support was provided by UNICEF, water departments, private sector, NGOs, parents, teachers, and community groups.

4. National Coordination

There are many activities, projects and programs from ministerial departments, NGOs and international organizations (UNICEF, PAHO) that are related to school health. However, there is very little coordination at the national level.

The Basic Life Skills Committee is the national coordinating body for the development and implementation of the Basic Life Skills program. In this committee representatives of the Ministry of Education and Health (BOG/GVO) are represented.

However, the RGD, who executes its School Health Program is not a member of this committee and the actual coordination between the Ministry of Education BLS department and RGD is minimal.

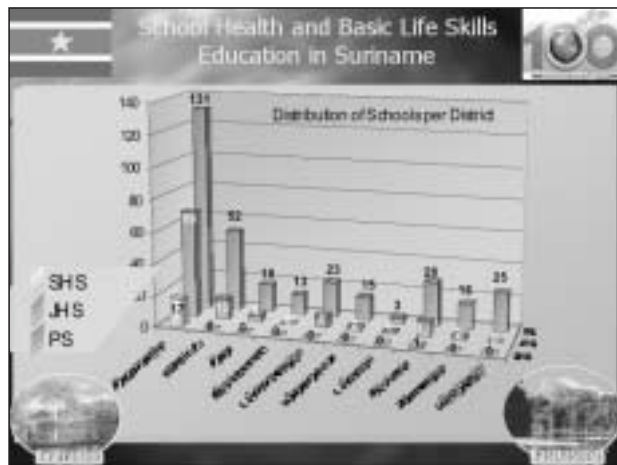
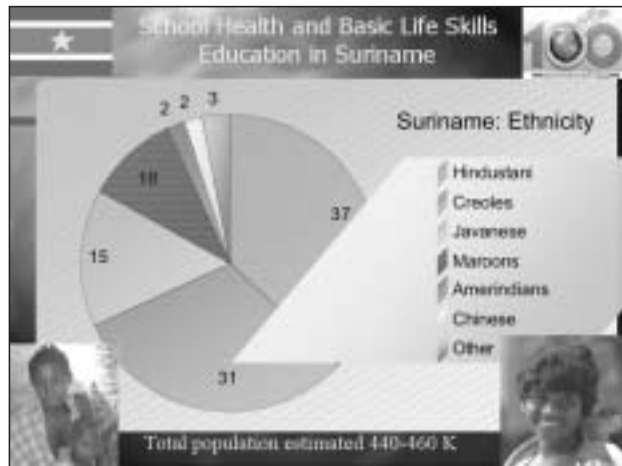
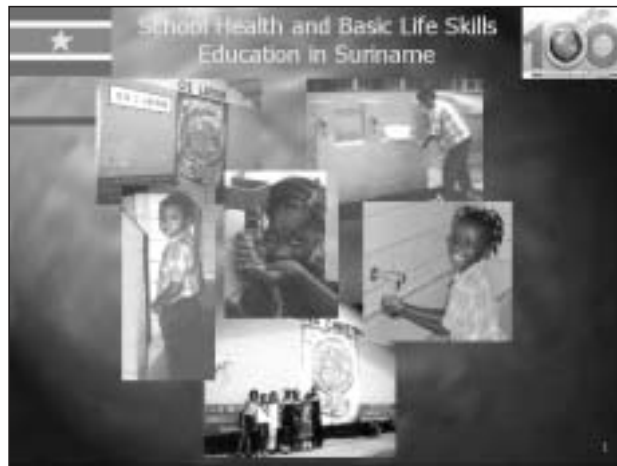
There is some coordination though, through the GOS/UNICEF joint Integrated Area Based Program (IABP), in which every collaborating ministry, including the Ministry of Health and the Ministry of Education has an appointed Sector Coordinator. BLS is part of this joint program and IABP has links with BLS activities.

The writers are of the opinion that the impact and efficiency of the activities described in this document could be significantly increased and improved if they were integrated in a coordinated school health program with representatives of the major partners.

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Country Presentations



-
- Basic Life Skill Committee established in 1997**
- Coordinate
 - Curriculum Development
 - Curriculum Implementation
- BLS materials are based on five themes:
- Responsible Environment maintenance and control
 - Dealing with ethnicity
 - Responsible sexual behavior and sexuality
 - Healthy nutrition and exercise
 - Socio-emotional development


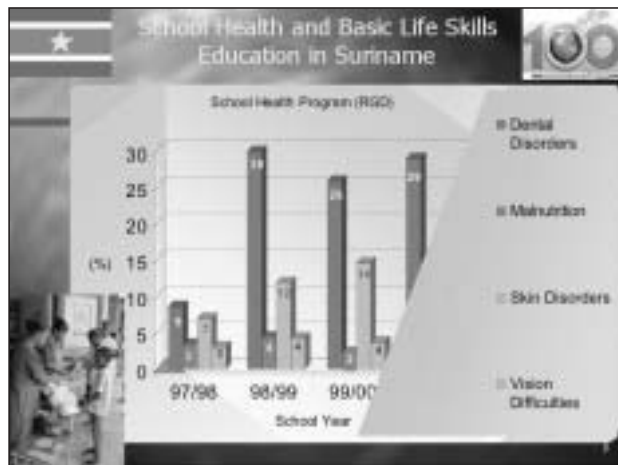
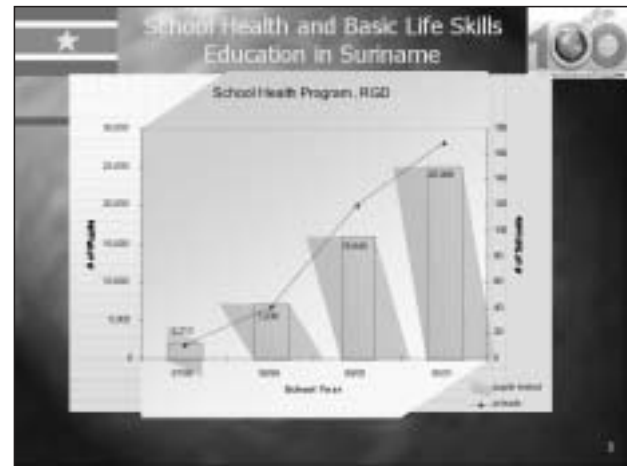
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- For these five themes 10 basic life skills written:
- 1 to make decisions
 - 2 to solve problems
 - 3 erect, into and maintain interpersonal relations
 - 4 communication skill
 - 5 empathy
 - 6 creative thinking
 - 7 critical thinking
 - 8 confidence
 - 9 dealing with emotions
 - 10 dealing with stress


-
- School Health Program RGD**
- Identify disorders and illnesses which could impede learning capacity
 - Surveillance of communicable diseases
 - Health promotion

School Health and Basic Life Skills Education in Suriname

Aspects surveyed in the SHP:

- Nutritional status 1
- Hearing and vision 2
- Respiratory infections 3
- Dental disorders 4
- Orthopaedic disorders 5
- Skin infections 6
- Poor school performance 7
- School hygiene 8






- School Health and Basic Life Skills Education in Suriname**
- Cohort of children entering primary school:
 - 16% underweight
 - 10% stunted
 - 6.5% wasted.
 - Mother with secondary or higher education have healthier children
- Source: Ministry of Health, Guyana Survey, 2003, Commission of Research, March 2004
- 

School Health and Basic Life Skills Education in Suriname

Presently some 1800 school children from 15 schools benefit from school feeding program

Ministry of Social Affairs
Ministry of Education
Ministry of Health
Private sector and NGO's



- School Health and Basic Life Skills Education in Suriname**
- Presently some 15,000 school children benefit from school dental health program in 4 districts.
- Preventive:
 - a. weekly fluoride varnish
 - b. Dental health education, brushing, tooth floss,
 - c. nutrition education,
 - Curative:
 - a. removal of plaque
 - b. polishing and removal of stains,
 - c. extraction of milk teeth,
 - d. X-rays
 - e. conservation of teeth (filling and extraction).
- 

Country Presentations

★ School Health and Basic Life Skills Education in Suriname



School Watering and Sanitation
A role for everyone



- School staff
- Students
- Parents
- Community
- Private sector
- NGO's
- Government
- International Organizations

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★ School Health and Basic Life Skills Education in Suriname





- Water facilities
 - flush toilets,
 - wash basins,
 - safe drinking water
- Sanitation
 - excreta disposal,
 - drainage,
 - garbage disposal
- Hardware
- Software

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★ School Health and Basic Life Skills Education in Suriname

Bathrooms: Everybody's Responsibility



- School staff
- Maintenance personnel
- Students
- Parents
- Technical assistance

15

★ School Health and Basic Life Skills Education in Suriname

Safe School Environment and Vector Control




- Safety
- Air Quality
- Light
- Noise reduction
- Waste management
- Waste disposal
- Breeding sites for Mosquitoes

16

★ School Health and Basic Life Skills Education in Suriname

Health and Hygiene Education






- Visits to the Toilet
 - Handwashing
- Nature Education
- Developing Materials
- Positive Approach
- Integration of Arts

17

★ School Health and Basic Life Skills Education in Suriname

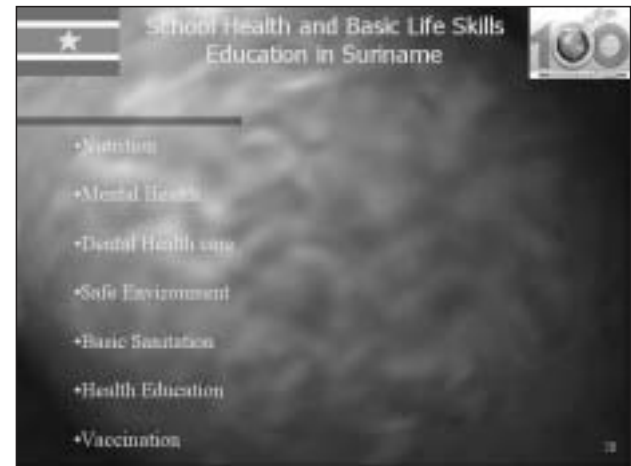
Water Day Celebrations

- Exhibitions
- Renditions
- Competitions
- Games
- Visits

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Suriname





Trinidad and Tobago

Carol Ann Senah, Ministry of Health

General

Trinidad/Tobago is the southernmost of the Caribbean islands, with a total area of 1980 square miles. Trinidad is the larger of the two islands. Trinidad and Tobago is an independent, twin-island unitary Democratic republic with a President as head of state.

Socioeconomic Trends

Main focus in the area of socioeconomic improvement, according to the Medium Term Policy Framework, is to improve the quality of life for all citizens, with a particular focus on the following:

- increasing the rate of economic growth
- increasing employment
- developing the country's most important asset: people
- preserving the country's natural environment

Trinidad and Tobago faces a number of socioeconomic issues that have an impact on health:

- Unemployment is more widespread among youths and women
- 3.5% of the people are living in poverty (as of 1981). This is believed to be increasing, with estimates of 14.8 % poverty in 1988 and 22% in 1997.
- Literacy of adults is said to be at 97.8%; this contrasts with a 1995 survey estimating 12.6% of the group as being functionally illiterate.
- High levels of crime plague the islands.
- There is a high rate of homicide and domestic violence, and these rates are increasing: Trinidad and Tobago has the 3rd highest per capita incidence of deaths caused by firearms.
- HIV infection has doubled every 3-4 years.
- Drug trafficking and high levels of illicit drug use continue to be a problem.
- More than 25% of youth are sexually active by age 12.
- Accidents are the most common problem for children.
- Intentional injury is a leading problem among those aged 15-24 years.
- All schools have security guards (the guard are not armed, but this is being considered).

Policy

Trinidad and Tobago has seen important policy developments in recent years. In 2000 a countrywide policy was established to guarantee placement for all children in secondary schools. In addition, approximately one billion dollars were allocated to the public health sector in 2000.

Project Lifestyle

Project Lifestyle is a collaborative, school-based health education program for adolescents 11-14, with teachers and families a secondary target. The program focuses on issues such as nutrition, sexuality, and self-confidence. The curriculum is knowledge-based and skills-based, with an emphasis on psychosocial education. A goal of the project is to increase teachers' knowledge of referral agencies and to improve referrals to psychosocial programs.

Project Lifestyle operates under the Directorate of Health Promotion and Public Health in the Ministry of Health.

School health programs have all been guided by surveys of adolescents, including the Caribbean survey and a modified survey for Trinidad and Tobago.

Project Lifestyle has been piloted in three secondary schools from urban and rural areas. The project is multifaceted and includes the following components:

- Consultations with stakeholders: school supervisors, PTA, teachers, principals, and children
- Sensitization seminars for parents, cafeteria staff, itinerant vendors, teachers, and the wider school population
- Baseline data collection on height, weight, BMI, and knowledge and attitude questionnaires of both teachers and students
- Skills training for teachers on such issues as measurement of BMI, physical fitness standards and assessment, special program on psychosocial issues
- Curriculum infusion workshops
- Workshops for teachers to develop specimen lesson plans with infused project lifestyle content and concepts

Project Lifestyle is part of the national health promotion plan from 1996-2001.

The final evaluation is being conducted and will be completed by March 2002.

Strengths and Barriers

- Collaboration amongst all the partners and stakeholders is one of the strengths of the project.
- The project has faced some barriers, as well, including difficulties with the labor-intensive nature of Project Lifestyle's implementation. Some teachers have felt that the program was an intrusion into a busy curriculum. In addition, the size and diversity of the schools' populations have presented a challenge.

The Way Forward

Trinidad and Tobago will be implementing the Health-Promoting Schools initiative over 2002 – 2004, building on Project Lifestyle. The participating agencies will collaborate with regional/community and NGO-based interventions with schools and youth groups.

Trinidad & Tobago

A Context for Health Promoting Schools

General Health Situation And Trends
(Health Conditions in the Americas 2001)

- Trinidad & Tobago is an independent twin-island Unitary State and a democratic republic with a President as Head of State.
- It is the southernmost of the Caribbean Islands.
- It has a total area of 1086 sq. miles with Trinidad being the larger of the two islands.

Socioeconomic Trends

- The main focus of the present Government as stated in the Medium Term Policy Framework (2001-2003) remains on people-oriented issues, as government seeks to improve quality of life for all citizens.

Socioeconomic Trends

The broad policies & goals include:

- Maintaining a high rate of economic growth with low inflation;
- Fostering an environment conducive to generating and sustaining increased employment opportunities;
- Developing the most important asset, the people;
- Enhancing the well-being of all our citizens; and
- Protecting and preserving the country's natural environment.

ECONOMY

- Although the energy sector continues to be the engine of growth, the non-oil sectors show a steady growth rate pattern with some 6,000 new jobs being created over the past five years in these sectors.
- This has resulted in a decrease in unemployment from 16% to 12.5% in 2000.

ECONOMY

- Unemployment is more widespread among the youths - 8.8% in the age group 15-19 and 23.1% in the 20-24 age group, and women.
- The percentage of population living in poverty is estimated at 3.5% at 1981
- Increasing to 14.8% in 1988 and 22% in 1997.

LITERACY

- 1997 – Adult Literacy (15yrs & over) - 97.8%, contrasting with a 1995 survey estimating 12.6% of this group as being functionally illiterate.
- A country policy has been established – 2000, and guarantees placements at secondary level for all students who complete primary school in the country.

IMPACT ON HEALTH

Social and political issues which have an impact on the delivery of health services include:

- High levels of crime - the number of homicides resulting from domestic violence has increased from 16 in 1996 to 23 in 1998, -widespread violence - Trinidad and Tobago has the third highest per capita incidence of deaths caused by firearms in the world.

IMPACT ON HEALTH

- Increase in HIV infection - the number of new cases of HIV has doubled every 3 to 4 years.
- Drug trafficking and the concomitant high levels of illicit drug use,
- Early age of onset of sexual activity -the average age of sexual encounter - 14 years, with more than 25% sexually active by 12 years of age.

IMPACT ON HEALTH

The government has placed crime, HIV/AIDS, domestic violence, poverty and drug abuse high on the national agenda and has increased allocations on basic social services.

In 2000, approximately one billion dollars (TT) were allocated to the public health sector, \$828 million for recurrent expenditure and \$142 million for capital works.

DEMOGRAPHIC TRENDS

- Trinidad and Tobago is a multi-ethnic, multi-cultural society with roots in Africa, India, China, Europe, and Mediterranean and the Middle East.
- It is estimated that 39.6% of the population are of African descent, 40.2% are of East Indian, 18.4% are of racial mixed ancestry and the remaining are Caucasian, Asian and others.

DEMOGRAPHIC TRENDS

- The 1997 mid-year population is estimated at 1,274,799 representing an increase of 0.9% when compared with 1996.
- The country is in a stage of advanced demographic transition, with a low birth rate and low mortality rates leading to a low rate of population growth.

DEMOGRAPHIC TRENDS

- Over the last 20 years the proportion of the population below 15 years has declined to below 30%, while the proportion over the age of 60 years has increased steadily to 8%.

