Health Promoting Schools

Strengthening of the Regional Initiative

Strategies and Lines of Action 2003-2012

Pan American Health Organization

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Health-Promoting Schools instill a sense of social responsibility in children and adolescents, developing their capacity to resolve conflicts through dialogue and negotiation factors to prevent violence and as instruments to promote harmonious relations.

Children and adolescents want to feel useful and are willing to work in the community, in hospitals, with the elderly, or with younger children. Such activities, that stimulate their spirit of social and community commitment while at the same time enabling them to use their free time creatively, are more effective when they are integrated into the process of school learning.

**Health-Promoting Schools**

*Healthy spaces and better health for future generations*

Pan American Health Organization, 1998
We would like to thank all people who, one way or the other, contributed with their valuable input, observations, and suggestions to enrich and improve this document. First, our special acknowledgment to the small group of colleagues and professionals, including Blanca Patricia Mantilla, Amanda Bravo, Verónica Molina, Gloria Briceño, Karina Cimmino, Nereida Arjona, María Paz Guzmán, Daniele Pompei, Sergio Meressman, Carlos dos Santos Silva, and Benjamin Puertas, who in a patient and generous manner met with us after a strenuous day of work during the Third Meeting of the Latin American Network of Health-Promoting Schools, held in Quito, Ecuador, from September 10-13, 2002, in order to jointly review a preliminary version of this Action Plan.

Based on the feedback provided by the aforementioned group, adjustments were made and a new version of the document was prepared. This document was presented and discussed during the School Health Experts Meeting, held at PAHO’s headquarters in Washington, October 2-4, 2002. Our sincere appreciation to the team of professionals and special guests from different countries, as well as staff and members from the Organization, for their enthusiastic and committed participation during the working sessions (the complete list of attendants is shown in the Annex), and for the validation and consensus on this proposal, through their vision, from their different areas of expertise and knowledge.

Special thanks to Roberto Paramo who translated the document and to Rita Parrilli, Leonardo Mantilla, and Christine Bell, who reviewed the different versions of the translated document.

We would like to acknowledge and express our gratitude to Dr. María Teresa Cerqueira, Chief of the Healthy Settings Unit of the Area of Environmental Health and Sustainable Development, not only for her support for the realization of the required activities with the preparation of this document and the editing of the final version, but also for her permanent leadership and enthusiasm with the work throughout the Region for the benefit of health promotion in the school setting.

Last but not least, our most sincere thanks to all teachers, parents, school authorities, children, and local teams of health workers and other professionals, who are making Health-Promoting Schools a tangible reality, with their daily work in different parts of Latin America and the Caribbean. Their enthusiasm, unselfishness, and belief in the implementation of this work, much too often among poverty and other adverse conditions, constitute the greatest incentive and the best encouragement for every person committed to the improvement of the health and education conditions, the quality of life, and the opportunities for the comprehensive development of the school-age population.
Never before in the history of Latin America and the Caribbean have countries had such large proportion of school-age children with access to schools and the opportunity to complete at least their elementary education. This fact highlights the over-arching role of educational institutions in the transformation of local communities, and in the education of men and women with a higher sense of solidarity, greater ability to make decisions, and more capable of successfully facing the challenges of today’s world and of living a fulfilling and healthy life.

Even though relationships between health and education are manifold and inseparable, perhaps the most important common element is that both share the aspirations and objectives for human development included in international policies such as Education for All, Health for All, and the Millennium Development Goals. From this broad and comprehensive perspective, health and education are both the source and the prerequisite for well-being, human development, and social, economic, and spiritual wealth of individuals and populations.

Health-Promoting Schools constitute an ambitious health promotion strategy in the school setting and a mechanism for joint multisectoral efforts and resources, aimed to improve health conditions and well-being, thus increasing the opportunities for quality education and sustainable human development for all members of the school communities.

Since the formal launching of the Regional Initiative in 1995, Health-Promoting Schools have demonstrated great potential as healthy communities, to contribute to the achievement of common goals of different social sectors. Together, health and education can bring about the implementation of healthy school policies; the creation and maintenance of secure, healthy, and equitable physical environments and harmonious school cultures, free from any form of violence or discrimination, to facilitate the teaching and learning processes; the development and implementation of health education curricula that reach beyond didactic transmission of information, and which promote participatory learning of attitudes, values, and skills necessary to live a healthy life and contribute to the health care of others; the strengthening of social participation and respect for all fundamental rights and freedom; and the timely access to quality services for disease prevention and treatment.

The Strategic Plan, presented in this document, reflects the vision of the Pan American Health Organization for strengthening the Regional Initiative throughout the next ten years. Once again, we encourage all Member States to continue their efforts to improve the health and quality of education of all school-age children and adolescents through the Health-Promoting Schools.

Mirta Roses Periago
Director
Pan American Health Organization
INTRODUCTION

The Millennium Development Goals (MDG), adopted at the 55th U.N. General Assembly, represent a global commitment in the struggle against poverty and inequity in income distribution within and among Member States. The health sector is directly involved in this grand commitment, through the achievement of three important goals: the reduction of maternal mortality (MDG No. 5) and child mortality (MDG No. 4), and the reduction of HIV-AIDS and other communicable diseases (MDG No. 6). Additionally, the health sector has the major responsibility to collaborate with other sectors in the achievement of the other goals. Particularly in the reduction of poverty and hunger (MDG No. 1), it is essential to promote sustainable human and social development through improvement in food and nutritional safety, as well as employment and income distribution. In addition, a close collaboration between health and education is required for the achievement of two other goals: to ensure full primary education for all children (MDG No. 2); and to eliminate gender disparities in primary and secondary education (MDG No. 3).

The MDG are interrelated in such a way that the achievement of one requires significant progress in the others. This goal interdependence requires capacity-building in countries for the implementation of strategies that sustain long-term human and social development processes, which in turn requires the strengthening of institutional capacity to design participatory and intersectoral planning processes, as well as to implement and evaluate them. In this sense, it is also critical to strengthen the technical capacity of different countries to implement comprehensive and integrating strategies, such as the Health-Promoting Schools, guaranteeing a greater continuity of the processes.

