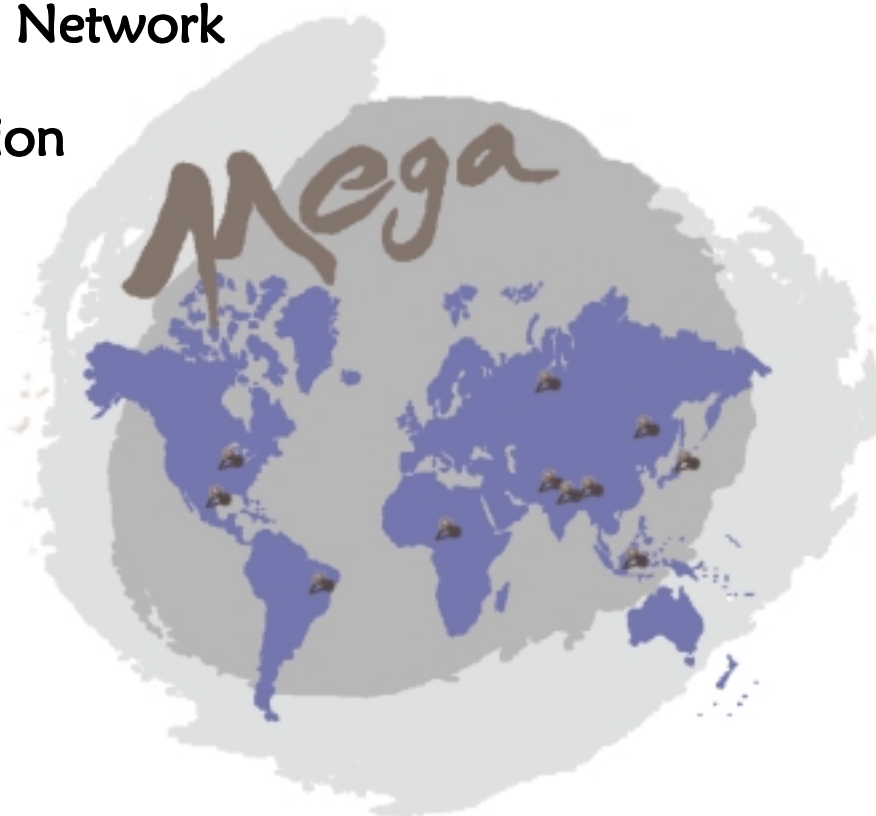


Improving Health Through Schools

National and International Strategies

School Health Component of
WHO's Mega Country Network
for Health Promotion



World Health Organization

WHO INFORMATION SERIES ON SCHOOL HEALTH

IMPROVING HEALTH THROUGH SCHOOLS:

National and International Strategies

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INTRODUCTION

The reasons for promoting health through schools are clear. With more children than ever receiving a formal education, schools are an efficient way to reach school-age youth and their families in an organised way, and to ensure the individual growth essential for national development. In almost every community, the school is a setting in which many people learn and work. It is a place where students and staff spend a great portion of their time. It is a place where education and health programmes can have their greatest impact because they can reach students at influential stages in their lives -- childhood and adolescence. Schools are not merely one of the institutions and settings in which health can be created, but are among the most important.

What is not so well understood, however, is *how* best to improve health through schools. What *strategies* are most likely to achieve this goal? The World Health Organization (WHO) has prepared this resource to explore that question. The chapters that follow present the current health concerns among school-age children and adolescents, and the strategic responses of governments and international and national organisations to address those health issues through schools. In Chapters 3 and 4, representatives of international organisations and ten of the world's most populous countries describe their strategic approaches to school health. The final chapter describes the efforts of an international network aiming to strengthen and unite the work of the "Mega" countries and their international partners.