MORTALITY & MORBIDITY

- The crude death rate in 1997 was 7.2 and this figure has remained the same for the past three years.
- Infant mortality has maintained a stable ratio at 17.1 per 1000 live births in 1995 and registers the same in 1997;
- Neonatal mortality rate decreased from 13.9 in 1995 to 13.1 in 1997;

COMMON HEALTH PROBLEMS BY TARGET GROUP

Reference: National Health Survey Trinidad and Tobago 1995

Young Children (1-4 years)

Male	Female
•Accidents	•Accidents
•Communicable Disease	•Acute Respiratory Tract
•Congenital Anomalies	•Infections
	•Congenital Anomalies

School-aged Childrel (5-14 years)

Male	Female
•Accidents	•Accidents
•Communicable Disease	•Cancer
•Cancer	•Acute Respiratory Tract

Young Adults (15-24 years)

Male	Female
•Intentional Injury	•Intentional Injury
•Accidents	•AIDS
•AIDS	•Cancer
	•Accidents



PROJECT LIFESTYLE



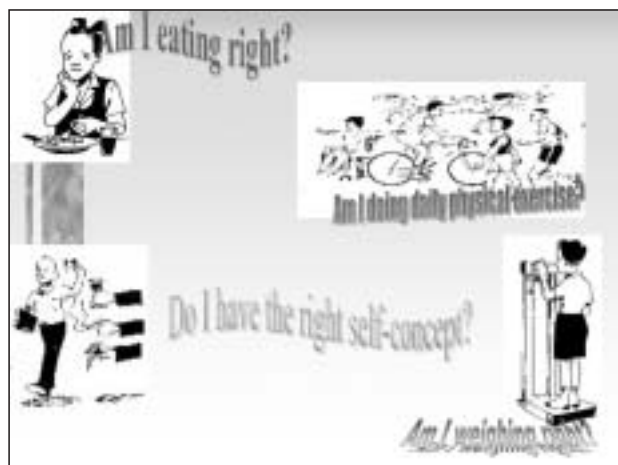
Directorate Health Promotion and Public Health
Ministry of Health
Trinidad and Tobago

Programme Description

Project Lifestyle is a school based health promotion programme, targeting adolescents 11 – 15 years, for the primary prevention of obesity, diabetes and hypertension.

Project Lifestyle attempts to promote healthy lifestyle habits such as:

- ✓ Weighing Right
- ✓ Eating Right
- ✓ Doing Daily Physical Exercise
- ✓ Not Smoking or drinking Alcohol
- ✓ Feeling Good About Oneself



Am I eating right?

Am I doing daily physical exercise?

Do I have the right self-concept?

Am I weighing right?

Aims

1. It aims at developing healthy lifestyles in school children, with the full involvement of teachers and parents.
2. The emphasis is on
 - skill development by the students
 - providing knowledge and motivation to continue positive healthy lifestyles even after leaving school.

Target Group

Primary Target :

Male and female secondary school students (11 – 14yrs)

Secondary Targets:

Teachers and families

Objectives

- To increase students' knowledge of food, nutrition and physical exercise and the relationship of these to health.
- To equip students with the knowledge and skills to enable them to make the right food choices, improve their eating habits and perform simple physical exercises.

Country Presentations

- To equip students with knowledge and skills to improve their psycho-social competence.
- To increase students' awareness of the relationship of tobacco use and alcohol abuse to health.
- To provide teachers with knowledge and skills to help them to identify their role in the psycho social development of their students

- To apply selected models of psycho-social education in equipping teachers with knowledge and skills for addressing psycho-social issues.
- To increase teachers' knowledge of appropriate referral agencies and their functions.
- To assist schools in devising a referral system for students who may need further assistance in dealing with psycho-social problems.

IMPLEMENTATION PROCESS

Site of Project

- Piloted in three secondary schools from urban and rural communities.
- Facilitated by HEDs supported by a technical team (MoH/MoE/PAHO/CFMI).

Consultations With Stakeholders

- > School Supervisors
- > Curriculum Officers
- > Principals and Teachers
- > PTA
- > Children
- > Community Health Teams

Sensitization Seminars

- > Parents and Cafeteria Staff
- > Teachers
- > School Population
- > Community Health Teams

Baseline Data Collection and Survey in Schools

- > Height
- > Weight
- > Body Mass Index
- > Blood Pressure
- > Physical Fitness Assessment
- > KAPB - Teachers and Students



Skills Training For Teachers

- > Measuring BMI
- > Weight and blood pressure monitoring and recording.
- > Training sessions for and establishment of standards for physical fitness assessment.
- > Programme for teachers in psycho-social development conducted by independent consultants.

Workshops

- > Curriculum infusion workshops for Curriculum Officers and School Supervisors.
- > Joint workshops for Curriculum Officers and Teachers.
- > Workshops for teachers to develop specimen lesson plans with infused project lifestyle content and concepts.
- > Continuing updates for teachers on Project Lifestyle concepts.

MARKETING

- Health Promoting Schools Competition for all students in participating schools.
- Project aired through school broadcasting.
- Advocacy and sensitisation for Health Promoting Schools Initiative.



Present Status of Project Lifestyle

- The implementation process was assessed in 2000.
- Assessment with SWOT analysis by teachers and facilitators – 2001.
- A final evaluation is being done in the context of the NHPP 1996-2001, to be completed by March 2002
- .

The Way Forward

- Implement Health Promoting School initiative over the period of 2002-2004 building on Project Lifestyle
- Collaborate with regional/community and NGO based interventions with schools and youth groups: risk practice survey, peer counselors, youth center (FPAL, TCC TRT/BAH and others
- Network with HFLE (recently approved by Cabinet) and Values Education Programme.

Nature and Scope of HFLE for TT

- To ensure that individuals acquire attitudes, knowledge, skills and values to develop healthy lifestyles.
- To empower individuals to make choices and decisions that will impact positively on themselves, their homes and their community.
- Designed to promote psychosocial competence.
- Life skills based intervention.

HFLE Process

- Appointment of National Multisectoral Committee coordinated by MoE.
- Design of plan of action and outlined policy document.
- Two island wide consultation on policy document.
- Policy approved by Cabinet.
- Development of curricula and initiation of infusion.
- Collaborate with Values Education Programme.

**MORALS AND VALUES EDUCATION: A
FRAMEWORK FOR INFUSING VALUES IN THE SCHOOL
CURRICULUM**



RATIONALE

The National Philosophy on Education according to the Education Policy Paper (1993-2003) of the Ministry of Education asserts:

- **‘That the educational system of Trinidad and Tobago must endeavour to develop spiritually, morally, physically, intellectually and emotionally sound individuals.’**

RATIONALE

- **‘That ethical and moral concerns are central to human development and survival. Fundamental constructs such as “decency,” “justice” “respect,” “kindness,” “equality,” “love,” “honesty,” and “sensitivity” are major determinants of the survival of our multi-cultural society.’**

RATIONALE

- **‘That there is the need to create and sustain a humanised and democratic system of education for the survival of our democracy.’**

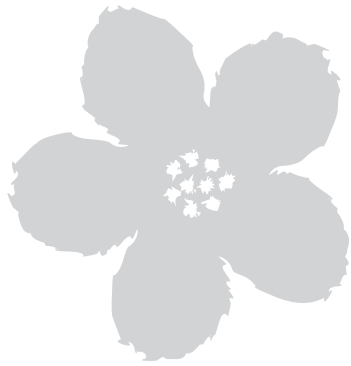
The Curriculum goals in relation to Morals and Values education are to:

- **explore the meaning and significance of a wide range of values and their contribution to the quality of life;**
- **assist teachers and others to reflect upon their theoretical formulations of Values education and their own value systems and their roles as models-in-relationship;**
- **allow for a social component that will facilitate the translation of values into attitudes and accepted behaviour’.**

THANK YOU



Mrs. Carol-Ann Senah



The Health- Promoting Schools Initiative in the Americas



The Health-Promoting Schools Initiative in the Americas

Josefa Ippolito-Shepherd, Ph.D., Health Education Advisor, Program of Family Health and Population, Division of Health Promotion and Protection, PAHO/WHO

Introduction

The Region of the Americas has a population of 850 million people, 13.5% of the world population. As infant mortality has decreased approximately 30%, it is estimated that over 220 million children survive beyond their fifth birthday. One hundred fifty six million children/adolescents are 5 to 19 years old. In 1990, 61 million children were enrolled in primary school while in 1998, 71 million were enrolled in school, with 5 million out of school. In Latin American and Caribbean countries, primary school enrollment has become almost universal, with the exception of rural poor children. Enrollment rates that reflect almost universal coverage are: Argentina 98.9%, Brazil 95.5%, Chile 99.7%, Colombia 95.1%, Costa Rica 97.8%, Ecuador 98.5%, Honduras 94%, Mexico 98.3%, Panama 99.3 Paraguay 98%, Uruguay 98.8%, and Venezuela 97.1%. However, there are marked differences between and within countries for indigenous, rural, periurban, and urban populations. Currently, the main causes of mortality for children and adolescents are “external causes,” including road traffic accidents that account for 25% of the deaths in this age group; violence 28%; and injuries 19%, with men bearing the largest burden for these factors.

There is a well-established tradition of school health programs throughout Latin American and Caribbean countries. Historically, school health departments were situated at the Ministries of Health and functioned as the country’s disease control office. The focus then was on disease prevention and control, reinforcing a medical and disease oriented strategy that reinforced a disengagement of teachers and students and a predominantly passive role on the part of the school community. A number of stages define the development and history of school health in the Region.

The school hygiene model, largely inspired by the European experience, introduced hygiene-related and disease control teaching in the school environment. Activities mostly addressed the threats of contagious diseases and included the inspection of individuals and environments, introduced standards of tidiness, and monitored the fulfillment of preventive measures. This model is still evident in some school health programs, representing the “use” of schools and their “captive” population to attain public health objectives.

In the 50s, *the medical school model* was an evolution of the school hygiene model that incorporated the progress archived by the medical sciences in the 1950s. Examples of this model are the massive vaccination campaigns and the presence of health education themes in the science curricula.

The 70s and 80s can be described as the “*policy years*” with the Alma Ata “Declaration on Health for All” and the Jomtien “Declaration of Education for All.”

The Health-Promoting Schools Initiative in the Americas

The 90s reflect integrated models of *school health* that are currently in the process of development in the Region. Two main approaches can be highlighted: schools as “*practical targets*” to reach children, adolescents and communities, and “*integrated*” school health programming. Within the first approach, schools are the targets of interventions to prevent the spread of disease, and the focus is on the health problems of children and their families. With this approach, schools represent a convenient delivery point for preventive and even curative interventions. Teachers and schools are involved in a range of activities from vaccination and maternal and child health campaigns to community health fairs that distribute health information to the school community. By contrast, the “*integrated*” school health program - where health and education stakeholders seek to complement various tasks and activities - are becoming increasingly popular in the Region. This model has been inspired by successful experiences in the United States of America and in Canada.

The Health-Promoting School Initiative in the Americas

The Health-Promoting Schools Initiative has three main components:

1. *Comprehensive school health education, including life skills training*
2. *Healthy and supportive environments and surroundings*
3. *Adequate health and nutrition services*

Regional Projects and Activities

PAHO/WHO technical cooperation in the Region has focused on sensitizing policy makers about the regional strategy, and in conducting training activities directed to technical personnel for the implementation of the strategy at the country level, including:

1. The conduction of regional and subregional meetings. Since 1993, several consultation meetings have been carried out, which provided support for the creation of the Latin American Network of Health-Promoting Schools in 1996.
2. The development of the **rapid assessment process and tools (RAP and RAT)** (1996).
3. The development of informational videos that document the development of the Health-Promoting Schools projects in countries of the Americas.
4. The construction and consolidation of the Latin American Network of Health-Promoting Schools is a project which provides a space for the exchange of knowledge, ideas, resources, and experiences. Currently registered in the Latin American Network are: Argentina, Chile, Uruguay, Paraguay, Peru, Brazil, Venezuela, Bolivia, Colombia, Ecuador, Panama, Costa Rica, Nicaragua, El Salvador, Honduras, Guatemala, Belize, Mexico, Cuba, and Dominican Republic.
5. The creation of the Network Newsletter “*Experiencias*.” The Newsletter is to be produced biannually to encourage the exchange of experiences and materials. It includes several sections, such as analysis of health and education policies, review of relevant documents to strengthen the Health-Promoting Schools Initiative of the Commissions and the National Networks.

The Health-Promoting Schools Initiative in the Americas

6. The creation of the partnership between the International School Health and Nutrition Initiative of the World Bank and the Health-Promoting Schools Initiative of the Pan American Health Organization. This partnership strives to provide a programmatic link between the school and the health sectors.
7. The development of “Life skills training for youth within the school system,” such as self-awareness, empathy, communication, interpersonal relationships, decision making, problem solving/conflict resolution, creative thinking, critical thinking, coping with emotion, coping with stress, and self-care skills.

Colombia

The Initiative started in 1996 with technical collaboration provided by PAHO. The country has been promoting activities such as training-continued education, academic training, political commitment, healthy public policies, community participation, such as the figure of “the personeros,” on preschool, primary and secondary school. The Colombian Network of HPS involves health, education sectors, family welfare, universities and NGO’s.

Colombia plans to expand and strengthen HPS activities to include:

- sexual and reproductive health
- tobacco, alcohol and other psychoactive substances, prevention and control
- nutrition
- environmental health
- violence
- community empowerment
- life skill training

There are other successful experiences in other Latin American countries:

Argentina

- Ministry of Health’s demand-driven initial health screening by teachers
- Ten thousand counselors employed by the Ministry of Education to provide support to students

Brazil

- Health Ministry’s TV topics such as STDs, are available to the Ministry of Education’s “TV Escola”
- Cooperation of MoE and the Brazilian Ophthalmology Council providing eyeglasses to students
- “National Curricular Parameters” for promoting healthy lifestyles and schools of citizenship

The Health-Promoting Schools Initiative in the Americas

- “Projecto Nessa Escola Eu Fico,” introduces health-promoting activities such as dance and drama
- R\$66 per year per student for preventative and curative services

Chile

- Junta Nacional de Becas (JUNAEB) provides free health for all children in primary schools

Colombia

- Life Skills Education provides workshops for families affected by violence

El Salvador

- “Escuelas Saludables” integrate education, health, nutrition and social protection in one curriculum

Paraguay

- “Escuelas Saludables” pilot, provides dental screening facilitated by the “Odontomóvil”

Peru

- “Teaching without Cholera” helped communities to provide basic sanitation infrastructure in 757 schools

Challenges

The most significant challenge is the mobilization of human resources and materials necessary to implement this Initiative, including the involvement of the society as a whole, international and technical cooperation agencies, political decision makers, private and public communication sectors, as well as teachers and parents. There is an immediate need to encourage community leaders, decision makers, and influential persons to become advocates for this Initiative, to provide the critical visibility and leadership to mobilize public opinion, and to convince key social actors to provide the necessary resources. The success of the Initiative depends to a great extent on the commitment of the countries as well as on the leadership role assumed by all sectors involved.

Plans for the Future

Strengthen/expand technical collaboration through:

- Dissemination of materials
- Development of HPS database
- Development of HPS Web site
- Development of Project Profiles for presentation to potential donors
- Regional/subregional/national operational plans
- Research
- Monitoring and evaluation, including Youth Risk Behavior Surveillance
- Latin American and Caribbean Networks of Health-Promoting Schools
- Use of Rapid Assessment Process and Tools (RAP and RAT) and preparation/dissemination of respective reports
- Regional implementation and evaluation of training workshops
- Regional implementation and evaluation of Life Skills training within the schools
- Implementation of activities responsive to the World Bank-PAHO/WHO partnership

In closing, health promotion and health education in schools is a pressing priority. Ensuring the right to health and education for all children is a responsibility shared by all. It is an investment that each society should make in order to generate and augment the creative and productive capacity of all young people and a sustainable social, healthy, and peaceful human future.