The Health-Promoting Schools Regional Initiative (HPSRI) faces both the great challenge and the opportunity of contributing to the achievement of the Millennium Development Goals. Within the context of the commitments of the social sectors, both health and education have the inevitable commitment to achieve such goals, particularly the following:

1. **Eradication of poverty and hunger**, which requires increasing the educational level of the population. Health-Promoting Schools (HPS) can offer support in the development of school vegetable gardens, contributing to the nutrition of the school-age population and the eradication of hunger in this age group.

2. **Universal primary education**, whose greatest challenge is achieving full primary education for all boys and girls from deprived communities, thus reducing inequities within and among countries in the Region.

3. **Gender equality and empowerment of women**. HPS face the great challenge of contributing to the elimination of gender disparity in secondary education.


5. **Improvement of maternal health**. Before the completion of secondary schooling, HPS can strengthen the education of adolescents, by means of the life skills approach, in aspects related to sexual and reproductive health.
Another recent study showed that the risk factors that young people face during their development are of such magnitude that if healthier environments and a risk-reduced child growth and development stage are not achieved, the Region will not advance in economic and social development, and surely will not achieve the MDG1. It is estimated that almost half the children and adolescents in Latin America have experienced some type of failure during their development. Estimates were based on infant mortality data from children aged 11 to 16 who are not enrolled in school, and young people between 17 and 18 years of age, who were unemployed and without school education. Once more, this conclusion from the Report on Failure Rates of Young People in Latin America shows the need for capacity-building in the countries to create physical and psychosocial environments that are healthier and supportive. The health sector has the responsibility of collaborating with the educational sector in order to face the big challenge presented by this situation: improving the health of the school-age population and offering educational opportunities and healthy environments which ensure better academic performance and a reduction of school failure. The document mentioned above clearly indicates the urgency of reducing the risks which lead to failure—which half of the children in Latin America experience—if the Region is to compete in the global market and improve the rates of human and social development.

6. **Fight against HIV/AIDS.** As mentioned in the previous paragraph, this can be achieved before leaving secondary school through the inclusion of a life skills approach to reproductive and sexual health, both in health education programs and in training of young people.

7. **Ensure environmental sustainability.** HPS can integrate and update the environmental health education contents and methodologies in the school curriculum, as well as strengthen ecologic teams and the leadership of young people in the care for the environment.

8. **Global alliance for development.** HPS provide a favorable setting for providing education in fundamental principles and values of peaceful coexistence, solidarity, democracy, and social participation from an early age.

The World Bank conducted a probability analysis for the achievement of the MDG in Latin America. It concluded that it is very low in most cases, and that health interventions have the highest priority. The analysis of the MDG revealed once more that the capacity to implement comprehensive strategies for health promotion, involving the civil society and different sectors in a planned and joint effort, is still deficient in many countries of Latin America and the Caribbean. The achievement of the MDG demands widening and strengthening the mechanisms for equitable distribution of income, as well as decentralizing and democratizing all decisions. The MDG represent an opportunity to establish social pacts among all sectors and with civil society in order to achieve sustainable human and social development.

Another recent study showed that the risk factors that young people face during their development are of such magnitude that if healthier environments and a risk-reduced child growth and development stage are not achieved, the Region will not advance in economic and social development, and surely will not achieve the MDG'. It is estimated that almost half the children and adolescents in Latin America have experienced some type of failure during their development. Estimates were based on infant mortality data from children aged 11 to 16 who are not enrolled in school, and young people between 17 and 18 years of age, who were unemployed and without school education. Once more, this conclusion from the Report on Failure Rates of Young People in Latin America shows the need for capacity-building in the countries to create physical and psychosocial environments that are healthier and supportive. The health sector has the responsibility of collaborating with the educational sector in order to face the big challenge presented by this situation: improving the health of the school-age population and offering educational opportunities and healthy environments which ensure better academic performance and a reduction of school failure. The document mentioned above clearly indicates the urgency of reducing the risks which lead to failure—which half of the children in Latin America experience—if the Region is to compete in the global market and improve the rates of human and social development.

Several experiences in the Region are encouraging and exemplify how it is possible to move forward with the MDG through integrating strategies such as the Health-Promoting Schools Regional Initiative. This Initiative is the result of several years of consensus that was developed based on the experiences of the countries in order to have an integrated framework of school health actions. In oper-
ational terms the Initiative is comparatively new, having been implemented in 1995. In countries where the Initiative has been evaluated, results show that it is successful and that it improves school environments and the quality and results of health education. The results also show that it is generally well rated by teachers and school managers.

So far, the Initiative has been fully evaluated in Chile and several components have been evaluated in other countries as well. Life Skills education was evaluated in Colombia; the component concerning violence and education for social harmony was evaluated in Brazil and Argentina. The health sector in Colombia has advanced in the implementation of Peace Education, with important results in terms of making the most out of the school experience and a more comprehensive health education, as it is based on the development of competencies. Students strengthen their self-esteem and show more confidence in themselves and when faced with difficult situations. There is more capacity to solve conflicts through dialogue, as well as more respect and tolerance.

The component concerning tobacco was evaluated in Venezuela and Costa Rica; the food and nutrition component was evaluated in Panama; oral health was evaluated in El Salvador; and social support networks, voluntary work of students, and coordination between schools and community were evaluated in Nicaragua. The strengthening of the Social Protection Network in Nicaragua is essential since it supports families in the enrollment and in keeping children in school, contributes to the improvement of nutrition and access to health services, and strengthens counseling to mothers on reproductive and sexual health issues.