In the world of business, strategic planning is defined as "a continuous process of systematically evaluating the nature of the business, defining its long-term objectives, identifying quantifiable goals, developing strategies to reach these objectives and goals and allocating resources to carry out those strategies." This process has also shown to be relevant and advantageous to organisations whose goal is to improve health and well-being. A strategic planning approach contributes to health promotion efforts in that it can help set directions, allocate resources and examine alternative courses of action. With health promotion, as with business, the results can be improved planning that leads to improved decision-making and improved results. The process can begin by addressing the following three questions: *Where are we today? Where are we going? And, how do we get there?* Such questions need to be asked by individual organisations and governments, but must also be asked collectively, by all of us working toward the common goals of health and education for all.

It is hoped that this compilation of school health strategies will reveal the extent to which strategic thinking is evident in the plans of international organisations and the world's largest countries, make clear the value of strategic planning in the area of school health, and elicit conclusions about how best to improve health through schools.

HEALTH STATUS OF SCHOOL-AGE CHILDREN AND ADOLESCENTS¹

During the past 50 years, the health of most children and young people between the ages of five and 19 has improved, at least in some ways. Their standard of living is generally higher, they are at risk of fewer infectious diseases, and they are better educated.

They are the children and adolescents who have survived the special risks of morbidity and mortality in the first five years of life and are not yet directly challenged by the health problems of adulthood. Of all the age groups, theirs is the healthiest, and it is one during which the foundations can be laid for a long and healthy life. Healthy children who become healthy adolescents are more likely to become healthy adults.

As children grow and become adolescents they demonstrate growing autonomy, and their decisions, behaviours and relationships increasingly determine their health and development. Yet while their self-reliance increases with age, older children and adolescents lack the status and resources of adults. This limits the range of health-related options open to them. An important feature that distinguishes them from adults is the initiation of risk behaviour. Adolescence is a time of experimentation. The transition from early childhood to maturity involves many hazards, some of which are increasing, and others that are new.

In addition to the personal choices and relationships young people make, the environment in which they live is a strong determinant of their health. Conditions in their homes, schools, communities and workplaces can either promote or detract from health, through such factors as the availability of clean water, exposure to toxic chemicals, a nutritious food supply and freedom from harassment and abuse. Such environmental conditions can affect health directly, or indirectly by influencing the decisions young people make.

Some health problems, conditions and behaviours are more prevalent among older children and adolescents than other age groups, and may influence their future health. Varying in prevalence from one country to another, these include maternity; sexually transmitted diseases, including HIV; other infectious diseases such as tuberculosis, schistosomiasis and helminth infection; mental health; substance abuse; road traffic accidents; injuries and suicide attempts.

Many of these are issues in developed and developing countries alike, and thus risk affecting all the adults of tomorrow. For these reasons, the health of this age group deserves more attention than it has received in the past. For while relatively few are likely to die at this age, many more may begin health-risk behaviours that continue into adulthood and ultimately increase their risk of premature death. The most obvious of these is tobacco use. Worldwide, most smokers begin before they are 19. It is also at about this time that other hazardous patterns may be established, such as poor nutrition, and alcohol and drug abuse. However, the 5 to 19-year period is also a time when health-related knowledge, skills, attitudes and values can be acquired. It is a long and unique period of continuous opportunity for healthy personal development and public health intervention.

¹Adapted from "Health across the lifespan." In *World Health Report 1998: Life in the 21st century, A vision for all*, World Health Organization, Geneva, pp 75-83.

In 1997, the world held approximately 1.7 million 5- to 19-year-olds, or almost 30 percent of the total world population of 5.8 billion. By 2025, they are projected to number at two billion, to represent one-quarter of a global population of 8 billion. Approximately 50 million of these young people will be in Africa.

Mortality

Only limited data exist on the **causes of death** for the age group 5-19 by region or for individual countries. The age groups tabulated are 5-14 and 15-24. For every country with reliable data, the death rate for young persons aged 5-19 is the lowest of any age group. While the risk of death is low, the available data show that in most countries, many of the leading causes of death are preventable, especially deaths related to intentional and unintentional injury. The leading cause of death for five to 14-year-olds varies by country and gender.