The Health-Promoting Schools Initiative in the Americas



Pan American Health Organization
Pan American Sanitary Bureau
Regional Office for the Americas for the
World Health Organization

**HEALTH-PROMOTING SCHOOL
INITIATIVE IN THE AMERICAS**

FIRST MEETING AND CREATION OF
THE CARIBBEAN NETWORK OF
HEALTH-PROMOTING SCHOOLS
Bridgetown, Barbados 31-39 November 2001

Josefa Ippolito-Shepherd, Ph.D
Health Education Adviser

Pan American Health Organization 2001

Region of the Americas

- 850 million people
- 13.5% of the world population
- Infant mortality has decreased aprox. 30%
- 220 million children survive beyond their 5th birthday
- 156 million children/adolescents 5 to 19 years old
- Countries with the least resources tend to be the ones with the highest percentages of young people

Pan American Health Organization 2001

Region of the Americas
(Primary school enrollment of over 90%)

	1990	1998
In Primary School	61 million	71 million
Out of School	11 million	5 million

Pan American Health Organization 2001

Region of the Americas

Primary school enrollment has become almost universal, except for rural poor children

- Argentina 98.9
- Brazil 95.5
- Chile 99.7
- Colombia 95.1
- Costa Rica 97.8
- Ecuador 98.5
- Honduras 94.0
- Mexico 98.3
- Panama 99.3
- Paraguay 98.0
- Uruguay 98.8
- Venezuela 97.1

Source: Cepal 1999

Pan American Health Organization 2001

Historical Approaches

- The School hygiene model and the European experience
- The medical school approach (50s)
- The "policy years" (70s and 80s)
 - » Alma Ata Declaration on Health for All
 - » Jomtien Declaration on EFA
- Integrated models of school health (90s)
 - Comprehensive programs focus on determinants and risk factors
 - School as "practical targets" to reach children, adolescents, and communities

Pan American Health Organization 2001

The Health-Promoting Schools Initiative in the Americas



Health-Promoting Schools in Central America and Panama

	Guatemala	El Salvador	Honduras	Costa Rica	Panama	Belize
HP5 policies	X	X	X	X	X	X
Coordination	X	X	X	X	X	X
Workshop	X	X	X	X	X	X
HP5 activities	X	X	X	X	X	X
Educational Material	X	X	X	X	X	X
Workshop LAMHS	X	X	X	X	X	X
Training	X	X	X	X	X	X
Community Participation	X	X	X	X	X	X
Workshop	X	X	X	X	X	X
Workshop	X	X	X	X	X	X
Publications	X	X	X	X	X	X
Learned lessons	X	X	X	X	X	X
Future Plans	X	X	X	X	X	X

Pan American Health Organization 2001

Health-Promoting Schools

ARGENTINA

- Ministry of Health's demand-driven initial health screening by teachers
- Ten thousand counselors employed by the Ministry of Education to provide support to students

BRAZIL

- Health Ministry's TV topics such as STDs, available to the Ministry of Education's "TV Escola"
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Pan American Health Organization 2001

Health-Promoting Schools

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EL SALVADOR

- "Escuelas Saludables" integrate education, health, nutrition and social protection in one curriculum

PARAGUAY

- "Escuelas Saludables" pilot, provides dental screening facilitated by the Odontomóvil

PERU

- "Teaching without Cholera" helped communities to provide basic sanitation infrastructure in 757 schools

Colombia

- "Escuelas Saludables", started in 1991, provides comprehensive health education - promotion - life skills education

Pan American Health Organization 2001

Challenges

- Mobilization of resources for the implementation of the initiative
- Involvement of the society as a whole
 - international and technical cooperation agencies
 - political decision makers
 - private and public communication sectors
 - teachers and parents
- Involvement of community leaders, decision makers, and other influential persons
- Commitment of the countries
- Leadership role for all relevant sectors

Pan American Health Organization 2001

Plans for the Future

- Strengthen/expand technical collaboration
 - Dissemination of materials
 - Development of HP5 data base
 - Web Site
 - Development of project profiles for presentation to potential donors
 - Regional/subregional/national operational plans
 - Research

Pan American Health Organization 2001

The Health-Promoting Schools Initiative in the Americas

Plans for the Future (cont.)

- Strengthen/expand technical collaboration
 - Monitoring and evaluation, including YRBS
 - Latin American and Caribbean Networks of Health-Promoting Schools
 - Use of RAP and RAT and preparation/dissemination of respective reports
 - Regional implementation and evaluation of training workshops
 - Regional implementation and evaluation of Life Skills training within the schools
 - Implementation of activities responsive to partnership World Bank-PAHO/WHO

Pan American Health Organization 2001

Health-Promoting School Initiative

Health promotion and health education in schools is a pressing priority. Ensuring the right to health and education for all children is a responsibility shared by all. It is an investment that each society should make in order to generate and augment the creative and productive capacity of all young people and a sustainable social, healthy and peaceful future.

Pan American Health Organization 2001



Health Promotion and Education in the School Setting: Status and Trends in the Latin American Region

Dr. Benjamín Puertas, Director of Masters in Public Health, Universidad San Francisco de Quito, Ecuador

Criteria for Analysis

- Policy development
- Coordinating mechanisms
- Comprehensive health education
- Healthy environments
- School health services
- Risk behavior surveys surveillance
- Monitoring and evaluation system
- Community participation

Policy Development

- The elements analyzed were education reform in the Region, with particular interest in curricula renovation
- The existence of intersectoral policies between the health and education sectors was also analyzed. All the countries in the region are going through a curricula reform.

Coordination Mechanisms

The existence and participation of intersectoral committees (health and education), commissions, or task groups was analyzed. The Latin American experience showed that although most of the countries have a national joint committee, it is not necessarily active currently. In some cases, local committees created to deal with a particular issue have a better impact.

Health Education

- Health education is approached as a subject in several countries. However, health education is included throughout the curricula in some countries of the Region.
- Teacher's training and continuing education in health promotion and education is not wide spread in Latin America. However, there are some interesting experiences of training programs for teachers in which health promotion is included.

The Health-Promoting Schools Initiative in the Americas

- The educational material produced in the Region is mostly traditional (hygiene, sanitation), but several countries are introducing more comprehensive and participative educational material (self-esteem, interpersonal relations, etc.)

School Environments and Services

Environments

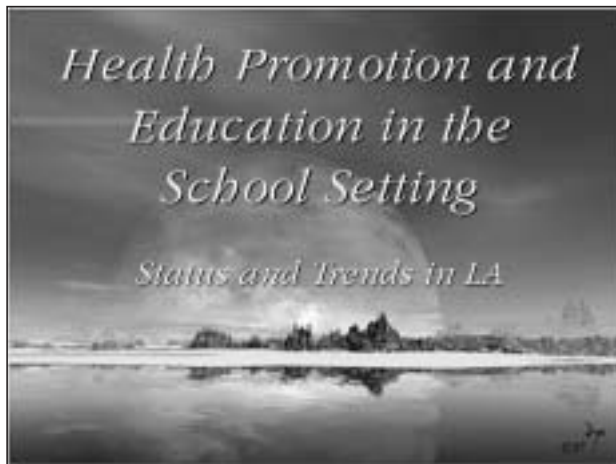
Most of the School Health Programs in the Region have included the improvement of the physical environment of the schools as one of their strategies. However, there are only a few countries, which include the psychosocial and emotional environment at the school level.

Services

- Health services are located at the schools, but children are usually referred to the health system for care. Mobile units have been implemented in some countries. Most of the services are related to screening (sight, hearing, weight and height), diagnosis and treatment of disease, and disease prevention. Health professionals at the school level do not provide services or information related to health promotion and do not become involved in health education.
- Feeding Services—all the countries have some type of school nutrition program (fortified milk, fortified cookie, etc).

Monitoring and Evaluation

Monitoring and evaluation of school health programs is limited in the Latin American Region. There are some efforts in certain countries to establish a continuous evaluation system (process, impact and results).



CRITERIA FOR ANALYSIS

- Policy development
- Coordinating mechanism
- Comprehensive health education
- Healthy environments
- School health services
- Risk behavior surveys surveillance
- Monitoring and evaluation system
- Community participation

Policy Development

- Education reform: Curricula renovation
- Intersectoral policies (health - education)
- Other policies, agreements, norms or legislation

Coordination Mechanisms

- Intersectoral committees, commissions, task groups

Health Education

- Health education as a subject or included throughout the curricula
- Teacher's training and continuing education in health promotion and education
- Educational material
traditional/comprehensive and participative

School Environments and Services

ENVIRONMENTS:	SERVICES:
■ Physical environ.	■ Health services
■ Psychosocial and emotional	■ Feeding Services

Research

- ◆ Youth risk behavior surveys and surveillance system

Monitoring and Evaluation

- Monitoring and evaluation of school health programs

Community Participation

- ◆ School - community integration
- ◆ Parent - teachers association



Multi-Risk Information Surveillance Systems: Behavior Surveillance Among Youth

Charles Gollmar, World Health Organization (WHO)

Mr. Gollmar described current surveillance efforts currently being conducted by the World Health Organization to gather global data on risk factors affecting the health of children and adolescents worldwide. The following is a brief summary of his presentation.

In partnership with UNICEF, UNESCO, UNAIDS, CDC, and the World Bank, the WHO will act as the Secretariat of a new surveillance system called Global Multi-Risk Information Surveillance Among Youth. The primary purposes of the system are:

1. To provide countries with high-quality data on risk factors affecting the health of children and adolescents to drive policies and programmes and to justify resource allocation decisions
2. To provide data that will enable countries and international agencies to compare the prevalence of important risk factors among youth, both within and across countries
3. To provide data that will enable countries and international agencies to track trends over time

This surveillance system is significant in that it focuses on collecting information not only about disease prevalence, but also about behavior. Behavior surveillance can increase efforts by showing that adolescents do not have either the knowledge base, or the appropriate behavior, to avoid disease.

The surveillance system will focus on risk factors related to the following health areas:

- injuries and violence
- tobacco use
- alcohol and other drug use
- sexual behaviors
- dietary behaviors
- physical activity
- mental health
- hygiene

The project will place a particular emphasis on building capacity within countries by providing technical support for data collection, assistance with dissemination of results, and assistance in applying the data to programs and policies addressing the health needs of children and adolescents.

The survey will consist of a core questionnaire with specific modules to assess different risk factors. The survey is designed to be flexible in its implementation and can be modified to meet individual country needs.

The Health-Promoting Schools Initiative in the Americas

At the next meeting of professionals involved in creating the Multi-Risk Information Surveillance Among Youth, the participants plan to draft a core set of questions for each of the 8 modules, draft add-on questions as time permits, and determine the next steps to further the development of school-based and non-school-based, multi-risk information surveillance among youth. Included in this meeting will be professionals from the WHO, UNESCO, UNICEF, UNAIDS, the World Bank, FAO, the Centers for Disease Control and Prevention, Education International, Education Development Center, Inc., and Family Health International. In addition, the following countries will be represented at the meeting: Botswana, Brazil, China, Costa Rica, India, Indonesia, Jamaica, Malawi, South Africa, the Russian Federation, and Zambia.

Multi-Risk Information Surveillance System

Behavior Surveillance Among Youth



Department of NCD Prevention and Health Promotion, WHO

Outline

- Where are youth?
- Special considerations
- What is already going on?
- Global Multi-Risk Factor Surveillance Among Youth

Where Are Youth?

- In-school
- Out-of-school
 - Households
 - Other settings

Special Considerations

- Gatekeepers
- Location
- Privacy
- Simplicity
- Duration

Global Multi-risk Information Surveillance Among Youth

- July 14, 2001 - 3rd meeting
- WHO, UNICEF, UNESCO, UNAIDS, CDC, World Bank, FHI,
- In school (WHO) and out-of-school (UNAIDS, UNICEF) components
- WHO will act as Secretariat

Primary Purposes of System

- To provide countries with high quality data to drive policies and programmes and to justify resource allocation decisions
- To provide data that will enable countries and international agencies to compare the prevalence of important risk factors among youth – within and across countries
- To provide data that will enable countries and international agencies to track trends over time

The Health-Promoting Schools Initiative in the Americas

Focus of System

- Injuries and violence
- Tobacco use
- Alcohol and other drug use
- Sexual behaviors
- Dietary behaviors
- Physical activity
- Mental health
- Hygiene

Capacity Building

- Technical support for data collection
- Dissemination of results
- Application to programs and policies

Survey Design

- Core questionnaire
- Risk factor specific modules
- Flexible implementation
- Modified to meet individual country needs

Disease surveillance can reduce a country's efforts where there is low prevalence, but...

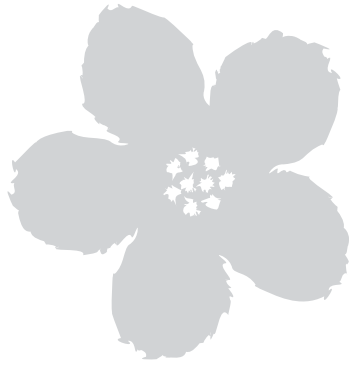
Behavior surveillance can increase efforts by showing that adolescents do not have either the knowledge base or the appropriate behavior to avoid disease.

Purpose of the 4th Meeting of Professionals Interested in Multi-risk Information Surveillance among Youth

- Draft a set of core questions for each of the 8 modules
- Draft add-on questions as time permits
- Determine next steps to further the development of school-based and non school-based Multi-Risk Information Surveillance Among Youth

4th Meeting of Professionals Interested in Multi-risk Information Surveillance Invitees

- WHO/HQ, WHO/RO
- UNESCO, UNICEF, UNAIDS, World Bank, FAO
- CDC, EI, EDC, HBSC, Family Health International
- Botswana, Brazil, China, Costa Rica, India, Indonesia, Jamaica, Malawi, South Africa, The Russian Federation, Zambia



Experiences of Health-Promoting Schools and Networks



Latin American Network of Health-Promoting Schools

Dr. Benjamín Puertas, Director of Masters in Public Health, Universidad San Francisco de Quito, Ecuador

Background

Consulting Meeting: Universidad Nacional Heredia, Costa Rica 1993.

Latin American Health-Promoting Schools Network: First Meeting and Conformation Session. *San José, Costa Rica, 1996.*

II Meeting of the Latin American Health-Promoting Schools Network, *México DF, April 1998.*

Original Country Members

- Argentina
- Bolivia
- Colombia
- Costa Rica
- Chile
- México
- Panamá

Network Levels

- International level
- National level
- School level

Objectives

- To promote the implementation of the Health-Promoting School Initiative within the region, as an intersectoral strategy which promotes the acquisition of knowledge and the adoption of healthy lifestyles within the school community.
- To facilitate exchange and inter-relation among the different groups which work in health promotion and health education activities at the school level.
- To establish common and complementary activities as determined by the technical consulting group, together with PAHO and the countries' Mixed Commissions.

Experiences of Health-Promoting Schools and Networks

- To stimulate and support the conformation and functioning of local and national networks to strengthen health promotion and health education activities.
- To strengthen the countries' technical capacity to design, implement and evaluate school health programs.
- To support the exchange of experiences, information and resources within the member countries.
- To facilitate technical cooperation in the area of health promotion and education at the school level.
- To promote the generation and dissemination of knowledge and technology related to school health.

Advantages

- Sharing of national experiences
- Systemization of experiences at the national level
- Identification of common problems
- Solutions which apply for most of the countries
- Interaction with other networks
- Increased horizontal technical cooperation
- Health promotion as an issue
- Enhanced need to evaluate school health programs at the national level
- Development of mechanisms to promote communication (bulletin)
- Promotion of youth risk behavior research and surveillance
- Exchange of information and educational material

Weaknesses

- Continuous funding
- Difficult coordination (time consuming)
- High turnover of country network representatives
- Insufficient and discontinuous government support
- Limitations for effective communication
- Experiences at the local level still unknown
- Duplication of activities
- Insufficient development and strengthening of national networks
- Lack of knowledge of the network presence within the member countries
- Poor involvement of new actors into the process (private sector, NGOs, universities)

- Responsibility in only one or two focal points in a country
- Training and continuing education limitations
- Insufficient experience in network dynamics

Challenges

- Strengthening of national networks
- Involvement of local experiences (and actors) in the national network
- Promoting the involvement of other actors to the process (private sector, NGOs, universities)
- Identification of committed country representatives (focal points)
- Enhancing communication among members: Bulletin, Web page, database.
- Expanding the network to other countries
- Increasing cooperation with similar regional networks
- Human resources development in health promotion in the school setting
- More national nodes (focal points) participating
- Ensure participation of all country members
- Improve technical cooperation in the areas of health promotion, education and organizational development
- Ensure continuous funding
- Support advocacy activities at the national level to ensure continuous political support.

Experiences of Health-Promoting Schools and Networks

Latin American Network of Health Promoting Schools



LA Network: Background

- Consulting Meeting: Universidad Nacional Heredia, *Costa Rica* 1993.
- Latin American Health Promoting Schools Network: First Meeting and Conformation Session. *San José, Costa Rica*, 1996.
- II Meeting of the Latin American Health Promoting Schools Network, *México DF*, April 1998.

Original Country Members

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- Bolivia
- Colombia
- Costa Rica
- Chile
- México
- Panamá

Network Levels

- International level
- National level
- School level

LA Network: Objectives

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LA Network: Objectives...

- To facilitate exchange and interrelation among the different groups which work in health promotion and health education activities at the school level.
- To establish common and complementary activities as determined by the technical consulting group, together with PAHO and the countries' mixed commissions.

LA Network: Objectives...

- To impulse and support the conformation and functioning of local and national networks to strenghten health promotion and health education activities.
- To strenghten the countries technical capacity to design, implement and evaluate school health programs.

LA Network: Objectives...

- To support the exchange of experiences, information and resources within the member countries.
- To facilitate technical cooperation in the area of health promotion and education at the school level.
- To promote the generation and dissemination of knowledge and technology related to school health.