The Initiative was fully evaluated in Cantones de Loja, Ecuador, as well as the health education modules produced by the Healthy Environments Project. The experience will be implemented on a wide scale by the Ministry of Education of Ecuador with the support of the Ministry of Health and PAHO/WHO. An adaptation of the Initiative is also being widely implemented in Mexico through the Healthy Educational Communities Program of the Secretary of Health, where the Programa Progresa, a program which consists of improvement in nutrition, access to health services and the increase of school attendance, yields important lessons for the improvement of human and social development. The Programa Progresa has increased the use of primary health care services for children under five and has also diminished school desertion, even in municipalities with the highest poverty rates.

The Strategies and Lines of Action proposed in this document for the Health-Promoting Schools Regional Initiative during 2003-2012, are the result of the analysis of the experiences accumulated during the last 6 to 7 years, as well as the result of multiple consultations and meetings regarding the construction of a proposal together with those responsible for health promotion and school health in the Health and Education sectors, non-governmental organizations, and universities working in this area. Thus, we deliver this document to serve as a guide in the continuous effort and commitment to improve health and school performance, assuring healthy social environments and protective factors, which facilitate the practice of healthier lifestyles and habits.

Maria Teresa Cerqueira
Chief
Healthy Settings Unit
Area of Sustainable Development and Environmental Health
This Strategic Plan for Strengthening the Health-Promoting Schools Regional Initiative during the period 2003 to 2012, is the result of a long process of analysis of the current status of the Health-Promoting Schools Strategy in Latin America and the Caribbean, and of the needs of children and adolescents, and of the countries in the Region. It is also the result of discussion sessions, consensus, and final validation with a group of professionals, mainly from the health and education sectors, with wide experience in the management of the strategy and school health programs in the countries of the Region.

Besides frequent contact with the people responsible for the strategy in the countries, many of whom I have had the opportunity to visit during the past two years while carrying out technical collaboration activities of the Organization, the implementation of the Health-Promoting Schools (HPS) in the Americas was greatly enriched through valuable information shared during the Third Meeting of the Latin American Network of Health-Promoting Schools and the First Meeting and Creation of the Caribbean Network of HPS, as well as the information provided by the 17 countries which, between 2001 and 2002, answered the Regional Survey on HPS in Latin America.

Based on the knowledge of the situation up to now, a preliminary version of the Strategic Plan was developed. This document was submitted for a first discussion session with a group of experts, who participated in the Third Meeting of the Latin American Network of Health-Promoting Schools, held in Quito, Ecuador, in September 10 to 13, 2002. The feedback from this informal consulting group, as well as the presentations and input from the 135 representatives of the 19 countries that attended the Quito meeting, were used to update the analysis of the situation and to make the necessary adjustments to the Strategic Plan.

The final discussion took place October 2 to 4, 2002, at the Headquarters of the Pan American Health Organization in Washington, DC, during the School Health Experts Meeting, in which professionals from various countries of the Region participated, along with prominent special guests and staff members of the Organization itself, especially from the different programs of the Division of Health Promotion and Protection.

No document could fully incorporate the inputs and suggestions from every one of the individuals who, in such an enthusiastic and unselfish manner, participated in the aforementioned processes. Nevertheless, we trust that this final version of the Strategic Plan reflects, as faithfully as possible, the agreements and fundamental elements discussed.

The first section of this document includes a review of the health conditions in the school-age population in Latin America and the Caribbean. The second section provides an overview and a summarized description of the current situation of school health programs in the Region.

The third section includes a synthesis of the most important background elements of the Health-Promoting Schools Regional Initiative, a description of the operational strategy of the Pan American Health Organization for the implementation of the Initiative, the summary of the development of the Latin American and Caribbean Networks of Health-Promoting Schools, and the accreditation mechanisms for HPS.
The fourth section includes a summary of the most important theoretical and conceptual aspects, which have served as the basis for the conceptual framework of the Health-Promoting Schools Strategy and the Regional Initiative. Finally, the fifth section of the document presents the six main strategies and the corresponding lines of action, which together form the Strategic Plan for strengthening the Regional Initiative during the next ten years.

We hope that this Strategic Plan will contribute efficiently to the purpose of the Regional Initiative and the Health-Promoting Schools, for articulating regional, national, and local efforts and resources for the improvement of health conditions and opportunities for well-being and comprehensive development of the school-age population and the educational community in all Member States.

Josefa Ippolito-Shepherd
Regional Adviser on Health Promotion and Health Education
Health-Promoting Schools Regional Initiative
Healthy Settings Unit
Area of Sustainable Development and Environmental Health
1. HEALTH CONDITIONS OF THE SCHOOL-AGE POPULATION IN LATIN AMERICA AND THE CARIBBEAN
The population of children and adolescents between the ages of 5 and 18 in the Americas is over 220 million, of whom 27 million live in the countries of the Andean Region; 53 million in Brazil and the Southern Cone; 41 million in Mexico, Central America, and the Spanish-speaking Caribbean; 2 million in the English-speaking Caribbean; and 103 million in the United States and Canada. Projections indicate that the school-age population under 15 will remain constant over the next 40 years. In an era of continuous innovation and growing access to the world of technology, the potential for this population to contribute to the material, cultural, and spiritual development of the Region is boundless; nevertheless, if the countries fail to fulfill their health, education, and comprehensive human development needs, their hopes and expectations, they could have an enormous destabilizing effect on the political, social, and economic systems of these countries.

Considerable progress was made during the last decade of the 20th century toward improving some problems that traditionally have affected children and adolescents in the Region. The principal achievements were in the field of social rights—health, nutrition, and education—, largely due to the international impetus provided by the World Summit for Children in 1990. Almost all countries of Latin America and the Caribbean increased life expectancy and decreased infant mortality, mainly as a result of the control of communicable diseases, through the expansion of vaccination coverage and the improvement of drinking water and environmental sanitation services. Poliomyelitis, for example, was eradicated from the Hemisphere, with no cases having been reported since 1991. Since that year, the incidence of measles has been reduced by 98% and mortality from this cause by 99%.