Diseases of Concern among Young People

Intestinal parasites are endemic in many developing areas. Treatment of helminth infection (trichuriasis, ascariasis) improves school performance. The prevalence of hookworm infection peaks around the age of fifteen. Because of the potential blood loss it causes, it can exacerbate anaemia in those whose diet contains inadequate iron.

While deaths from **malaria** tend to occur before the age of five, the disease takes its toll on the young working population because of its recurrent nature, and contributes to absence from work and school. Cerebral malaria is becoming more and more common in adolescents, perhaps due to decreased immunity, increased drug resistance, or the use of counterfeit drugs. Malaria is particularly destructive for young pregnant women as it exacerbates anaemia.

Schistosomiasis is the second most prevalent tropical parasitic disease after malaria. As transmission occurs through contact with water contaminated by infected snails, prevalence is highest in young people because of the contact they have with water sources: women fetching water and men swimming. In some African countries schistosomiasis is so common in young men that it is considered to be a sign of passage into adolescence. In young women, as well as causing anaemia it can result in social stigma which reduces chances of marriage. Detection is essential, since a single-dose treatment exists.

Tuberculosis has re-emerged as a major disease in young people in developing countries. If untreated, it can be fatal, and it tends to be more aggressive in this age group, leading from infection to development of the disease sooner. For example, the incidence of tuberculosis among 15 to 24-year-olds in the United Republic of Tanzania is 14 percent of the total number of new cases, and 11 percent of tuberculosis-related deaths occur in this age group.

Vaccine-preventable diseases

As a result of immunisation programmes, about eight out of ten school-age children and adolescents worldwide have been immunised against six major infectious diseases of childhood. Immunization schedules for basic vaccines vary among different countries. Many boosters are recommended during the school-age period. For example, boosters for BCG have been suggested in many countries at ages 5-7 and 11-14. A tetanus booster is recommended during adolescence, especially for pregnant women, and oral polio is also usually given once during school age. Recent studies on immunization in adolescents have focused on mass campaigns that target this age group, especially concerning hepatitis B.

Conditions and Lifestyles Affecting Health

Injuries

Mortality rates due to injury are higher for men than for women. For example, adolescent men aged 15-19 in South Africa are up to 2.5 times as likely to die from violent injuries as are women in the same age group. In the same country, injuries account for 57 percent of all deaths among 10-19-year-olds. A similar pattern holds for many developing and developed countries. Unintentional injuries such as those resulting from sports, falls and especially traffic accidents, are important causes of death in Nigeria, Singapore and the United States, for example. Other countries have a higher number of intentional injuries that result in death (e.g., some Latin American countries). Injuries happen less at home and more in sports contexts or school after the age of eleven. Boys tend to have higher rates of injury, and more broken bones, than girls. Women are at risk of violence from men they know, often their husband, partner, or ex-partner. In countries where reliable large-scale studies have been carried out, 20-67 percent of women report being assaulted by the man with whom they live.

Depression and Suicide

Adolescence is not an easy time psychosocially, and adjustment indicators are important. The Health of Youth study carried out in European countries found that depression, or the percentage of those reporting that they felt depressed once a week or more, was more common in boys than in girls, and varied considerably among countries. The first symptoms of mental illness emerge before the age of 25, for half of those who will be affected by it. The effects of unipolar depression and bipolar disorder have recently emerged as important, and can lead to problems in social interaction and to suicide in extreme cases.

Deaths from suicide are underreported because of a tendency to group them as accidental deaths or deaths from undetermined causes. Currently information is collected on suicides and parasuicidal acts (deliberate acts with non-fatal outcomes that attempt to cause or actually cause self-harm). In 10 community survey studies on adolescents published since 1986, the yearly prevalence of parasuicidal acts varied between over two percent and 20 percent. The differences in rates are due to different definitions and measurement issues. The prevalence of parasuicide is estimated to be 10-20 times higher than that of completed suicides. Three times more women than men attempt suicide, while three times more men than women succeed.