LA Network: Advantages

- Sharing of national experiences
- Systemization of experiences at the national level
- Identification of common problems
- Solutions which apply for most of the countries
- Interaction with other networks

LA Network: Advantages (2)

- Increased horizontal technical cooperation
- Health promotion as an issue
- Enhanced need to evaluate school health programs at the national level
- Development of mechanisms to promote communication (bulletin)

LA Network: Advantages (3)

- Promotion of youth risk behavior research and surveillance
- Exchange of information and educational material

LA Network: Weaknesses

- Continuous funding
- Difficult coordination (time consuming)
- High turnover of country network representatives
- Insufficient and discontinuous government support
- Limitations for effective communication

Experiences of Health-Promoting Schools and Networks

LA Network: Weaknesses (2)

- Experiences at the local level still unknown
- Duplication of activities
- Insufficient development and strengthening of national networks
- Lack of knowledge of the network presence within the member countries

LA Network: Weaknesses (3)

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LA Network: Challenges

- Strengthening of national networks
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LA Network: Challenges (2)

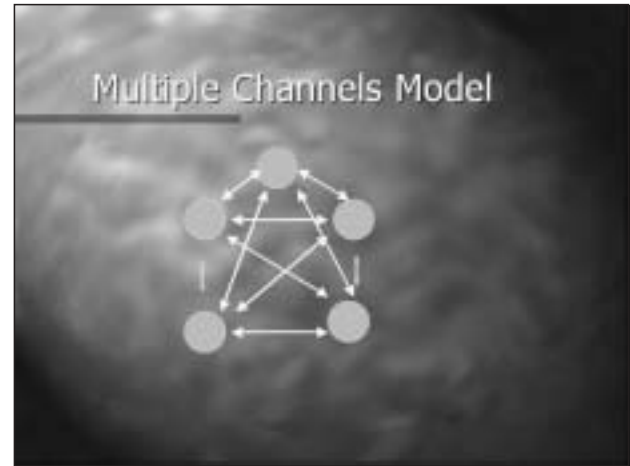
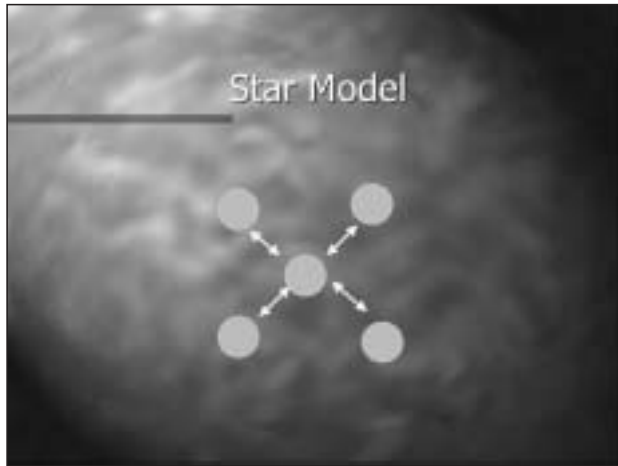
- Enhancing communication among members: Bulletin, Web page, data base.
- Expanding the network to other countries
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- Human resources development in health promotion in the school setting

LA Network: Challenges (3)

- More national nodes (focal points) participating
- Ensure participation of all country members
- Improve technical cooperation in the areas of health promotion, education and organizational development
- Ensure continuous funding

LA Network: Challenges (4)

- Support advocacy activities at the national level to ensure continuous political support.





The Spanish Experience

Prof. Dr. Antonio Saéz, MD, PhD, MPH, MBA, Catedrático de la Universidad Complutense; Presidente Asociación Iberoamericana de Salud Escolar; Tesorero Mundial de la OMEP

“The physician is the first line specialist to whom all the school problems are delegated.”

“The promotion of health cannot be considered separate from a person’s general education. Health is a resource for life and health education is a part of education for life. Thus, health must be a part of the person’s development from the beginning of life itself, starting in nursery school.”

Introduction

In the past, there was no relationship between school and health services. At the beginning of the 20th century, the prevalent public health problems were infectious diseases and limited resources, conditioned by environmental problems; limited food; and people’s ignorance about factors that affect health, poverty, and hunger. These led to an increased risk of epidemics that affected particularly children. With the development of the public education process, the increased frequency of communicable diseases in schools resulted in the establishment of an inspection system for School Health Services.

Historical Evolution of School Medical Services

According to Sainz of the Terreros, school and university medical and health services evolved in three stages.

Initiation Period - In the past, there was no connection between school and health services. In 1883, obligatory school attendance and frequent epidemics made it necessary to create a “Body of Chief Medical Inspectors.” The precarious situation of children in 1904, due mostly to poverty, ignorance, malnutrition, and child labor, led Dr. Tolosa Latour to enact the Childhood Protection Law, at the same time that the General Health Office dictated the monthly inspection of the public and private schools by Municipal Inspectors.

On 5 May 1913, a decree was published for the inspections of school medical services. In this decree, it was ordered to have a school physicians for populations larger than 100,000.

In 1914, Normal Schools and Superior Teaching Schools included the teaching of Hygiene and Physiology.

In 1922, the Institute of School Hygiene was created, whose mission was to impart training to teachers about medicine, hygiene, evolutionary psychology, sociology, and other related courses.

Experiences of Health-Promoting Schools and Networks

In 1932, while Don Fernando Giner de los Ríos was Minister of Public Instruction, the first Central Clinic of School Medicine was created in Madrid. At this time, school medicine was limited to controlling communicable diseases and evaluating growth and development through the measurement of height and weight.

Development Period - Starting in 1930, school medical services included areas of public health dimensions, such as infant/child preventive medical services (tuberculosis prevention, special education, health education for teachers, and various related publications). Key figures of this “golden age” of school medical services include: Sainz of the Terreros, Rodríguez Vicente, Juarro, and others. Juarro, the first ‘expert’ on “Rochard for children,” studied children’s psychomotor skills.

On June 5, 1933, the National Body for School Medical Inspections was defined and implemented (obligatory) and on December 18, 1934, the State Regulations of the School Medical Inspectors were published. Article 28 of these Regulations outlines the specific functions for these inspectors:

- Medical diagnoses for children attending national, municipal or private primary or secondary schools
- Medical diagnoses for teachers whenever there was a personal interest in these services or whenever the administration deemed it necessary
- Inspection of educational buildings
- All necessary health related control measures
- Organization of the school health services
- Organization of school physical education activities, etc.

Modern period (1940-1975) - On July 12, 1941 the Infant and Maternal Health Law was published, which was an advance in the fight for children’s and women’s health rights. School medical services became individualized during this period, going from collective health testing to individualized testing.

The improvements in socio-economic and cultural standards of living - together with the economic advances resulting from the process of industrialization, improvements in housing and sanitary conditions, along with appropriate nutrition and effective preventative and therapeutic strategies - changed the epidemiological pattern of child health. The obligatory school attendance policy, from 6 to 14 years of age, added another problem, characteristic of the turn of the century: “School Failure.”

During this period, the school physician worked with the school health team (the school nurse and auxiliary personnel) with the teachers, the family, and the psycho-pedagogic team of the Center.

School Medicine evolved into “school medical learning” as physicians were requested to provide solutions for students’ learning problems and to do diagnosis and prognosis of student’s school success, while the student was in the process of developing his or her potential. The medical decisions weighed heavily on the parents’ and teachers’ decisions about the student’s future.

Based on this, A. Serigó Segarra published “Medicine and School Health as an Introduction to Health Teaching,” where the physician was to address and consider the combined psychological, physical, pedagogical and social aspects affecting the student.

This time was a period of expansion, of development of regulations and technical norms, of creating networks and connections, as well as to exchange information and knowledge with other organizations and institutions responsible for children, for the development of scientific documents, and for international connections.

Contemporary period - The responsibility of the school physician changed from the prevention of disease to the promotion of health, from individualized actions to collective actions, from controlling physical environments to controlling psycho-social factors, from health services and specialized team work to interdisciplinary and multi-sectorial team work.

This change in school medical services took place under the leadership of Dr. Juan del Rey Calero. Dr. Calero knew well how to capitalize the importance of school medical service to improve the work of school physicians, by incorporating the study of epidemiology and health statistics; the use of computer science for accurately assessing school pathology and risk factors; and by proposing a new system for child and adolescent testing. Dr. Calero's studies are well known, including prevalence studies of students' diseases and control, hepatitis B markers in children with mental deficiencies and Down syndrome, seroepidemiological surveillance, and nutrition and cholesterol levels in the Madrid school population with elevated cholesterol levels.

On October 31, 1975, the Interim School Sanitary Regulations were approved. These regulated the medical-preventive interventions for the school-age population in public and private education institutions, as well as for the teachers and staff of these institutions. These activities included medical record-keeping, periodic check-ups, medical control for the teaching personnel and other school employees, and sanitary inspections of buildings and facilities.

In 1977, the State School Medical Inspection Services of the Ministry of Education and Science were transferred to the Ministry of Sanitation and Social Security and the Real Ordinance of August 25, 1978 was developed on the systematization of the Medical Services and School Hygiene. The functions were noted in article 7 of the Real Ordinance, in order of priority:

- Periodic health exams for the school-age population and teachers
- Health education in schools for students, teachers, and parents
- Study of proposals for the correction of sanitary conditions of schools and surrounding environments
- Healthy food and physical education
- Prevention of communicable diseases in schools
- Prevention and promotion of health activities (not clinical), with the technical support of the Ministry of Health and Social Security delegations

With the development of the General Health Law, the Autonomous Communities had the capacity to legislate on this matter, existing as a result of various School Health Laws within the Spanish State.

One of the most important changes during this period was the introduction of the concept of Health Promotion as “the process of training individuals and the community to increase their control on the determinants of health and, therefore, to improve it (Ottawa Charter, 1986).”

Experiences of Health-Promoting Schools and Networks

The theory of Health Promotion, which created a body of knowledge, is based on:

- The Strategy of Health For All, proposed by theWHO
- Community participation in the planning, administration, and evaluation of the programs that affect health
- Inter-sectoral collaboration related to health, for the creation of healthy spaces

The last two aspects broadened the range of responsibility from the health sector to the political sector, as a basic transforming element. Spain adopted the World Health Organization proposal “Health for All in the Year 2000.” Thirty-eight objectives were defined. The development of the health promotion in schools theory resulted in the Health-Promoting Schools Movement, with the participation of municipalities with experience in the area of promotion and prevention intervention and community participation for the creation of healthy school environments and for improving the quality of life in urban areas.

The Health-Promoting Schools Project is a strategy that allows for the integration of essential elements of health promotion and disease prevention in the school community.

Spain is now at a departure point from the diagnosis of the concrete necessities. Through the participation of all social agents, it will be possible to integrate the solutions planned through the curriculum, in order to generate respect for others and for peaceful coexistence.

A Healthy School is a school that has a vital space; is a generator of autonomy, participation, and creativity; and offers the student the possibility to develop to the maximum his or her physical, social and intellectual potential, by means of creating appropriate conditions for recreation, coexistence, security, and knowledge acquisition; resulting in the students’ adoption of healthy lifestyles and behaviors.

The Healthy Schools Project offers three developmental environments:

1. *The promotion of healthy lifestyles*, in which participatory activities and reflection play a fundamental role. In the context of the Educational Center, it becomes possible to implement the elements of health promotion and disease prevention and to transform them into ways of life. Health Education develops from a cognitive activity into a mechanism of social intervention.
2. *A healthy school environment* that addresses:
 - Physical and sanitary conditions of the school, which could become risk factors
 - Working conditions for teachers
 - Generating a space to mediate problems, to communicate and to respect others, making possible the development of healthy lifestyles and a harmonic coexistence,
 - Tolerance, generated and assumed by the all school and community members
3. *Appropriate health services*, focused on health promotion and prevention programs, with the purpose of guaranteeing the right to Health, as noted in the Spanish Constitution and the General Health Law.

Benefits of belonging to the Network:

- To share knowledge, experiences, and technological resources of the Healthy Schools Project
- Participation of municipal, national, and international organizations
- Participation in meetings, symposia, congresses, and seminars
- Sharing of publications and research with other national and international networks
- To contribute to the implementation of new Healthy Schools
- To support the evaluation of the strategies of Healthy Schools, at the conceptual and operative levels
- To share the Organization's projects through newsletters



Prosamusa: Health Promotion through Music

Dr. Benjamín Puertas, Director of Masters in Public Health, Universidad San Francisco de Quito, Ecuador

Prosamusa is an innovative program that uses music in school settings to teach children and their families, about health, nutrition, and the importance of healthy environments. The program is offered in Cotopaxi, the central region of Ecuador, and reaches 26 indigenous Andean communities in 13 primary schools and one high school.

The Health program includes the following components:

- Health education through music
- Child and youth risk-behavior surveillance
- Health protection
- Screening at the school level
- Primary health care
- Oral health
- Health brigades

Nutritional education is an important element of Prosamusa, and is reinforced through musical performances and role-plays. Mothers, and more recently fathers, cook meals within the school grounds, demonstrating the importance of good nutrition and applying what they have learned through the program.

The program also educates the community about the importance of a healthy physical and social environment and the maintenance of a sustainable ecosystem.

Music is the cornerstone of the program. Prosamusa not only raises musical awareness in the children and in the community, but also uses the music to teach health messages. Children learn to construct and play traditional Andean musical instruments, and they participate in choral clinics in which they sing traditional, indigenous music. The entire community is involved in the composition of songs, and a songbook of their creations has been created. Social participation is an important part of Prosamusa and is rooted in the concept of Mingas, an Andean tradition in which the community comes together to accomplish a common goal in a spirit of fun.

Results

Thus far, the results of the program are as follows:

- Over 15 health and music workshops have been offered, reaching approximately 350 participants, including parents and teachers

Experiences of Health-Promoting Schools and Networks

- Over 100 instruments have been built, including payas, quenás, and flutes
- Five songs with health messages have been composed
- 100% of activities involved music
- Two traditional bands were created
- Doctors and nurses are now playing instruments in order to participate in the use of music to teach about health
- Local NGOs and people from universities are now involved with the program

Challenges

- There is a need for local leadership and coordination to create sustainability of the program.
- Evaluation: it is difficult to measure the impact of the program after only one year, so this will require more time.
- The program seeks to improve local capacity and expansion to other areas; the Latin American Network of Health-Promoting Schools assists with this process.
- The program seeks mid- and long-term financing. It remains difficult to get funding for an entire program rather than individual components. The challenge is to view your program as comprehensive even when the funding comes from multiple sources.
- Intersectoral coordination is important but remains a challenge.



Background: Music and health

- Hip-hop music to prevent HIV/AIDS among afro-american teenagers
- Rap music for promoting condom use among youth (from inner city in Paris. (Jeyle, D. et al)
- Music for tobacco use prevention (David, F. et al)
- Pavarotti Music Center: children from Bosnia Herzegovina
- Bambiela Center in Kwa Mashu, South Africa: music against racial discrimination

"Music breaks with language, cultural, sexual and religious barriers, empowering the individual to trust his/her inner resources" (Circle for Life)

PLANCHALOMA

Unión de Org. Campesinas del Norte del Cotopaxi (UNOCANC)

UNOCANC - 2000 Health Program

Components:

- Improvement of health infrastructure
- Comprehensive health care
- Decentralized health system
- Health promotion and protection program: PROSAMUSA



Experiences of Health-Promoting Schools and Networks



Health Component

- > Children and youth risk behavior surveillance
- > Health protection
- > Screening at the school level
- > Primary health care
- > Oral Health: prophylaxis and treatment
- > Health Brigades

Nutrition component

- > Nutritional education: socio-drama, music with health messages
- > Health and nutrition workshops: promotion of healthy and unexpensive diets

Focus group at the school yard



Social Participation component

- > Participative decision-making
- > High degree of participation and control
- > Mingas
- > Health Fair

Health Fair: local band



Music Component

WORKSHOPS:

- Music awareness
- Andean music instruments: construction and performance
- Choral clinics
- Composition of songs with health messages

Construction of Andean Instruments



Performing and Choral Clinics



Healthy Environment Component

At the school level:

- A healthy physical and social environment
- A sustainable ecosystem
- Satisfaction of basic services

Results

- Over 15 health and music workshops (approx. 350 participants)
- Over 100 instruments built: payas, queñas and flutes
- Five songs with health messages (music and lyrics composed by community members)
- 100% of the activities had a music component

Results (2)

- Two traditional bands created (Chisulchi Crito and Planchaloma)
- New actors involved
- Active participation of girls and women in the workshops
- Health personnel and promoters trained in health and music
- Massive community participation in combined activities (health and music)

Challenges

- > Local leadership and coordination
- > Impact evaluation
- > Local capacity and expansion to other regions
- > Mid- and long term financing
- > Intersectorial coordination
- > Health personnel open to music alternatives



Puerto Rico's Experience

Dr. Lourdes E. Soto de Laurido, Coordinator, University of Puerto Rico Medical Sciences Campus

Why the Medical Sciences Campus of the University of Puerto Rico?

The University is a multiunit, state-supported, university system consisting of eleven campuses. It is a co-educational university system offering graduate, first professional, five, four and two year programs with over 50,000 students, 3,000 faculty members and 7,000 other employees.