However, progress has not been uniform across all countries and does not always correlate with the level of development that they have achieved. Moreover, enormous inequalities persist within the countries themselves related to the socioeconomic level, geographical location, or ethnic origin of various population groups, among other factors.

In spite of the achievements of recent years, many problems and challenges still threaten the possibilities for healthy development of children and adolescents in Latin America and the Caribbean. The profile of the health conditions of the child and adolescent population is woven into the specific context of major social, economic, geographic, ethnic and gender inequities, and inequities in access to basic services such as health and education, which still prevail and characterize the Region.

A recent study warns that the climate generated by current development models is shaping the social and economic events of this century in such a way that it will limit the possibilities of achieving greater advances in the short, medium, and long term, thus impeding the attainment of benefits expected from the social investment made in recent years and increasing the trend toward inequity among and within the countries.

Health and well-being are social and population-based concepts, rather than individually-oriented ones. In population groups with major social and economic inequalities among individuals, the levels of health and...
well-being—physical, cognitive, and psychosocial—are lower than in communities where the differences are less pronounced, demonstrating the key role played by inequity as a determinant factor for health.

Poverty, exclusion, social vulnerability, lack of opportunities, child labor, domestic violence, and sociopolitical violence—including forced displacement—are other factors that threaten the lives and healthy development of thousands of children and adolescents in the Region, where more than half live in poverty.

The health profile of Latin American and Caribbean countries is also characterized by epidemiological transition, the overlapping or accumulation of different disease patterns and their unequal distribution among the population. Although in recent years, in the majority of countries, there has been a gradual transition of the burden of disease from the group of communicable diseases to the groups of non-communicable diseases and injuries, the former have not been completely eliminated.

In many communities where fatal diseases typical of childhood have declined or been eliminated, these have been replaced by injuries—accidents, induced injuries—, mental illnesses and behavioral problems, chronic disorders, reemerging diseases such as tuberculosis, and other health problems rooted in preventable psychosocial and environmental factors. It is estimated that nearly 600,000 children and adolescents still die each year in Ibero-America as a result of preventable disorders, which can be grouped into three major categories:

- Deaths from diseases preventable by timely vaccination or resulting from malnutrition, inadequate living conditions, lack of safe drinking water, and absence of excreta disposal systems;
- Deaths from disorders that could have been treated successfully through timely access to good-quality health services; and
- Deaths caused by violence, either by direct action (homicides) or negligence (accidents).

Despite the fact that significant progress has been achieved in reducing child malnutrition in Latin America and the Caribbean, high rates of micro-nutrient deficiency and chronic malnutrition still exist, especially in some countries with large populations and high infant mortality rates. It is calculated that in the year 2000, nearly 36% of children under the age of two, in the Region, were at high risk with regard to nutrition, especially in rural areas, where the proportion was even greater (46%). A typical consequence of malnutrition is its considerable impact on school performance due to intermediate neuro-psychological variables. In addition, malnourished children do not attend school regularly or drop out completely, and they frequently repeat academic years. As a result, child malnutrition is one of the leading causes of decreased efficiency and effectiveness of educational systems.

Health problems of adolescents and young adults in Latin America and the Caribbean differ substantially from those of children, and are mainly associated with the physical and psychosocial changes that characterize this stage of development, the conditions in their environment, and the support and opportunities offered by the society to which they belong.
Adolescence is a stage of life full of opportunities and risks, and the quality of the adolescence that a person lives can have long-term consequences for the individual as well as for the society. In spite of progress made in recent years, the health and comprehensive development of many adolescents and young adults in the Hemisphere—and at times their very lives—are still seriously threatened. Unlike other younger groups, the majority of deaths of adolescents and young adults result from acts of violence—accidents, homicides, and suicides—that cause on average 40% of all deaths in this group. Mortality is greatest in males and in adolescents and young adults between the ages of 15 and 24.

Besides the ethical considerations and economic loss it represents, mortality in this group has enormous psychosocial impact: for each child or adolescent who dies as result of an accident or violent act, 15 suffer serious consequences, another 30 or 40 will require medical, psychological, or rehabilitative treatment. Automobile accidents are the leading cause of violent death among adolescents in Latin America. Homicide is a particularly important cause of mortality in Colombia, where it represents 54% of the deaths in this age group, compared with Ecuador, where it represents only 11% of the total.

Although the information available suggests that in general the fertility rate among adolescents in Latin America is lower now than it was 30 years ago, this trend was not sustained over the last decade and the rate may even be rising again. The countries with the highest rate of adolescent fertility are Nicaragua, Honduras, Guatemala, El Salvador, and Venezuela. Countries in Central America generally have a higher fertility rate (87 x 1000) than countries in the Caribbean (78 x 1000) and those of South America (75 x 1000).

High fertility in adolescents is a public health problem for several reasons. First, it has negative consequences for adolescent parents, especially mothers: it frequently forces young people to quit school, considerably reducing the time they devote to educational activities; it promotes the early and detrimental entry of young people into the labor market; it implies health risks, especially when pregnancies occur at a very early age; and it leads to fragile conjugal unions. There can also be negative consequences for the children of adolescent parents, related first to the biological immaturity of the mother’s body and the insufficient psychosocial development to assume the responsibility for raising children, as well as an increased risk of living in broken homes and suffering multiple deficiencies associated with poverty.

The adolescent population faces the risks involved in the early initiation of sexual relations within the context of greater vulnerability. Accordingly, problems such as sexually transmitted infections almost always affect adolescents with the greatest severity. It has been reported, for example, that each year 15% of adolescents between the ages of 15 and 19 contract trichomoniasis, chlamydia, gonorrhea, or syphilis.

According to a recent report, 1,660,000 people in Latin America have been infected with HIV/AIDS, of whom approximately 37,600 are children between the ages of 0 and 14. In general, Latin America presents some differences with regard to the evolution of the epidemics and rates of infection that are lower than in other regions.
of the world, although there is a clear rising trend, especially in the subregion of the Caribbean.