Tobacco and Substance Use

Adolescence and young adulthood are the periods most associated with the onset of **illicit drug use** worldwide. A European study on drug abuse in 13 cities found that by age 18 more than 20 percent had tried cannabis. Solvent use is reported in higher proportions among the under-15s. A study in the United States found that the period of highest risk for cannabis initiation was generally over by age 20, having peaked at 18. Cocaine initiation peaks later, between 21 and 24. Age patterns in Asia and Latin America are slightly different, although inhalant abuse is always concentrated among the youngest age group. In Thailand consumers of solvents are generally 15-19 years old. In Pakistan the age of onset of heroin use is just over 12, but cannabis is more widespread among those under 20. Research suggests that adolescents most prone to drug use are concerned with personal autonomy, are uninterested in conventional goals and receive less parental support and more support from friends. Peer use of the substance is a primary influence, and early onset of use is associated with more intense and wider use of other drugs later. A Brazilian survey of drug use in high school students found that violence in the home was the factor most frequently associated with the use of drugs. Young people who cannot see jobs or a better quality of life in their future sometimes use drugs to counteract extreme despair and frustration. The glamorisation of drug use through association with pop music culture, television and film portrayals has been noted in some countries.

The age of initiation to injectables is falling in certain population subgroups, such as street children, including those in inner cities of developed countries. In Pakistan the share of those who started using heroin between 15 and 20 years of age is reported to have doubled to 24 percent of those surveyed. In the Czech Republic 37 percent of new problem users are aged between 15 and 19, as are 50 percent of drug addicts in Bratislava, Slovakia. In Bulgaria the age of initiation has fallen from around 18 in the mid-1970s to 15 for heroin and 12 or younger for volatile substances. This pattern also occurs in the United Kingdom, where a survey found that 50 percent of 16-year-olds in north-western England had tried illicit drugs, and 20 percent were considered current users. In the United States, the average age for cannabis initiation is around 14 years, and approximately 2 percent of high school students have reported that they had injected illegal drugs. Male students are more likely than female students to report this behaviour.

Excessive **alcohol drinking** is likely to lead to traffic accidents, injury-related death and disability, and over time, serious degenerative disease of the liver. At least half of those who report drinking started before the age of 15, and a large portion of these started earlier than 12. In studies of high school students in Ghana, Kenya and Zambia, prevalence of drinking was 70 to 80 percent. A study of high school students in the United States showed that during 1990-1995 the proportion who had drunk alcohol on one or more of the past 30 days, declined from 59 to 52 percent, while the proportion who had five or more drinks of alcohol on at least one occasion on one or more of the 30 days preceding the survey declined from 37 to 33 percent during the same period.

Various studies report that the majority of smokers began **smoking** by the age of 19; in some cases the majority of smokers had adopted the habit by 12 years of age. The median age of tobacco use initiation in many countries is under the age of fifteen, and this age is decreasing. Young people are not only starting to use tobacco at an earlier age, but the daily consumption is also increasing as the economic situation in developing countries is improving. Evidence shows that persons who start using tobacco early have more difficulty quitting, are more likely to become heavy smokers and are more likely to develop a smoking-related disease. Given the health consequences, there is a clear need for smoking cessation initiatives targeted towards young people.

Nutrition

In developing countries, commonly used measures include **stunting**, which refers to being below the fifth percentile of the WHO height-for-age distribution. Stunting was found to have a prevalence of 27-65 percent in nine out of 11 studies. It occurs in early childhood, when rapid growth should normally occur. Children who are already stunted when they reach adolescence tend not to improve during adolescence. Furthermore, there appears to be a tendency for smallness to be perpetuated across generations. Thinness, or being below the fifth percentile of the WHO Body Mass Index (BMI) distribution for age, was only found to be prevalent in three studies. Its prevalence was 23-53 percent and in seven out of eight studies it was twice as prevalent in boys as in girls. BMI improved in girls throughout adolescence, but improved only in boys who had a

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