History of the Medical Sciences Campus

In 1904, the Government of Puerto Rico created the Anemia Commission in response to a pressing health problem in the Island. Dr. Bailey K. Ashford and others pioneered the mass treatment of hookworm disease, establishing the grounds for the Institute of Tropical Medicine, which began operations in 1912. In 1926, under the auspices of Columbia University the Institute became the School of Tropical Medicine of the University of Puerto Rico. A specially designed and equipped building for research and teaching was erected next to the capitol building in old San Juan.

The Medical Sciences Campus comprises three complementary areas: education, research and service. In the same way the student's formative process is attained through a variety of educational experiences, both in the classroom and a multiple service setting in the public and private sectors in Puerto Rico.

Health Education is a combination of concepts related to education but also related to health. It is an applied science basic to the general education of children, youth and adults. Its body of knowledge represents a synthesis of facts, principles and concepts drawn from biological, behavioral, sociological, and health sciences; but interpreted in terms of human needs, human values, and human potential.

Acquisition of information is a desired purpose but not the primary goal of instruction. Rather, growth in critical thinking ability and problem-solving skills are both the process and the product of instruction.

The health educator must develop intellectual predispositions that are rigorously interdisciplinary, must have an open perspective on human problems, and must have a sense of decency for what it means to be socially conscious. As a professional he or she must have the basic skills needed to diagnose and analyze problems and to prepare educational programs suitable for individuals, and for groups. The mission of the Health Education Program establishes that our student must develop their intellectual skills according to the critical thinking theories. The goal of health education is to promote, maintain, and improve individual and community

Experiences of Health-Promoting Schools and Networks

health. The teaching-learning process is the hallmark and social agenda that differentiates the practice of health education from that of other helping professions in achieving this goal. Like that of the other helping professions, health education's methodologies require its entry into a social contract for dealing with people; however, it is the emphasis on the teaching-learning process that highlights our inherent belief in the individual's capacity to learn and assume responsibility.

Cultural sensitivity is a very important principle of health education. This principle is a key to changing behaviors. As a comprehensive system of beliefs and behaviors, culture provides a powerful framework for understanding the world.

When did we start working with the HPS Network in Puerto Rico?

- May 1999- Meeting with the coordinator of the PAHO Office in Puerto Rico- Department of Health explored its interest in the development of the HPS initiative in Puerto Rico.
- June, 1999- Meeting with Dr. María Teresa Cerqueira in Washington to get documents and information about the constitution of a Network.
- November, 1999- 1st Meeting Puerto Rican HPS Network-UPR- After the research of different documents, a group of health professionals met to discuss the possibility to create the HPS Network in Puerto Rico. Attendants included: Department of Education, Department of Health, University of Puerto Rico, NGOs, a leader from CDC, and private schools, among others.
- December, 1999- Meeting in Haiti. The interest of this country to be part of the Caribbean Network prompted a visit to make a formal presentation to the Minister of Education and to an Advisor of the Minister of Health.
- June, 2000- Sharing experiences in the World Conference in Health Promotion in Mexico. We identified the resources of Barbados a met Dr. Josefa Ippolito-Shepherd.
- October, 2000- Planning Committee Meeting in Puerto Rico for the coordination of the 1st Caribbean HPS Network. Attendants from PAHO headquarters, WHO-Geneva, CPS-Barbados, LAHPS Network and Puerto Rico.
- March , 2001- Coordination for the 2nd Meeting of the Puerto Rican HPS Network
- July, 2001- Definition of some publications of Puerto Rico's experience; working with risk behavior and curriculum development; search for funding.
- October 2000 until now- Coordination of the 1st Caribbean HPS Network.

Youth Risk Behavior Surveillance

It is used as the database for curriculum design, community work, and proposals.

According to the US Public Health Service, of the 10 leading causes of death in the U.S, at least seven could be reduced substantially if people at risk would change just five behaviors: compliance, diet, smoking, lack of exercise, and alcohol and drug abuse. Consumer psychologists can contribute to health promotion and disease prevention through: (1) basic research to

expand our understanding of cognitive representations and effective interventions; and (2) applied research to assess the effectiveness of various interventions and ways to more effectively implement what is already known about promoting health and preventing disease (Cacioppo, 2000). The design of an intervention plan to reduce risk behaviors of adolescents will contribute positively in the reduction of chronic disease in their adult lives. Reducing the risk is not an easy goal. When we talk about people, we have to consider the differences and interests of every one.

The 1997 Youth Risk Behavior Survey in Puerto Rico reported that 31% of 9th, 10th, 11th and 12th grade adolescents reported being currently sexually active, 7% reported having more than four sex partners during their lifetime. Only 34% reported using a condom during their last intercourse and 3% reported using contraception pills. The 1997 YRBS reported also that 20% thought that they are overweight, 29% reported being on a diet, and 40% reported participating in any strengthening exercises.

Objectives

- Organize a Health-Promoting Schools Network in Puerto Rico
- Draft the conformation document
- Identify experiences from other regions' HPS Networks that can be helpful in the development of the HPS Network in Puerto Rico
- Define guidelines to facilitate the development of the HPS Network in Puerto Rico
- Identify human resources for the development of the Network in Puerto Rico
- Identify sources of funding

Purposes

- To strength the formation of knowledge, attitudes and practices related to health
- To develop in students the skills that help them in decision making processes
- To work in the development of skills to empower the student's self-esteem
- To work with the community and school environments
- To identify Health Promotion and Health Education activities that contribute to the development of the Network around the island
- To design and develop a health education project with the participation of human resources of the Department of Education and the Department of Health

Our commitments

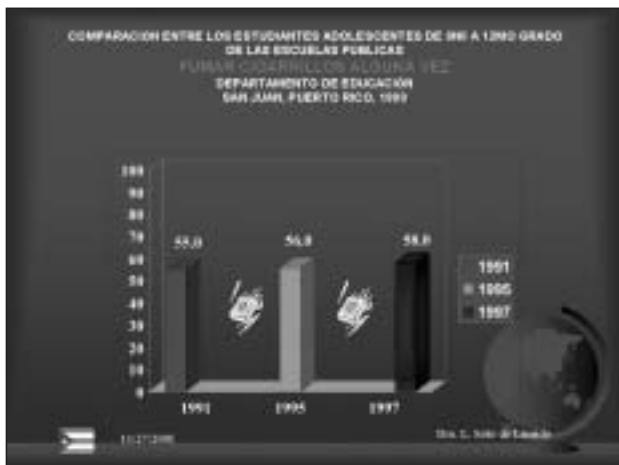
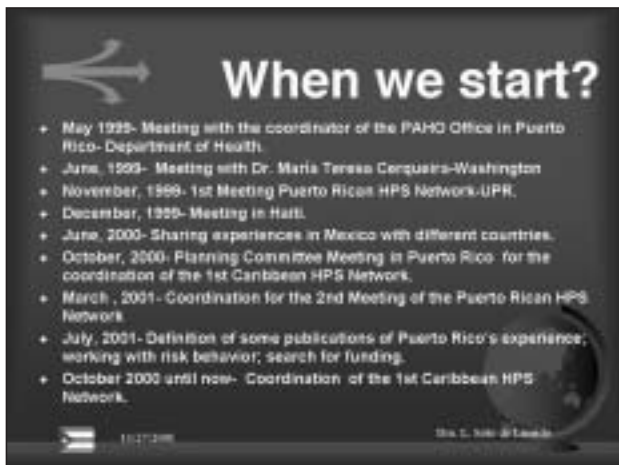
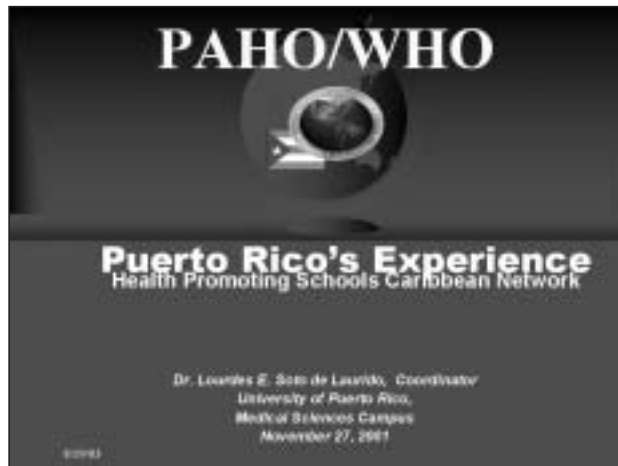
- Diffuse the health-promoting school concept
- Strength the institutional capacity to develop school health programs with gender equity

Experiences of Health-Promoting Schools and Networks

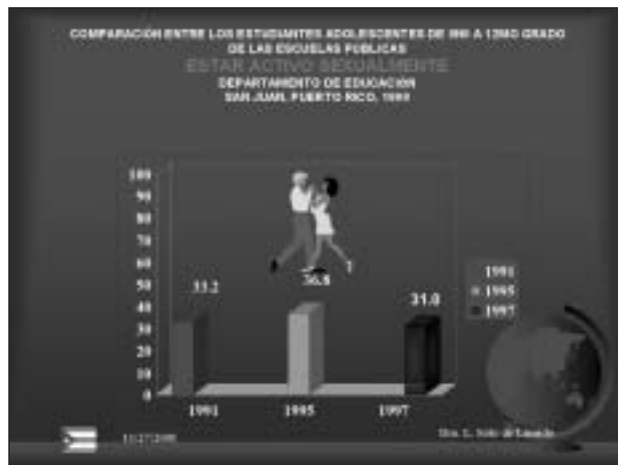
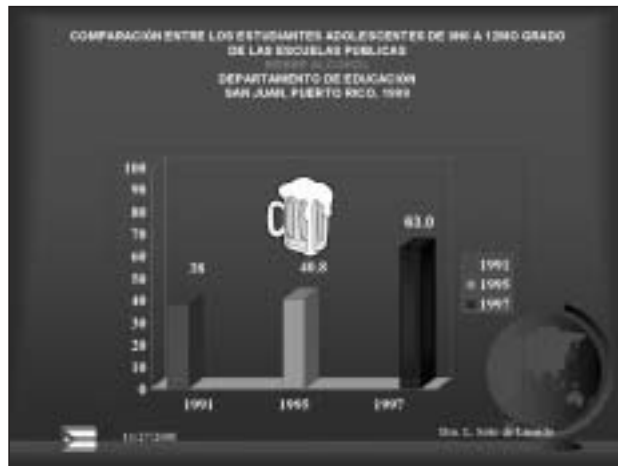
- Develop a working group to discuss different experiences
- Constitute an Advisory Committee
- Promote training programs to develop better aptitudes among the participants
- Design educational materials

In Puerto Rico

- We strengthened the health promotion and health education vision in an intersectoral relationship at a high level
- We organized a group to create a HPS Network in Puerto Rico
- We conducted two meetings
- Publicized a book about risk behaviors and curricula
- We designated the Medical Sciences Campus as the Center for the coordination of the Network's activities



Experiences of Health-Promoting Schools and Networks



OBJETIVOS

- Organize a Health Promoting Schools Network in Puerto Rico.
- Work in a draft of the conformation document.
- Identify experiences from other region's HPS Networks that can be helpful in the development of the HPS Network in Puerto Rico.
- To define guidelines to facilitate the development of the HPS Network in Puerto Rico.
- Identify human resources for the development of the Network in Puerto Rico.
- Identify sources of funding.

10/27/2006 Dra. C. Nido @ Leash

PURPOSES

- To strengthen the formation of knowledge, attitudes and practices relates with health.
- To develop in the students skills that help them in the decision making process.
- To work in the development of skills to empower the student's self-esteem.
- To work with the community and school's environment.
- To identify Health Promotion and Health Education activities that contribute to the development of the Network around the island.
- To design and develop a health education project with the participation of human resources of the Department of Education and the Department of Health.

10/27/2006 Dra. C. Nido @ Leash

Cuadro 1
ESTRATEGIA REGIONAL PARA DESARROLLAR Y FORTALECER LA PROMOCIÓN DE LA SALUD EN EL ÁMBITO ESCOLAR
DIFUSIÓN DE CONOCIMIENTOS Y EXPERIENCIAS

- Promoción de la Salud en el Ambiente Escolar: Marco Conceptual y Guía de Acción
Educación para la Salud en el Ambiente Escolar: Una Perspectiva Integral Red de Escuelas Promotoras de Salud en Latinoamérica y el Caribe
- REUNIONES Y TALLERES REGIONALES Y NACIONALES
Análisis de la situación actual
Diagnóstico rápido de la capacidad institucional
Identificación de necesidades
Enfoque integral en la educación para la salud
Recomendaciones para implementar el enfoque integral
- ACTIVIDADES PARA DESARROLLAR Y FORTALECER LA INICIATIVA DE ESCUELAS PROMOTORAS DE SALUD 1998-2000:
 - Cooperación técnica para implementar el proceso a nivel nacional y local.
 - Identificar las necesidades, técnica de diagnóstico y análisis rápido.
 - Actualizar el marco político y los mecanismos de coordinación.
 - Educación para la salud con una perspectiva integral: diseño curricular, capacitación de docentes y personal de apoyo.
 - Sectores, elaboración de materiales, fortalecer sistemas de monitoreo y evaluación, promover la investigación, promover actividades entre escuela, comunidad y familia.
 - Mejorar los servicios de salud y alimentación en el ámbito escolar.
 - Mejorar los entornos y ambientes en el ámbito escolar.

Our commitments


- Diffuse the health promoting school concept.
- Strength the institutional capacity to develop school health programs with gender's equity.
- Develop a working group to discuss different experiences.
- Constitute an Advisory Committee.
- Promote training's programs to develop a better aptitudes between the participants.
- Design educational materials.



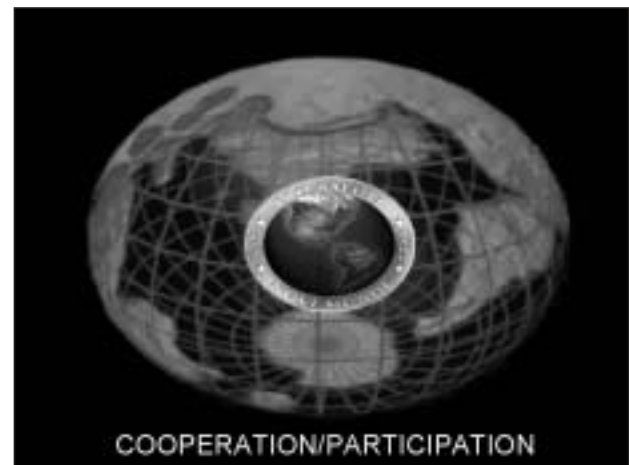
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In Puerto Rico...

- + We strength the health promotion and health education vision in an intersectorial relationship at a high level.
- + We organize a group to created a HPS Network in Puerto Rico.
2 meetings; topic of interest- violence;
- Publicate a book about risk behavior and curriculum.
- + We designated the Medical Sciences Campus as the Center for the coordination of the Network's activities.



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The Loja Experience

Eng. Leo Nederveen, Education and Communications Coordinator, PAHO, Loja, Ecuador

Antecedents

Considering the school as a dynamic and mobilizing environment in the collective construction of health, the Health-Promoting Schools Initiative has been implemented in 5 outlying municipalities in the province of Loja, Southern Ecuador, in the context of the “Project for the Development of Healthy Spaces”. The project promotes health by the action of 3 components: Reorientation of Health Services, Protection of the Environment and Education and communication. It includes cross-cutting strategies like Gender, Social Participation, Strengthening of Institutions and Intersectorial Coordination.

The project started in 1998 and will finish in December 2001. It is financed by the Dutch Government and implemented by the PAHO, in collaboration with the Ministries of Health and Education, the National University of Loja and other provincial and municipal counterparts.

At the start of the project a baseline study was executed, showing poor sanitary conditions of the schools. Teachers had deficient training and limited knowledge of health issues. Even if they had the knowledge, they were not able to teach the children adequately, due to a lack of educational materials for health education.

Another important conclusion from the baseline study was the fact that teachers were not aware of the role schools could play in health promotion. When they were asked for possible activities that schools could play in health, they responded that “they could send sick children to the doctor”, neglecting the health education tasks of schools. The important role children could play as change agents were not recognized. Instead the education was rather traditional in that children were just receivers of knowledge.

After the execution of the baseline study, the education strategy was defined. Its general objective was the inclusion of health promotion in formal education as part of the construction of healthy policies. Its specific objective was the incorporation of health in the curriculum and practice of schools within the framework of the curricular reform of the Ministry of Education.

The strategy is based on health promotion and included the formulation of healthy schools annual plans, the application of the child-to-child approach and the introduction and pre-testing of educational health guides of the series “The Health-Promoting School”,

National strategy

At national level the project created 13 health promotion guides for the 2nd to 10th year of basic education, which included different key issues of health promotion within the curriculum for the 10 years of basic education. There was a need for an integrated proposal, since an

Experiences of Health-Promoting Schools and Networks

analysis of existing material showed a series of limitations, such as: monothematic proposals in health, for example children's rights or hygiene, materials without any relation to the curricular reform and representing an additional workload for teachers, materials produced by projects with limited duration and diffusion, materials oriented to teachers, reinforcing the traditional pedagogical model with children as information receivers.