The scourge of HIV/AIDS affects the young population most intensely: half of all new cases occur in adolescents and young adults between the ages of 15 and 24, and the average age of new cases declined from 32 years in 1983 to 25 in 1992. It is estimated that 29% of all infected males in Brazil and 31% in Honduras are between the ages of 10 and 19, while in the Dominican Republic, Guatemala, Haiti, Honduras, and Panama, more than 1% of the population between the ages of 15 and 24 is seropositive.\footnote{Source: World Health Organization.}
OVERVIEW AND CURRENT STATUS OF SCHOOL HEALTH PROGRAMS IN LATIN AMERICA AND THE CARIBBEAN
2.1

OVERVIEW

There is a trend of several decades of school health programs in Latin America and the Caribbean, and in consonance with current practices in other regions of the world, until the 1980s and in the early 1990s, school health programs were characterized by a strong tendency to concentrate efforts on improving conditions of hygiene and environmental sanitation, preventing communicable diseases, treating specific diseases, and performing periodic and indiscriminate medical examinations or screening tests.

Educational communities were often overloaded with multiple haphazard interventions aimed at solving specific problems or achieving specific objectives, without clear operational strategies to facilitate the integration of the various components—school policies, health education, health and nutrition services, etc.—within a conceptual framework that would make it possible to move toward the achievement of objectives, common and relevant to different sectors, especially to health and education.

School health programs were traditionally considered the exclusive responsibility of the health sector, with schools being regarded as simple “passive receptors” of interventions, almost always sporadic in nature—vaccination campaigns, health campaigns, talks or conferences on specific diseases—and carried out by agents external to the educational community.

It is evident that in the context of this vertical, “medicalized”, and “care-oriented” model in which the schools were considered passive targets (“captive populations”) of actions by the health sector, neither the members of the educational community themselves nor the local health teams or other members of the community in general, had much influence on decisions with regard to the content of or the approach to such interventions. School health programs frequently reflected the priorities of central governments or financing agencies, instead of the actual needs and expectations of the educational communities.

In accordance with this “medicalized” approach—hence the emphasis on actions of a preventive and care-oriented nature—the health of schoolchildren continued to be understood more in terms of the absence of disease than as the result of a process involving the collective transformation of factors that determine health and well-being, in which health professionals and all members of the educational community can and must become active partners.

Health education, which in one way or another has always been part of school health programs, was basically characterized by the didactical transmission of information on isolated subjects—generally related to specific diseases or physical aspects of health—rather than the development of abilities or skills to live a full and healthy life. There was still a great reluctance to include certain topics such as human sexuality or mental health in educational programs, and other topics such as suicide or violence were not considered public health matters.

In fact, the results of a comparative analysis conducted in the late 1980s, which included more than 30 case studies in 20 countries of the Region of the Americas, showed that the contents, educational approaches, and health education methodology used in the various par-
ticipating countries were vertical, based on health impairments, and the causes of disease and death. The study also revealed the lack of innovative approaches for the development of educational materials.

Although *these trends have not completely vanished from school health programs in Latin America and the Caribbean* at the beginning of the New Millennium, it is indisputable that considerable progress has been achieved in almost all countries towards a comprehensive approach to health in schools. Over the last two decades, the Region has been the setting for important processes of transformation and changes that reflect the megatrends of economic globalization and internationalization, the strategies of decentralization and deconcentration of power, the reduction of the state apparatus, the health paradigm crisis, and the opening of new and growing opportunities for social participation. In one way or another, all of these factors have influenced the understanding of public health in general, as well as school health and the delivery of these services.

The reforms of the health and education sectors, currently underway in most countries in the Americas, have strengthened the strategy of health promotion, encouraging the flexible treatment of school curricula, and increasing the autonomy of educational communities, thus creating new opportunities and institutional spaces for school health programs with a comprehensive approach.

The change of health paradigms has meant, among other things, *greater consensus about the close relationship between health and development*. Health is now considered to be not only a basic component of the development process, but essentially its "reason to be". From this perspective, health is above all a *social product*, since it depends on and results from all those actions carried out in its favor, or against it, by the various social and political actors who intervene in the living conditions of the population. Reduction of poverty levels and progress in the economic development of countries are possible only when their citizens have the freedom or opportunity to gain access to basic education and health care.

The trend toward *decentralization and deconcentration* of power, that redefines the role of the State in the area of health, has also helped emphasize the *importance of new actors and spaces in the management of what is healthy*, within the framework of local communities and within the private sector. The definition of the new role of the State led to reflection about the relationships within the State, the democratization of its roles, and the participation of the population in decision-making. The foregoing has implied the *strengthening of communities or local spaces*, the recognition of their particular ethnic and cultural features, the struggle for a greater degree of autonomy, and the demand for greater participation by them in the development of health policies and programs.

In the midst of this complex scenario of new relationships and forms of public administration and a new vision of public health in Latin America and the Caribbean, the critical role of educational communities in

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* It is at the local level where most health promotion actions and almost all prevention and recovery actions take place, in addition to being the local reality—close to people’s daily living—where most health population problems happen and get solved, which is subject and object of public health.
improving the health conditions, well-being, and comprehensive development of children and adolescents has acquired growing recognition and leadership.

Since its launching in 1995, the Regional Initiative of the Pan American Health Organization has contributed without interruption to the dissemination of the Health-Promoting Schools (HPS) model to all Member States, as a comprehensive and integrating strategy for the delivery of school health services, that transcend traditional medical care and that are based on health promotion actions in the school setting.

The Third Meeting of the Latin American Network of Health-Promoting Schools (Quito, September 10 to 13, 2002) showed that presently all the subregions and countries of the Hemisphere are, without exception and in a greater or lesser degree of development, settings of important experiences and innovations in school health with a comprehensive approach.