Another important activity at national level was the preparation of an Agreement, signed by the Ministries of Health and Education and different Development Organizations, including the Pan American Health Organization, the Dutch Development Organization, UNICEF, Foster Parents Plan and others to increment the coverage of the Health-Promoting Schools Initiative. The project has supported the creation of a National Coordinating Committee to give follow-up to the implementation of the Agreement.

A first step in the creation of the health guides was the revision of the curricular reform identifying the different topics and life skills related to the health promotion, corresponding to each school year. The selection includes health content and life skills within the 10 years of basic education and all the key themes in health promotion, including physical, mental and social health.

Instead of being directed to the teacher they are directed to the children, promoting interactive learning and including diverse individual and group activities for use in schools, the family and the community. Activities include small investigations, reflection, lecture, and suggestions for experiments, dramas and games. The health guides can be transversally integrated in the curriculum as part of natural sciences, languages and mathematics.

The guides were technically revised by experts of the Ministries of Health and NGO's and are now accepted by different organizations as a common material. Furthermore they were pre-tested in Loja and in other parts of the country. The Ministry of Health has approved the series for official use.

The series of educational materials "The health-Promoting School includes 2 flipcharts, 11 health guides for children and a teacher's manual:

- 2nd year: Flipchart "I am important".
- 3rd year: Flipchart "Me and the others".
- 4th year: I grow healthy, because I eat well and play a lot. The world I am part of.
- 5th year: I protect my health and my family's health. Living our rights and responsibilities
- 6th year: Healthy food and nutrition. Preparing me for growing.
- 7th year: The natural environment and I. I know myself and protect myself.
- 8th year: Learning to prevent.
- 9th year: My sexuality.
- 10th year: Boys and girls take care of our future.

Provincial strategy

The provincial strategy included training of primary and secondary school teachers and the creation of coordination mechanisms at a provincial and municipal level. The provincial coor-

dination mechanism includes the participation of provincial state departments, development cooperation agencies, NGO's and others. As part of these activities a deworming campaign was planned and executed in the schools of the province. At the municipal level, education committees have the participation of health services, municipalities, school networks and community organizations. Both provincial and local coordination mechanisms have made strategic plans for the coming year.

For the training of teachers first a provincial training team was created, consisting of professionals from counterpart organizations. Besides that, in the second year in each of the five municipalities a training team of teachers was also created. They were responsible for the training of teachers in the following three action lines: creation and implementation of Healthy Schools Plans, implementation of the Child-to-Child Approach and the use of health guides. A total of 142 (34%) primary schools and 27 (70%) of secondary schools were benefited by the intervention.

After each training course the schools were visited by the training teams to discuss difficulties in the implementation of the new learning methods. These visits also served to pre-test the health guides and to collect suggestions of teachers and children about content, language and illustrations. The suggestions of teachers and children were analyzed and incorporated in the second editions of the health guides.

Results

The Health-Promoting Schools Initiative and the curricular innovation in Loja has contributed to health promotion strategies, generating changes in pedagogical paradigms towards more participatory and child-centered teaching methods and a facilitation role of the educator. The intervention proved to have a favorable balance between its scale and the profoundness of changes. The materials produced by the project support the implementation of the curricular reform and are widely accepted by teachers, students and the community, as well as education experts. The strategy supports health promotion, including long term changes in life skills and life styles, strengthening of school-family-community relations and establishing mechanisms for the reorientation of health services, responding to needs of the school community.

The most important results of the implementation of the HPS-Initiative in Loja include:

- The participation of 34% of primary schools and 70% of secondary schools in the HPS-Initiative.
- The creation of 13 health guides, which were pre-tested and approved by the Ministry of Education.
- The Agreements between the Ministries and Development Cooperation Agencies has been important to extend the HPS-Initiative.
- The creation of Coordinating Mechanisms at the national, provincial and municipality level.
- Strategic alliances with NGO's, Municipalities and Cooperation Agencies.
- The inclusion of the health guides in the PALTEX-Program.

Lessons Learned

The participation of counterparts and teachers in the training teams and teachers in general in the pre-testing of the materials developed by the project, helped to sustain the strategy and promoted a sense of ownership for the health guides.

The participation of NGO's in the preparation of the health guides was important for their acceptance of the material as a material for common use, preventing every NGO from introducing it's own material in the schools, which leads to confusion and a heavy work load of teachers.

Limiting factors of the implementation of the strategy include the instability and rigid norms of the education system, the centralization, the high rotation of personnel, the weak coordination between sectors and the difficulties of teachers changing the traditional teaching methods.

Future plans and felt needs

To reach sustainability and dissemination of the strategy, the strengthening of agreements between the Education and Health Ministries and their dependents at the provincial level are required, as well as alliances with other development actors, international development agencies and NGOs.

Future plans include technical assistance to NGO's, like Foster Parents Plan and CARE-Ecuador, and municipalities which have shown interest in implementing the Health-Promoting Schools Initiative and the health guides in their schools. The training teams of Loja can be used to train training teams in other parts of the country.

The promotion and distribution of the health guides will be coordinated within the promotion of PAHO's text book program PALTEX.

Another important aspect is the strengthening of coordinating mechanisms at the national, provincial and municipal levels.



**HEALTH-PROMOTING SCHOOLS:
THE CASE OF LOJA, ECUADOR**



**Project of Healthy Spaces Loja
(PAHO/WHO)**

COMPONENTS:

- Reorientation of Health Services
- Protection of the environment
- Education and communication

CROSS-CUTTING STRATEGIES:

- Gender, Social participation, Strengthening institutions, Intersectorial coordination




**PROJECT OF
HEALTHY SPACES
LOJA**



Antecedents

- Poor sanitary conditions of schools.
- Deficient training of teachers in health education.
- Lack of educational materials for health education.
- Teachers are not aware of role of schools in health promotion and role of children as change agents.



Education strategy

- Health promotion from a gender perspective in formal education as a part of the development of healthy policies.
- Incorporation of health in the curriculum and practice of schools within the framework of the curricular reform of the Ministry of Education.

National strategy

- Creation of 13 health promotion guides for the 2nd to 10th year of basic education.
- National Framework Agreement between the Ministries of Education and Health and Agencies for Health-Promoting Schools.
- Coordination with the National Committee of Health-Promoting Schools.

Experiences of Health-Promoting Schools and Networks

Characteristics health guides

- Interactive learning guides, including diverse activities.
- Topics and selected life skills form part of the curricular reform(transversally integrated).
- Pre-tested in Loja and at national level.
- Participation of specialist from Ministries, CARE-Ecuador, Foster Parents Plan, and others in it's revision.
- Revised and approved by the Ministry of Education.



Interactive learning health promotion guides



- 2nd year: Flipchart "I am important"
- 3th year: Flipchart "Me and the others".
- 4th year: I grow healthy, because I eat well and play a lot. The world I am part of.
- 5th year: I protect my health and my family's health. Living our rights and responsibilities.

Continuation..



- 6th year: Healthy food and nutrition. Preparing me for growing.
- 7th year: The natural environment and I know myself and protect myself.
- 8th year: Learning to prevent.
- 9th year: My sexuality.
- 10th year: Boys and girls take care of our future.
- +
- Teacher's manual.

Provincial strategy

- Training in Health-Promoting Schools Initiative (Healthy Schools Plans) and Child-to-Child Approach.
- Implementation and pre-testing of health guides.
- Coordination at provincial level with state departments, Development Cooperation Agencies and NGO's (Interinstitutional Health-Promoting Schools Committee).
- Coordination at municipal level (health services, municipalities, school networks and community).

Training and pre-testing of educational materials.

- Creation of Provincial Training team and 5 training teams at municipal level.
- Training of training teams and teachers of 142 (34%) primary schools and 27 (70%) of secondary schools in Health-Promoting Schools Initiative (Healthy Schools Annual Plans), child-to-child approach and use of health guides.
- Visits to schools for monitoring and pre-testing.
- Sistematizing of the experiences of teachers and children.



Results

- 13 health guides created, pre-tested and approved by the Ministry of Education.
- Agreement between Ministries and Agencies.
- 34% of participation of primary schools and 70% of secondary schools in the Loja-Province.
- Creation and strengthening of Coordinating Mechanisms.
- Creation of alliances.
- Inclusion in PALTEX-Program.

Lessons learned

- Participation of counterparts and teachers essential to sustain the strategy and promote ownership.
- Alliances with NGO's supported a common strategy.
- Educational materials must be adopted to the curricular reform.

Dificulties

- Instability (high turnover) in education sector.
- Weak coordination culture between sectors.
- Difficulties of teachers changing the traditional learning methods.

Future plans

- Technical assistance to Foster Parents Plan, CARE-Ecuador and other projects in the adoption of the Health-Promoting Schools Initiative and the use of health guides.
- Advocacy and agreements with the Ministry of Health for diffusion of health guides in the official curriculum.
- Create training teams in other provinces.

Continuation...

- Promote the health guides as part of the PALTEX-Serie.
- Strengthening of Coordinating Mechanisms at the national, provincial and municipality level.
- Evaluation of the experience and the strategy's impact.



THANK YOU



Rapid Assessment and Action Planning Process to Promote Health through Schools

*Cheryl Vince Whitman, Senior Vice President, Education Development Center, Inc.
and Director, Health and Human Development Programs and the WHO Collaborating
Center to Promote Health Through Schools and Communities*

Introduction

The RAAPP—Rapid Assessment and Action Planning Process—is a method and set of tools for countries to assess their capacities to address the healthy development of students and staff primarily through schools and the educational system. Most importantly, the RAAPP goes beyond assessment and engages decision-makers and staff in using the findings to engage in strategic planning and action to strengthen capacities to deliver school health programmes. The RAAPP involves in-country teams at the national level from ministries of education and health and other relevant agencies, working together to collect and analyze data for their own decision-making. The RAAPP has now been co-developed and pilot-tested with ministries and other partnering organizations in Bolivia, Costa Rica, Indonesia, and Nigeria.

On behalf of the World Health Organization (WHO) in Geneva, Switzerland, Health and Human Development Programs, a division of Education Development Center, Inc. (EDC), began work in 1997 to apply the techniques of rapid assessment to improve infrastructure for school health programmes. WHO's Global School Health Initiative has provided leadership, technical input, and funding to develop the RAAPP. PAHO, based in Washington, D.C.; the Division of Adolescent and School Health of the U.S. Centers for Disease Control and Prevention; and the global teachers' union, Education International, originally provided guidance and linkages with countries to begin defining the elements of capacity and to develop the instruments. Since that time, many national ministries in Indonesia and Nigeria have been extensively involved in advancing the development of the tools and methods, which this presentation describes (More information is available on-line at www.edc.org/HHD/RAAPP). It is the hope of WHO, PAHO, and the Office of Caribbean Program Coordination, Barbados, that several countries involved in the Caribbean Network of Health-Promoting Schools will be leaders in using the RAAPP in their countries. This presentation is designed to provide interested Caribbean countries with background information to help them decide whether to use the RAAPP.

Development of the Method

In the 1970s, rapid assessment procedures emerged as investigators searched for efficient means to plan agricultural improvements or respond to natural disasters. First used widely in Africa, India, and Latin America, rapid assessments provided an alternative to the limitations, high cost, and time it took to collect information through large-scale traditional research, usual-

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ly involving surveys and randomized samples. One of the most significant innovations of rapid assessment techniques was to enlist the involvement of local field investigators in the design and wording of the instruments to collect information, thus ensuring the relevance and cultural sensitivity of the questions. This method has proven valuable in eliciting a range and quality of information and insights unavailable through large-scale quantitative methods. Most important, rapid assessment is based on the recognition that local people provide the most valuable, rich, and indispensable knowledge and information, and that their familiarity with their particular situation is much more likely to lead to effective action planning. This sample is purposeful to the study, is diverse and inclusive, and involves many sectors and levels. Until recently, the RAAPP has not been applied to the field of school health; this project is a new and exciting use of this method to look at the capacity of countries to improve their school health programmes.

We strongly believe that the rapid assessment process in school health should not end with the collection of data. Instead, built into the process must be the interpretation and translation of that data into an action plan. Accordingly, we have changed the name of the methodology by adding, “Action Planning” to both the title and the methods used (i.e., Rapid Assessment and Action Planning Process—RAAPP).

Benefits of RAAPP for Country Participants

Country participants who have been involved in the RAAPP report that the experience has provided many benefits. First and most importantly, the process of conducting the RAAPP has produced meaningful collaboration among leaders and staff within and across ministries of education, health, culture, and religion. As a RAAPP participant from Nigeria noted, “The RAAPP was the first time the Ministries of Education and Health have worked together in a significant way.” The activities of the RAAPP enable staff across ministries to share the vision and framework of a Health-Promoting School and to work to increase capacity, using the methods of RAAPP.

The RAAPP does not simply leave a country with its findings. Rather, RAAPP activities involve in-country teams in analyzing and transforming the findings into priorities for decision-making and action, setting goals and objectives, identifying milestones, developing flowcharts, and using other simple management techniques to ensure progress. The RAAPP process provides in-country team members with a high-quality professional development experience, building skills in teamwork, interviewing and facilitation, data collection and management, instrument development and adaptation, analysis and advocacy, and strategic planning. A RAAPP leader from Indonesia commented, “I feel the RAAPP activity is very important for us all. This programme is for the development of a healthy life, beginning with early education, to achieve a healthy Indonesia. I can contribute through RAAPP to the development of my country.”

What Is a Health-Promoting School, and Why Should the Ministries of Education and Health Both Be Involved?

A Health-Promoting School is one that uses all means at its disposal to address the healthy development of students and staff through policies dedicated to health, health instruction,

availability of health services, and a safe and healthy school environment—both physical and psychological. WHO, UNICEF, UNESCO, Food and Agriculture Organization (FAO), the World Bank, and other United Nations agencies have together agreed that nations should focus resources on, at minimum, four, effective and coordinated school health strategies, called FRESH (Focusing Resources on Effective School Health):

- Clear health policies for schools
- A healthy school environment, beginning with safe water and sanitation
- Skills-based health, hygiene, and nutrition education
- School-based health and nutrition services

The most effective school health programmes involve students themselves in the effort, as well as teachers, families and communities.

Research has shown that a basic cost-effective package of the components outlined above can reduce 8 percent of the disease burden in low-income countries. Schools have the potential to reach billions of young people and staff worldwide, especially in developing countries. Further, health and nutritional status have a direct effect on students' ability to learn and stay in school, especially for girls. While traditionally health education has been the primary component of school health programmes, it is important but inadequate alone and must expand to include health, mental health, and nutrition services and improvements in the physical and psychological environments of the school itself. Education and health systems need to work together to improve their capacity to provide these basic components of a school health programme.

What Core Capacities of National Infrastructure Does the RAAPP Assess?

Building capacity can be defined as finding ways to strengthen individuals, organizations, and even entire nations so they can assume a greater role in planning, managing, and sustaining forward movement. Capacity building is a way to nurture, enhance, and use the skills and talents of people and institutions at all levels so they can make progress toward specific goals. The RAAPP addresses five core capacities in the ministries of education and health that are essential for creating Health-Promoting Schools (HPS) and to Focusing Resources on Effective School Health Programs (FRESH):

1. Knowledge Base
2. Policy
3. Leadership and Management
4. Collaboration
5. Monitoring and Evaluation

The RAAPP instruments enable in-country teams to gather information so that staff can learn more about what they are able to do in each area; for example:

- Knowledge base—pertaining to evidence-based information concerning effective policies and programmes for school health. Do staff in the ministries have a way to:

Experiences of Health-Promoting Schools and Networks

- access published documents or locate experts and use the Internet?
- produce and disseminate information and materials?
- provide training to apply their knowledge base?
- evaluate new knowledge and skills?

- Policy. Do staff have a way to:
 - create policy that supports all components of an HPS and FRESH?
 - assess the quality of each policy and its relationship to larger national goals?
 - revise policies?
 - implement policies?
 - assess whether policies are implemented?

- Leadership and management. This includes the capacity to:
 - promote a shared vision and framework
 - designate a person or group with the authority to carry out a mandate
 - motivate staff, from the top levels for funding to the school level for implementation
 - manage human and financial resources
 - continually assess and respond to needs

- Collaboration across sectors. This includes the capacity to:
 - identify common ground and unique contributions
 - coordinate to leverage resources of each sector
 - encourage multi-stakeholder participation in planning and implementation of school health programmes

- Monitoring and evaluation of the processes and outcomes in school health programmes includes the capacity to:
 - regularly monitor determinants of health, and health and educational outcomes
 - evaluate implementation and effectiveness
 - disseminate and use evaluation results to publicize achievements and improve efforts

Taken together, the RAAPP assesses these five core elements of capacity — the roots of the infrastructure to support Health-Promoting Schools.

What Do the RAAPP Tools Look Like, and Who Is Involved at the Country Level?