In Central America, for example, besides the implementation of the Health-Promoting Schools strategy in almost all countries of the subregion, advances have been made during the last two years in terms of the articulation of this strategy and the component of Alimentary and Nutritional Security with sustainable human development in the regional, national, and municipal settings. This initiative was presented and approved at the Fifth Regular Meeting of the Central America Educational and Cultural Council (CECC), held in Antigua, Guatemala, October 6 to 8, 2000. Recently, a joint effort between PAHO/WHO and the Central America and Panama Nutrition Center (INCAP) made it possible to complete the systematization regarding the experience of seven countries of the subregion* in the implementation of the Health-Promoting Schools strategy.

In the Municipality of Rio de Janeiro, the project called “En Esta Escuela Me Quedo” (I Stay In This School), which started in low income communities in 1999, aims to improve the learning setting in disadvantaged schools through a combination of artistic, sports, and cultural activities within the historical and social context of the community. This project has now a network of 120 Health-Promoting Schools and is progressing gradually toward the consolidation of the necessary mechanisms to turn itself into a great initiative covering the entire network of municipal public schools.

The Ministry of Education in Chile has implemented a comprehensive school health program offering free examinations for posture, hearing, and vision, as well as other benefits. Teachers are responsible for performing the first examination of children, a most important mechanism to ensure equal access for all to the services provided by the program, as well as for the success of the daily treatment given to students and the follow-up services.

In Barbados, Chile, Colombia, and Costa Rica advances have been made in psychosocial skills education (Life Skills) as an important component of school health programs and health education activities of Health-Promoting Schools.

Similarly, the English-speaking countries of the Caribbean, associated today as members of the Caribbean

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* Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
Community* (CARICOM), also constitute a very active subregion of the Hemisphere in the field of school health promotion.

In the last 15 years, there has been increased recognition of the negative impact of risk factors and new threats related to the complex changes in socioeconomic and cultural patterns experienced by Caribbean families and communities in general with respect to the health, well-being, development, and opportunities for learning of the child and adolescent population. Accordingly, a progressive acceptance by the health and education sectors of the need to strengthen the role of schools in the reformulation of health-related values and practices has also occurred.

Since 1997, in an effort to deal with this situation, while avoiding the lack of intersectoral and interagency coordination and duplication of actions that characterized various interventions in the past, several member countries of CARICOM implemented a health and health education initiative in the school setting (“Health and Family Life Education” – HFLE), coordinated by UNICEF with the technical support of the Pan American Health Organization and the support of the Ministries of Health and Education.

The following are some of the most relevant aspects of this Initiative.

- Completion of a needs assessment in five countries and of research on adolescent health in nine countries;
- Development of a new conceptual framework as a basis for education actions in health and family life, with emphasis on the skills approach and the creation of support environments. The conceptual framework attempts to condense and refocus the multiple health problems characteristic of schoolchildren into five major categories:
  - healthy nutrition and good physical condition;
  - sexual and reproductive health protection;
  - development of skills for managing emotions and interpersonal relationships;
  - management of the environment; and
  - promotion and maintenance of healthier lifestyles and environments;
- Advocacy of health interventions in the school setting and family life education and support for the implementation of health sector policies in eight countries, through the implementation of intersectoral workshops—including non-governmental organizations and universities of the Region—and the promotion of dialogue;
- Training of teachers and adult educators in the community, to increase human resources capacity for the implementation of strategies in life skills education and to guarantee the sustainability of the Initiative; and
- Creation of a database on the educational support materials available in the Caribbean Region.

* Membership in CARICOM currently includes the English-speaking countries of the Caribbean Region, as well as the associated members comprised of the British overseas territories, Haiti and Surinam.
In the future, the Caribbean Initiative should meet challenges such as:

- Developing sound arguments to facilitate multisectoral coordination, advocacy, the expansion and strengthening of policies, and support for the School Health and Family Life Education Initiative;

- Revitalizing and strengthening the mechanisms that guarantee continuity of multisectoral coordination at the national level, especially the full participation of the education sector;

- Reviewing the design of and continuing the training strategy, to increase the integration of the Life Skills approach into university programs and teacher training institutions;

- Developing norms and standards to serve as reference points in identifying and guiding the countries with regard to the abilities, knowledge, and minimum support required for achieving the objectives of the School Health and Family Life Education Initiative; and

- Continuing to develop the database of support materials available in the Caribbean.

2.2 CURRENT STATUS OF SCHOOL HEALTH PROGRAMS

In order to determine the current status of the Health-Promoting Schools Regional Initiative (HPSRI) and to create a database that will facilitate future comparative analyses and planning that is appropriate to and consistent with the needs of the Member States, the HPSRI, of the Family Health and Population Program, Division of Health Promotion and Protection of the Pan American Health Organization, designed and applied in 2001 a self-administered survey ("Health-Promoting Schools in Latin America") in 19 countries of Latin America and the Caribbean.

The questionnaire, which was completed by 17 countries—90% response rate—was based on the following variables: general information about the context of each country, school health policies, intersectoral coordination, training, research and evaluation, financing, health education, healthy environments, health and nutrition services, participation and publications.

A summary of the principal results and conclusions of the survey, based on the information provided by the 17 countries that completed the survey, is presented in the table below.