RAAPP uses a variety of instruments, from structured rating scales to open-ended interview and focus group questions. For example, people working within the ministries are asked to rate their capacity to deliver the essential components of a Health-Promoting School: skills-based health education, basic health services, and safe and secure school environments. More open-ended questions ask about what mechanisms are in place for the ministry to create, review, implement, and enforce policy and where improvements could be made. Data are collected from people working at a variety of levels and sectors, for example:

- senior-level policymakers
- senior and mid-level managers
- non-governmental organizations, funders, media, and advocacy groups
- WHO, UNICEF, UNDCP, and FAO regional and country offices
- local-level school and health staff

There are numerous forms to display the tabulated data and an “Action Planning Worksheet” for each capacity area. See the Appendix for examples.

Conducting the RAAPP requires assembling in-country teams, made up of members across the Ministries of Education, Health, and other agencies relevant to school health efforts in that country. The team needs a strong leader or champion, a person with the ability to garner high-level support for the process. An in-country coordinator or manager is also needed to handle all the logistics and to support this leader. Strong leadership from within the country is needed to galvanize support and motivate staff throughout the process.

Among the participating country team members, it is important that some have basic skills in evaluation research, strategic planning and management, as well as the ability to conduct interviews and collect, code, and analyze data.

How Long Does It Take to Conduct the RAAPP?

The RAAPP is divided into three phases. Phase I, which concentrates on pre-RAAPP planning, can take one to two months. Phase I involves getting the team in place, finding and analyzing any relevant existing data, conducting a preliminary review of the instruments to ensure that they are relevant to the current situation, selecting and inviting the sample to be interviewed, and managing the scheduling and logistics. This preparation can be started by telephone, but a face-to-face meeting may prove advantageous.

Phase II, which typically takes from five days to three weeks, depending on the size of the country and volume of data to be collected, involves professional development workshops to prepare in-country staff to conduct the interviews and focus groups and to collect and record the data. In Phase III, ranging from 5-10 days, in-country participants analyze and interpret the data and use it to develop their Action Plan.

Why Should Ministries Bother to Conduct the RAAPP?

The health status — physical, emotional, and social—of students and staff affects students' educational performance, the productivity and effectiveness of teachers, and the longer-term economic growth of a nation. The authors of "Education for All 2000 Assessment, Thematic Studies on School Health and Nutrition" noted studies over the past decade showing the relationship between a child's nutritional status and his or her performance on cognitive tests. In the United States, health promotion programmes for teachers resulted in improvements in teachers' morale and health, as well as reductions in teacher absenteeism.

Health interventions and reduced death rates can contribute to slower population growth. Educated girls are likely to delay their first pregnancy and have fewer and healthier children.

Addressing health and preventing disease can have major benefits for a nation's economy. For example, it costs far, far less to invest in education to prevent AIDS than to treat the disease and care for its ill people. AIDS is a threat to the global market and Caribbean economy. It has been predicted that the world impact of AIDS could be as high as 4 percent of the GDP of the United States or to the GDP of the entire country of India. It has also been estimated that Kenya's GDP will be 15 percent less by 2005 than it would be otherwise – i.e., without the spread of AIDS.



The World Bank has documented that countries that invest in the development of their human capital through education and health have higher rates of economic growth. For example, countries that make a high investment in human capital have on average a 2.3 percent increase in economic growth. In comparison, countries with low investments in human capital experience no growth, and, in fact, decline.

Investing in health by reaching billions of young people and staff through educational systems can have numerous benefits, such as increasing individual students' ability to learn, improving teachers' attendance and morale, and fostering economic growth. However, the importance of enjoying good health in its own right cannot be overstressed. As Nobel Prize-winning economist Amartya Sen has said, "Health (like education) is among the basic capabilities that gives value to human life." According to a United Nations' survey, good health is consistently ranked as the number-one desire of men and women around the world. For individuals, families, and nations, health brings the capacity for personal development and economic security in the future.

The RAAPP: Rapid Assessment and Action Planning Process to Promote Health through Schools

Developed with funding and guidance from
WHO and PAHO
in partnership with
Health and Human Development Programs,
IDC, Inc.

Ms. Cheryl Viver Whitman
Senior Vice President, Education Development Center, Inc.
Director, Health and Human Development Programs

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Purpose: Rapid Assessment and Action Planning Process

Strengthen the capacity of ministries
of education and health, working
together, to improve the quality of
learning and health of students and
the workforce.

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What Is the RAAPP?

A method and tools for in-country
teams to collect and use data to
improve their ministries' capacity to
promote health through schools.

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RAAPP and Traditional Research

RAAPP	Traditional
• Dedicated to people	• Dedicated to researchers
• Study owned by country staff	• Study owned by researchers
• Less time & money (2-6 months)	• Expensive & time consuming
• Results in action plan	• Results in findings & a report
• Address socioeconomic & cultural issues	• May not address socioeconomic or cultural issues
• Open-ended exploratory questions	• Highly structured closed questions
• Inclusive of diverse sample — many sectors, many levels, women & men, & end users	• Random or stratified statistical sample that may not be particularly diverse
• Findings presented visually — pictures, photos, drawings	• Findings presented quantitatively — e.g., numerical charts, tables, graphs

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RAAPP in Nigeria

"The RAAPP was the first time the ministries of education and health have worked together in a significant way."




—Nigerian RAAPP participant

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RAAPP Benefits

- Shared vision and framework: Health Promoting School (HPS), RAAPP
- Collaboration among leaders and staff within and across ministries
- Many players offer insights and solutions
- Transforms data into specific action plans

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Experiences of Health-Promoting Schools and Networks

Professional Development in Many Areas

- Teamwork
- Interviewing & facilitation
- Data collection & management
- Instrument development & adaptation
- Analysis & advocacy
- Strategic planning

1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities

"I feel that the RAAPP activity is very important for all of us. This program is for the development of a healthy life, beginning with early education, to achieve a healthy Indonesia. I can contribute through RAAPP to the development of my country." – RAAPP leader, Indonesia



RAAPP participants & WHO/UNICEF/EDC staff

1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities



Indonesian RAAPP Interministerial Team

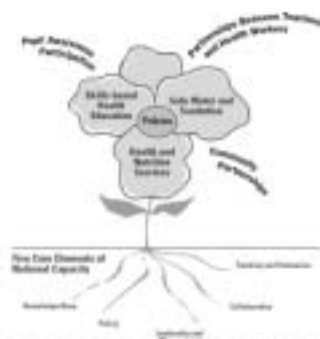
1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities

Why Involve Both the Ministries of Education & Health?

- Schools are an efficient delivery system
- Health education is critical but inadequate alone
- Health sector is needed for service delivery
- Research has shown basic cost-effective package of school health interventions can reduce 8 percent of the disease burden in low-income countries
- health outcomes, educational performance, and teaching quality can benefit from essential package

1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities

Health Promoting Schools and National Capacity to Support Them



1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities

Core Elements of Focusing Resources on Effective School Health (FRESH)

- Clear health policies for schools
- A healthy school environment (physical and psychosocial), beginning with safe water & sanitation for all schools
- Skills-based health, hygiene, & nutrition education
- School-based health & nutrition services

1883/2011/WHO Collaborating Centre for Primary Health, Through Schools and Communities

The RAAPP Strives for *Capacity Building*, a way to:

- Strengthen individuals, organizations, & even entire nations so they can assume a greater role in planning, managing, & sustaining forward movement.
- Nurture, enhance, & use the skills & talents of people & institutions at all levels so they can make better progress toward specific goals.

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Five Core Capacities

Area of Capacity	Strengths	Limitations	Suggestions for Improvement
Knowledge Base			
Policy			
Leadership & Management			
Collaboration			
Monitoring & Evaluation			
Other:			

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Knowledge Base includes the capacity to:

- Access published documents, use the Internet, or locate experts
- Produce & disseminate information & materials
- Provide training to apply knowledge base
- Evaluate new knowledge & skills

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Policy includes the capacity to:

- Create policy that supports school health
- Assess the quality of each policy & its relationship to larger national goals
- Revise policies
- Implement policies
- Assess whether a policy is implemented

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Leadership and Management includes the capacity to:

- Promote a shared vision & framework
- Designate a person or group with the authority to carry out mandate
- Motivate staff, from the top levels for funding to the school level for implementation
- Manage human & financial resources
- Continually assess & respond to needs

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Collaboration across sectors includes the capacity to:

- Identify common ground & unique contributions
- Coordinate to leverage resources of each sector
- Encourage multi-stakeholder participation in planning & implementation of school health programmes

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Monitoring and Evaluation of processes and outcomes in school health includes the capacity to:

- Regularly monitor determinants of health & health educational outcomes
- Evaluate implementation & effectiveness
- Disseminate & use evaluation results to publicize achievements & improve efforts

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Type of RAAPP Questions

School Health Policies

On a scale of 1 - 4, rate your ministry's capacity to *develop policy* to:

- Deliver skills-based education
- Provide basic health services
- Provide safe and secure school environments

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Policy

Describe your ministry's capacity to create and implement policies that support school health.

Using the 1 - 4 scale, please rate this capacity:

- What mechanisms is in place for your ministry to create or review & revise policy for health promotion?
- Are these mechanisms effective? Do they need to be created? Changed?
- What mechanisms exist, if any, to inform people about policy, implement it, & enforce it?

What else can be done, if anything, to strengthen policies that promote health through schools?

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Data: Existing data and focus groups and interviews with:

- Senior-level policymakers
- Senior & mid-level managers
- NGOs, funders, media, & advocacy groups
- WHO, UNICEF, UNDCP, & FAO regional & country offices
- Local-level school & health staff

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Country Skills to Conduct RAAPP

- Evaluation research, strategic planning, & management
- Qualitative evaluation techniques: interviewing, facilitating, & recording
- Managing & analyzing data; open-ended content analysis
- Interpretation of data & action planning skills
- Strong leadership to gain support & motivate staff
- Coordination; logistical & technical support

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Action Planning Worksheet Capacity Area _____

1. Goal	
2. Objective	
3. Strengths	
4. Activities	
5. Immediate Action	
6. Obstacles	
7. Strategy	
8. Responsibility	
9. Resources	
10. Monitoring	
11. Time Frame	
12. Evaluation	

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Who Must Be Involved?

- A committed, in-country Core Team
- The team is inter-ministerial, including representatives from the education & health ministries
- Team collects data & develops plans to improve national capacity to improve school health programs
- Team is led by a strong leader/champion, a high-level official with the ability to garner support for the process
- Leader is supported by a coordinator, dedicated to managing the three phases of RAAPP

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The Three Phases of RAAPP

- Phase I: Planning (one - two months)
- Phase II: In-Country Data Collection (five days - three weeks)
- Phase III: Analysis & Action Planning (five - ten days)

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Why Should Ministries Bother? Health of Students and Workforce Affects:

- Educational performance
- Job productivity
- Population growth
- Economic growth

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Health and Educational Performance

Nine studies in the 1990s showed that better health & nutritional status were consistently linked to higher cognitive test scores & attendance.

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Health and Job Productivity

Health programs for teachers have resulted in reduced weight, blood pressure, & absenteeism & improvements in morale & quality of learning.

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Health and Population Growth

- Health interventions & reduced death rates can contribute to slower population growth.
- Educated girls are likely to delay their first pregnancies & have fewer & healthier children.

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Health and Economic Productivity

- AIDS is a threat to the global market & Caribbean economy. It has been predicted that the world impact of AIDS could be as high as 4 percent of the GDP of the United States or to the GDP of the entire country of India.
- It has been estimated that Kenya's GDP will be 15 percent less by 2005 than it would be without the spread of AIDS.

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Investment in Development and Growth Performance 1990 - 98

Investment in Human Development	Economic Growth
• High	• 2.3%
• Medium	• 1.9%
• Low	• None: 15/39 countries declined

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Health and Education Are Cornerstones of Human Capital

The importance of health in its own right cannot be overstressed. "Health (like education) is among the basic capabilities that gives value to human life" (Sen). Good health is consistently ranked as the number-one desire of men & women around the world (UN survey). For individuals, families, & nations, health brings the capacity for personal development & economic security in the future.

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Acknowledgements

The RAAPP has been made possible by Mr. Jack Jones of WHO/HQ; Scott Pullzzi, Phyllis Scattergood, Isolde Birdthistle and Carmen Aldinger of HHD/EDC; and original input from Dr. Maria Teresa Cerqueira of PAHO.

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Caribbean Network of Health-Promoting Schools: The Gathering of Baseline Data

Josefa Ippolito-Shepherd, Ph.D., Regional Health Education Advisor, Health-Promoting Schools Regional Initiative, Program of Family Health and Population, Division of Health Promotion and Protection, PAHO/WHO

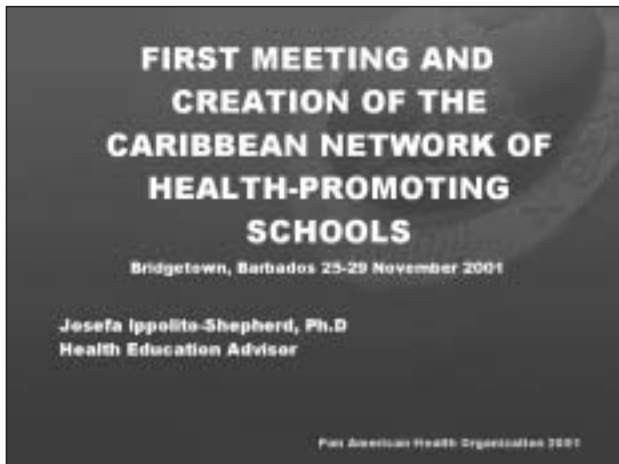
Dr. Ippolito-Shepherd described a new, 19-page questionnaire currently being finalized by PAHO that will be used to gather baseline data for the Health-Promoting Schools Initiative in Caribbean Region. Once the survey instrument is available, PAHO will send it to the Ministries to complete.

Collection of this valuable data will be an ongoing, dynamic process and the information will be updated on a regular basis. The survey instrument will eventually enable comparative studies between the countries and the results will be posted on the PAHO web site so that other countries can view it.

The questionnaire will collect information from each country on the following areas:

- a. General context of the country
 - total population of school-age children and adolescents
 - school data – private versus public, rural vs. urban
 - student data
- b. National health policy
- c. Coordination – between the ministries
- d. Training
- e. Research, monitoring, and evaluation – what research has been done in each country, how is the research used, and could it be published?
- f. Financing – What kind of funding do you currently have? What kind of funding would you be interested in seeing?
- g. Health education – integrated health education, including life skills
- h. Healthy environments – for example, what kind of spaces do schools have for physical education or sports?
- i. Health services and healthy diet – health services received by students within the system; coordination for referral to health services; etc.
- j. Information, participation, and publications – what kind of materials or information does each country have that could be shared with other countries?

Experiences of Health-Promoting Schools
and Networks





Communication and Interchange of Information – Bulletin of the Latin-American Network of Health-Promoting Schools

Dr. Benjamín Puertas, Director of Masters in Public Health, Universidad San Francisco de Quito, Ecuador

Dr. Puertas described the importance and usefulness of creating a bulletin or newsletter to facilitate communication between members of the Caribbean Network of Health-Promoting Schools. The Latin-American Network of Health-Promoting Schools has created its own bulletin and obtained funding from Nestle for publication.


The contents of such a bulletin should be creative and engaging. It should be free of jargon so it will be accessible not only to professionals familiar with health-promoting schools initiatives, but also to other individuals who might be interested in the concepts. It should be short in length, with simple and motivating language, and should contain photographs of children and teachers to make it more familiar and accessible. Dr. Puertas encouraged the Network to start slowly, beginning perhaps with one issue each year, focusing on a theme of common interest.

A typical bulletin might contain the following elements:

- Presentation
- Editorial
- Letter section
- Articles on a related issue
- Experiences at the local/regional area
- Program of forthcoming events
- Publicity
- Photographs


Finally, Dr. Puertas stressed that the publication can give the Network a visible identity, with a recognizable logo and colors. It is also an excellent opportunity to honor sponsors and funders.

Experiences of Health-Promoting Schools and Networks




BULLETIN: What is it?

- ◆ A short publication produced on a periodic basis, with the purpose of providing information on a related issue




BULLETIN: What is its purpose?

- ◆ The purpose of the bulletin is to disseminate information among people and organizations which share a common interest.



BULLETIN: What does it contain?

- ◆ Presentation
- ◆ Editorial
- ◆ Letter section
- ◆ Articles on a related issue
- ◆ Experiences at the local/regional area
- ◆ Program of forthcoming events
- ◆ Publicity
- ◆ Photographs



BULLETIN: Characteristics

- ◆ Short in length
- ◆ Easy and motivating language
- ◆ Graphic
- ◆ Friendly
- ◆ Own style (logo, fonts)



Communication and Information Exchange

Prof. Dr. Antonio Saéz, MD, PhD, MPH, MBA, Catedrático de la Universidad Complutense; Presidente Asociación Iberoamericana de Salud Escolar; Tesorero Mundial de la OMEP

In moving forward with a new network, it is essential to identify the network's operating mechanism and to clarify its mission. This step is not a trivial issue; it is the only way to achieve the creation of an effective network. The guiding principle in a democratic network is that members have power. Therefore, deciding upon a specific structure is of great importance.