* Argentina, Bolivia, Brazil, Colombia, Costa Rica, Cuba, Chile, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru, Dominican Republic, and Uruguay.
<table>
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<tr>
<th>Variables</th>
<th>Principal results and conclusions</th>
<th>Other remarks</th>
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| National policies and plans for health promotion in the school-age population | • 94% of the countries have policies aimed at health promotion for the school-age population and 82% have specific policies related to the Health-Promoting Schools (HPS) strategy.  
• 82% of the countries have school health plans (applied predominantly in primary schools) and 57% of these include actions related to the three HPS strategy components (health education, creation of healthy school environments, and health and nutrition services).  
• 94% of the countries now have school health programs. | • The existence of public policies, technical and scientific standards, and plans of action directed specifically to the promotion and care of health of the child and adolescent school population, is an indicator of the level of priority given to school health on the public and sanitary agendas of the countries of the Region. |
| Financing of school health programs and activities               | • Only 30% of the countries reported having specific budgets to finance school health programs. | • The recognition of school health as an important subject and the existence of national policies do not always result into the allocation of the necessary resources. |
| Mechanisms of multisectoral coordination to support health promotion in the school setting | | In general, the formation of Mixed National Commissions has proven to be a mechanism that facilitates intersectoral coordination, although its approach, or the approach of the agreements between Ministries, can sometimes be too “bureaucratic” and largely ineffective.

- The difficulty for intersectoral work was identified by the countries as one of the main obstacles that still persist for the development of the HPS strategy, meaning that it is necessary to consolidate the current formal mechanisms and to explore new ways of strengthening effective multisectoral coordination.

| Degree of dissemination of the Health-Promoting Schools (HPS) approach | | An important achievement of the Regional Initiative is its contribution, during the seven years after its

- 94% of the countries are currently developing the HPS strategy.

- Non-governmental organizations (national or local) support the financing of such activities in 71% of the cases.

- Fewer than one-third of the countries (29.4%) reported receiving loans or financing from international organizations such as the World Bank or the Inter-American Development Bank (IDB) to support school health programs.

- 65% of the countries have Mixed National Commissions on school health, a percentage that rises to 75% if consideration is given to other modalities of intersectoral work apart from the commissions (e.g., intersectoral technical committees or mixed groups) that operate in some countries.

- Given the crucial role played by NGOs in the development of school health programs, their participation should always be considered in the plans of action through strategic alliances or other mechanisms.
- In almost all cases (90%), the HPS strategy is being implemented in public primary schools in urban areas.

- The degree of dissemination of the strategy—estimated as the ratio of HPS to total schools—varies substantially, with an average of 16.3%.

- While the strategy is still in its early stages in some countries such as Paraguay, in others, such as Chile, Colombia, El Salvador, and Mexico, the HPS have achieved broad dissemination at the national level. In El Salvador, for example, the “Healthy Schools” program increased coverage from 124 schools, in the Department of La Libertad in 1996, to 3,593 schools in 14 Departments of the country in 1999.17

- To increase the HPS national coverage, it is important to keep strengthening the dissemination of the strategy within the countries.

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<tr>
<th>Creation of and participation in the national and international networks of HPS</th>
<th>launching, to the continental dissemination of the Health-Promoting Schools model as a strategy for the promotion of health in the school setting.</th>
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<tr>
<td>- 29% of the countries have created national networks of HPS.</td>
<td>- It is necessary to promote the creation of national networks of HPS in the countries that have not yet established them, as well as to strengthen the management of the existing ones, including the Latin-American and Caribbean Networks.</td>
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<tr>
<td>- 47% of the countries are currently participating in the Latin-American Network of HPS.</td>
<td>- Although a formal network of HPS may not have been created, it is worth noting that in some cases—as it has</td>
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</table>
been happening in the last 4 years in the countries of Central America—in practice effective mechanisms for sharing experiences and horizontal cooperation are being developed.

<p>| Components of school health programs | • There is widespread delivery of school health services in the countries of the Region, including actions and interventions related to: implementation of healthy policies; creation of healthy school environments; health promotion and education; preventive school services and treatment of disease; and nutrition and food supplement programs (see the detailed description of results by component in the following four shadowed rows of the table). Nevertheless, the approach, content, and articulation of these different elements vary considerably from one place to another. | • The content of school health programs in the countries of the Region is quite varied, and in many cases there is no clear consensus on the components that should be included in these programs17. |
| Healthy policies in the school setting | • 70% of the countries reported having policies to prevent smoking in schools and 64% have programs to prevent violence in the school setting. | |
| Healthy school environments | • The specific information available in the majority of countries about the conditions of hygiene and environmental sanitation in schools is limited and deficient. | • The increasing understanding of the enormous impact that physical and psychosocial school environments have on comprehensive health (including nutrition) and the learning |</p>
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<th>Health education</th>
<th>Delivery of preventive services in the school setting, treatment of</th>
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<td>• There are major disparities among the countries of the Region with regard to the number of schools with access to water and drinking water and in at least half of the countries where this information is available, the coverage of these services is low or unsatisfactory.</td>
<td>• 76% of countries have guidelines established by their Ministries of</td>
<td>• A recent study indicates that despite the fact that screening tests have potential of students; calls for the need to continue working in the development of this component as well as in the systems for monitoring and evaluation of actions.</td>
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<td>All the countries reported that health education is included in school programs, almost always (88%) as a transversal subject.</td>
<td>• There is a very broad range of topics covered through the health educational activities, for example: addictions (94%); personal hygiene, sexual and reproductive health, physical education and sports (88%); HIV/AIDS, food and nutrition, utilization of health services (82%); and self-esteem, immunizations, waste management, and life skills (70%).</td>
<td>• The growing dissemination of Life Skills education in many countries of the Region is worth noting; some of them, such as Mexico, Costa Rica, Colombia, Chile or Argentina, currently have projects of several years’ duration that are rendering experience and extremely valuable lessons on the application of this approach within the specific context of Latin America.</td>
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<tr>
<td>• There is a very broad range of topics covered through the health educational activities, for example: addictions (94%); personal hygiene, sexual and reproductive health, physical education and sports (88%); HIV/AIDS, food and nutrition, utilization of health services (82%); and self-esteem, immunizations, waste management, and life skills (70%).</td>
<td>• Most of the countries reported that school programs include activities for physical exercise and recreation (76% have specific programs and in 86% of the cases they are included in the curriculum).</td>
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disease, and nutrition or food supplements

Health or Education on the health services that should be provided to the school population, which almost always include periodic medical assessments and vaccination and, to a very limited extent, other interventions such as early detection of scoliosis, psychological counseling, or gynecological care.