An example of an effective network structure is the Network of the World Organization for Early Childhood Education. The members of this organization created special committees to address various issues. One committee addressed the functions; another considered the research capabilities and the strengths of members and how they could contribute to collaboration within the emerging network; another committee covered budgeting for personnel, research, and other areas. The last committee was charged with the program development, evaluation, and priority settings.

Each country within a network has its own priorities and special expertise, and therefore it should be easy to locate publications, expertise, and so forth in developing various program priorities. At this meeting, a resolution is being adopted. At future meetings, it will be possible to develop new charters and resolutions on new topics. The current situation of the world demands relationships among similar organizations. Collaboration within this network should help each Member Country to come closer to achieving its objectives.

Finally, one must remember the importance of publishing and disseminating the work completed within the network. Those within the Network of Health-Promoting Schools, as well as those that are not part of the Network, must have access to the work presented in professional journals, television, and on the Internet.

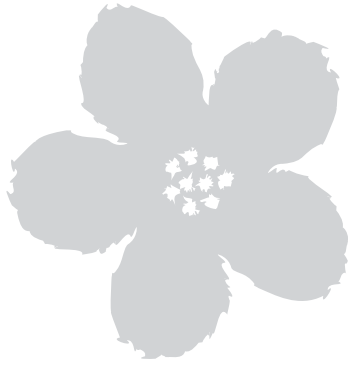
As an example, the World Organization on Early Childhood Education, as it relates to publications, has a representative in each country and every country has a National Committee. Together, they comprise the World Assembly. Periodically, the members of the Assembly elect a new Executive Secretary. The World Assembly decides the priorities for the organization; considers which activities to pursue; and makes decisions about training, participation in various programs, modification and expansion of the organization's journal, and so forth. The World Organization on Early Childhood Education also provides training for its members, benefiting from their vast expertise. The committees decide on common topics for training across countries. Using a global database, the organization identifies the best people to consult or to provide the training on particular topics.

Coordination is essential to make the best use of the resources of a Network. For example, a central repository may be designated for all the documents that the Network produces, including reports, studies, research, and other documentation. A catalogue of these resources could be created and sent to all members of the Network.

Experiences of Health-Promoting Schools and Networks

The Web site www.saludescolar.com may be helpful in promoting your activities and sharing research results and resources. This Web site addresses the importance of health promotion in schools. The site contains sections for teachers, school personnel, families, sanitation engineers, and other professionals. It also provides lesson plans and activities on school health promotion, as well as links to international resources, such as the Centers for Disease Control and Prevention.

In closing, the Caribbean Network of Health-Promoting Schools must use 21st century communication methods and instruments. Information exchange mechanisms are changing rapidly. Organizations must be able to communicate with each other in order to be informed in an efficient and timely manner and at the same time to mutually benefit from each other's expertise.



Group Presentations, Discussion, and Closing Remarks

At the end of the three-day meeting, Veta Brown, Caribbean Program Coordinator for PAHO, rejoined the group to hear the results of the participants' deliberations. Three country representatives, one from each work group, presented the newly formulated vision, mission, objectives, structure, plan of action, and declaration to create the Caribbean Network of Health-Promoting Schools.

After listening to the summaries, Ms. Brown expressed her sincere appreciation for the level of work the group accomplished and challenged them to keep the burning enthusiasm as they move forward with practical steps to make the Caribbean Network of Health-Promoting Schools a reality. She stressed that the process of establishing a Network and moving it forward would not be easy and emphasized the importance of getting ratification from each of the countries as the next step. She urged participants to be active in selling the process to the other stakeholders in their countries, including the chief education officers, ministers of health and education, medical officers of health, school nurses, and other key country personnel to convince them of the importance of moving this initiative forward. She reminded participants to be prepared to indicate how the proposed Network activities can happen within existing resources, and to identify where those resources may be found. Ms. Brown stressed that while PAHO can help move the process along, the Network could only be successful through the active involvement of each participating country.

Ms. Brown then challenged the participants to examine closely their expectations of/from the designated focal point or task force to move the process forward. After a brief discussion, several participants recognized that while they had designated the representative from Erdiston's Teacher's College in Barbados, Maxine Moore, to serve as the "focal point" for the Network (with support promised from PAHO, CFNI, and other CARICOM state representatives), more work would still need to be done to support this focal point and clarify the structure and operating mechanisms of the newly created Network.

After further discussion, the group agreed that, before the formal Proceedings would be distributed, PAHO would first need to create a document summarizing the vision, mission, objectives, workplan, and draft structure for the Network, and distribute it to each of the participants for their comments. This document would then be revised and serve as a tool for members to use to garner support for the Network in their home countries. It was agreed that this document would be drafted by Education Development Center, Inc. (responsible for taking minutes of the meeting and for compiling the documents for creating the formal Proceedings) in collaboration with PAHO/WHO. The completed document will be distributed by PAHO/WHO to all participants for their feedback by December 17, 2001. Participants would

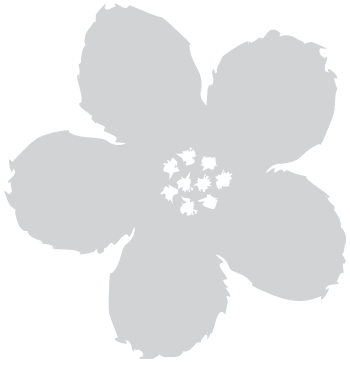
Group Presentations, Discussion, and Closing Remarks

then have until January 7, 2002 to make comments and corrections to the document⁷. Later, a small group (the focal point and selected advisors), would take the document and further clarify the structure, objectives, and plan of action for the newly created Caribbean Network of Health-Promoting Schools.

Ms. Brown also stressed the importance of determining how this document would be distributed in each country, as well as how the formal proceedings would be shared and disseminated.

Dr. Josefa Ippolito-Shepherd thanked all participants for their commitment and diligent work in preparation of this meeting and throughout this event.

⁷ As agreed, this document was created and distributed to all countries' representatives. The comments provided were included and are reflected in this Report



Appendices

Appendix I



Guidelines for the preparation of documents on countries experiences with the HFLE Programs

TABLE OF CONTENTS

HEALTH AND FAMILY LIFE EDUCATION PROGRAMS/ SCHOOL HEALTH IN THE CARIBBEAN

COUNTRIES EXPERIENCES¹

(Ministry of Education and Ministry of Health)

1980-2000

(GENERAL GUIDELINES)

A. Background

(General introduction, summarized, of the overall content of the chapter)

B. General Context of the Country

All aspects (i.e., economics, geographic, cultural, social, administrative, and education)

C. Health and Family Life Education Program in the country:

1. History of the Program

(How, when, and why the Program was to begin, who participated in the planning, reference materials used, etc.)

2. Health and Family Life Education Program Methodology

a. Management (i.e., Does a regulatory agency exist?, Committee?, commission?, Who are the members?, At what level?, resolution response)

b. Health Promotion and Health Education (including Life Skills training/ education)

c. Healthy environmental water, sanitation, without violence, and without abuse, etc.)

¹ Document prepared by each participating Caribbean country (jointly by Ministry of Education and Ministry of Health), as background documents to be shared with all participants and to be included as part of the formal Proceedings of this meeting. A hard copy and a diskette are to be sent to Ms. Pat Brandon on or before November 20, 2001. The entire document will be placed in the PAHO/HPP/HPF/HED Web site. Providing the diskette will facilitate this process. This document (as presented) will form part of the formal Proceedings of this meeting. For this, it is requested the following format:

- font size: 12
- font style: Times New Roman, regular
- margins: 1 1/2"
- page size: 8 1/2" x 11"

Appendix 1

- d. Nutrition and Health services (What types of health services, how, and when are these provided, referral services, and monitoring; food, etc.)
3. Current Situation of the Health and Family Life Education Program (Descriptions of examples of each component, including quantitative and qualitative data with their respective references)
 - a. Policy development (which?)
 - b. Coordinating Mechanism (how, capacity to resolve)
 - c. Implementation of activities (which?)
 - d. Elaboration of educational materials (what, how, when, field testing, materials distribution, etc.)
 - e. Participation in School Health Networks, i.e., Latin American Network of Health-Promoting Schools (what, how, when, etc.)
 - f. Training of teaching staff (coursework, educational resources, etc.)
 - g. Surveillance and monitoring (mechanism, YRBS)
 - h. Community participation (Parent Associations, relations with municipalities, Student Associations, etc.)
 - i. Evaluation (what, how, and who participates)
 - j. Publications (which, where)
4. Lessons Learned
(Positive and negative)
5. Future plans and felt needs
(Aspects that need to be strengthened, program activities that need to be implemented, in order to solidify the Program) Specific network functions or activities that could advance or support efforts

Appendix II



Guidelines for the preparation of presentations

Both the text and the ppt presentation (as presented) will be included in the formal Proceedings of this meeting. For this, please send a hard copy and a diskette of the document and ppt of the presentation to Ms. Pat Brandon on or before November 20, 2001. It is expected that the entire document will be placed in the PAHO/HPP/HPF/HED Web site. Providing the diskette will facilitate this process. For this, please follow the following format:

- font size: 12
- font style: Times New Roman, regular
- margins: 1 1/2"
- page size: 8 1/2" x 11"



Appendix III

Plenary Discussion of Country Presentations

During the plenary discussion that followed the country presentations, the participants identified common successes, challenges, and needs shared by the countries, and suggested issues they might address collaboratively in the future.

Successes:

- Most of the countries have accomplished a school health instruction plan in family and health education.
- Most have teacher-training programs in place.
- Every country has made some strides toward establishing the Health and Family Life Program, even though they are at different stages of implementation.
- Many countries are actively addressing the readiness of the teachers to present the material.
- Countries seem very aware of the need to involve the entire community, as well as parents and guardians. There is a shared recognition that the success of the program depends upon the contributions of parents and the wider community.

Common challenges:

- Difficulties with collaboration
- Convincing policymakers of the need for such a program
- General understanding that it is very difficult to cannot forward without a formal policy in place
- Helping teachers feel comfortable with teaching the material, particularly sensitive issues such human sexuality
- Lack of evaluation to document the impact of existing programs
- Even where HFLE is mandated, it is not always being taught in schools

Collectively, the participants expressed several needs that this Network might address:

- Need the opportunity to come together to share different strategies for developing and establishing policies
- Need to focus on research and evaluation to show the evidence that programs work, with a particular focus on impact and outcome evaluations that can help document positive results

- Need to improve materials for teacher preparation and training
- Need to strategize around helping teachers present the material more effectively, and helping them feel more comfortable addressing sensitive issues
- Advocacy and resources are needed: not many countries have allocated resources for any part of the Health-Promoting Schools initiative. Advocacy must not only include policy but also the tangible support to drive it.

Ideas for addressing these needs:

- Most countries seem to have programs on HIV/AIDS – this could be a focal point for an evaluation.
- Those countries that are further along in developing policies or curricula could share their successes and processes through this Network.
- Many materials have been produced independently by the different Caribbean countries; the Network may be able to consider standardizing or sharing these materials.
- Strategize around ensuring that HFLE programs are taught in schools:
 - Make HFLE be a subject for entrance/exit exams that must be passed to enter secondary schools?
 - Require students to present an exhibit or creative presentation on some topic related to health education/HFLE?
 - Make HFLE a core subject, which means that it will be included in examinations?
- Strategize around teaching different themes, such as human sexuality



Appendix IV

Discussion and Recommendations from Participants, following Mr. Gollmar’s presentation “Multi-Risk Information Surveillance Systems: Behavior Surveillance Among Youth

Following Mr. Gollmar’s presentation, the meeting participants provided feedback for Mr. Gollmar to bring to the next meeting regarding the new surveillance system.

Participants made the following comments and recommendations:

- Participants were very interested in this study and expressed a desire to be informed of similar efforts in the future. Mr. Gollmar stressed that the WHO hopes that networks like the Caribbean Network of Health-Promoting Schools will facilitate the exchange of such information in the future. He urged the participating countries to let the WHO and PAHO know about related efforts in their country and about their interest in participating in similar projects in the future.
- Participants expressed some concerns about Jamaica being the only English-speaking Caribbean country included in the process, as they felt it may not be representative of the region.
- Countries sometimes feel burdened by multiple questionnaires on related topics and would like to see this process streamlined better in the future.
- Researchers preparing youth surveillance questionnaires must take the issue of sentence construction into account – even when sentences are simple, students may not be able to understand them. Survey creators will need to keep reading levels, literacy, and linguistic issues in mind.
- If you expect students to self-administer the questionnaire, you will lose data. Youth surveillance projects need to include some sort of mechanism, either a person or a methodology, for assuring students that their responses will be confidential and for clarifying any of the questions.



Summary of Work Group Activities to Create the Caribbean Network of Health-Promoting Schools

Beginning on the afternoon of Tuesday, November 27, 2001, the participants began the process of creating the Caribbean Network of Health-Promoting Schools. They worked in small groups to discuss their vision of the network and to draft a preliminary vision statement, mission statement, and list of objectives for the Caribbean Network of Health-Promoting Schools. The following were the initial proposals from the three groups:

Group One

St. Kitts and Nevis, British Virgin Islands, Puerto Rico, Dominican Republic

Vision: A strong and interactive HPS Network, enhancing the health and well being of school communities in the Caribbean region.

Mission: To build and strengthen HPS concepts, through collaborative efforts of countries in the Caribbean region, by advocating for comprehensive school health policy and the development of programs to enhance health and well-being in school communities

We are designating the school community as a whole (not the health of all people in all countries).

Objectives:

- To establish baseline data
- To establish common and complementary activities and services
- To develop communication links creating mechanisms for ongoing communication, such as mailing list (email) to continue the discussions and communication
- To identify areas of technical strength and weakness, and compile a directory
- To undertake outreach activities to encourage active participation by all countries in the region (including those countries not represented here at this meeting)
- To set standards and guidelines to help develop HPS policy
- To design training to meet country-specific needs
- To establish mechanisms for monitoring and evaluating school health programs
- To organize regional advisory committee

Group Two

Guyana, Antigua/Barbuda, Bahamas, Suriname, Jamaica, Trinidad and Tobago

Vision: Health children in healthy schools throughout the Caribbean

Mission: To strengthen alliances among Caribbean countries in creating health-promoting schools through intersectorial collaboration and community participation

Objective 1: To formalize the network for HPS in the Caribbean by December 2002

Activities:

1. PAHO to notify governments on the recommendations for CNHPS (short-term)
2. Obtain formal agreement from member countries to participate (short-term)
3. Identify liaison person at the country level (short-term)
4. Develop the structure, functions, powers, terms of reference (middle term)
5. By end of the meeting (November 29), identify 4 to 5 representatives of the Caribbean region to carry the process forward (short-term)

Objective 2: Design a mechanism for sharing information/resources, materials, experiences by June 2002

Activities:

1. Form a working group to determine what exists with respect to resources.

Group Three

Grenada, Dominica, St. Lucia, Barbados, St. Vincent and the Grenadines

Vision: Empowered Caribbean schools obtaining optimum health and well being in a supportive environment through inter-country collaboration and cooperation

Mission: The Caribbean network will harness all skills, knowledge, expertise, experiences, and financial resources between and within countries to facilitate the Health-Promoting Initiative.

Objectives:

1. To establish structures at national and regional levels to sustain the effective implementation of HPS initiative (policy, piloting, monitoring, evaluating)
2. To establish a network system within the Caribbean countries for the purpose of sharing and disseminating information
3. To establish common and complimentary activities in collaboration with PAHO, UNICEF, and other technical and funding agencies
4. To establish a Caribbean research and documentation center for easy access to information

5. To develop a cadre of resource persons within the Caribbean to facilitate the implementation of the HPS initiative
6. To establish a Caribbean network that will give support to the country network for HPS initiative

During a plenary discussion, the participants then worked to refine the vision and mission statements, using the small-group work as a starting point. After much discussion, the participants agreed to the following statements:

VISION

Healthy communities through Health-Promoting Schools across the Caribbean

MISSION

The Caribbean Network of Health-Promoting Schools will share knowledge, skills, and resources within and among member countries and build and/or strengthen alliances with regional and international agencies and institutions to gain support for and build the capacity of the Health-Promoting Schools Initiative.

They adjourned for the evening.

On Wednesday, November 28, 2001, the participants rejoined their small groups to continue planning the Network. This time, each group had different assignments:

- Group One was charged with further clarifying the Objectives and Activities of the Network, using the previous day's small group work as the basis. Group One also developed a proposed Terms of Reference.
- Group Two was asked to consider the Structure of the Network and create a Plan of Action to formalize the Network by the following year.
- Group Three was responsible for drafting a Formal Agreement to be signed by the participants that would call for the creation of the Network.

The three groups presented their proposals, then the participants engaged in a plenary discussion to refine each of the proposed elements. The results of this discussion are presented in the Executive Summary of these Proceedings.

At 3:45 p.m. on November 28, 2001, the participants formally agreed to create the Caribbean Network of Health-Promoting Schools.



Celebrating 100 Years of Health

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