- Although it cannot be generalized, the delivery of these services tends to be carried out using a combination of modalities within and outside the school, and those responsible for coordinating these services are usually professionals in the health sector.

- Educators also fulfill important functions in the delivery of health services to schoolchildren, especially with regard to activities related to the early detection of behavioral problems, learning disabilities, or physical disorders, and referrals for assessment or specialized treatment; and to a lesser extent, they also perform height and weight controls and vision and hearing screening tests.

- Nutrition or food supplement programs also have been almost always closely related to school health programs. In countries such as

been a part of traditional school health programs in many countries of the Region for decades, there is now a strong tendency to explore more effective alternatives to the common practice of universal, indiscriminate screening that is not accompanied by appropriate referral mechanisms and definitive solution to the problems detected.

- Most countries have a high percentage of schools with their own school lunchrooms, providing an opportunity for the HPS to carry out actions related to nutrition and education on eating habits.

- A different modality is being put to test in El Salvador, which consists of delivering a food voucher, transferable to community or school organizations for its management and the local purchase of items for school snacks. The evaluation of this initiative showed that the voucher, instead of the actual delivery of raw foods, is an incentive for the local economy and allows for more variation in menus.
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<tr>
<th>Training of human resources in school health promotion</th>
<th>Monitoring, follow-up, and evaluation of school health programs</th>
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<tr>
<td>• 70% of the countries reported the existence of professional training programs in school health-related subjects, although only Cuba, Ecuador, and Mexico offer a certified specialization in that field.</td>
<td>• Although nearly 71% of the countries indicated that they have methods for evaluating the HPS strategy (mainly of a qualitative type, on process and results, or evaluation and monitoring grids), only very few have models available for the assessment of impact. Almost all the countries mentioned the need for improving these.</td>
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<td>• The professionals most often trained in these subjects belong to the health field (nursing and medicine), although 65% of the countries also have educators with specific training in school health or who are responsible for the HPS strategy, the majority of them associated with the area of primary education.</td>
<td>• Monitoring and evaluation continue to be the “Achilles’ heel” of many school health and nutrition programs in the majority of countries.</td>
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<td>El Salvador, Bolivia, Brazil, Ecuador, and some provinces of Argentina, there is specific legislation that includes these programs as part of the national strategies for food safety, while others are testing schemes to decentralize these programs17.</td>
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**Principal barriers (in descending order of importance) to the implementation of the Health-Promoting Schools strategy, based on information from the regional survey:**

- Insufficient human (health and education workers overloaded with activities) and financial resources;
- Insufficient awareness by political leaders of the importance of school health programs and lack of support for these programs;
- Difficulty working in a coordinated manner with other sectors;
- Inadequate or insufficient infrastructure;
- Problems related to public administration (bureaucracy, limited continuity of technical teams, insufficient project sustainability);
- Unmet need for human resources training; and
- Difficulty incorporating health promotion into school programs.

### Research

- The percentage of countries that reported research projects in subjects related to school health promotion is low (41.2%), as is the percentage of surveillance systems for risk behavior in schoolchildren (35%) or that have conducted surveys on risk practices (41.2%).
- The net result is that there is limited scientifically-based information on successful interventions in the school setting originating in the countries of Latin America and the Caribbean, unlike the information that comes from the United States and Europe. Not only there is a need for more research and better documentation of experiences, but more effective use must be made of the existing information and assurance that it is available for a larger number of people. It has been suggested, for example, that creative use be made of the Internet in the field of school health as a means of disseminating relevant information14.
Priority actions (in descending order of importance) for strengthening the Health-Promoting Schools strategy, based on information from the regional survey:

- Increase the human and financial resources available;
- Consolidate and improve mechanisms of intersectoral coordination;
- Train human resources in school health promotion;
- Institutionalize the Health-Promoting Schools strategy;
- Facilitate the sharing of experiences;
- Improve mechanisms for monitoring and supervision of participating schools;
- Improve the supply of educational support materials to schools;
- Strengthen community participation in schools;
- Increase dissemination of the Health-Promoting Schools strategy; and
- Improve the processes of accreditation and certification of Health-Promoting Schools.
3.

THE HEALTH-PROMOTING SCHOOLS REGIONAL INITIATIVE
3.1 WHAT IS THE INITIATIVE AND HOW DID IT ARISE?

The Health-Promoting Schools Regional Initiative of the Pan American Health Organization emerged formally in 1995, in response to the situation of school health programs identified in the countries of the Region of the Americas, and as a result of the Organization’s commitment since the 1980s to comprehensive school health promotion and education.

The initiative to develop and/or strengthen comprehensive health promotion and education in schools, based on the Latin American experience, was proposed by the Organization and accepted during the Advisory Meeting, held in 1993 in Costa Rica. Representatives from the health and education sectors from 12 countries participated at this meeting, as well as members of international organizations, such as UNICEF, UNESCO, UNFPA, and the International Union for Health Promotion and Education. In this meeting recommendations were made to Member State Governments for the development of the Regional Initiative, and its purposes and principal actions were proposed.

The Initiative, framed within the broad context of the regional approach to healthy municipalities and communities, is intended to facilitate the multisectoral coordination and mobilization of regional, subregional, and national resources allocated to health promotion in the educational communities through the Health-Promoting Schools Strategy, to support the creation of conditions conducive to learning and comprehensive human development, and to improve the quality of life and collective well-being of children, adolescents, and other members of the educational communities.

The Initiative is based on a comprehensive view and a multidisciplinary approach that regards people in the context of their daily life, within the family, the community, and society. It promotes the development of knowledge, abilities, and skills to allow people to care for their health and that of others, and to minimize risk behaviors. It promotes a critical and reflexive analysis of values, behaviors, social conditions, and lifestyles, with the goal of strengthening those factors that favor health and human development and helping members of the educational community to make decisions that promote their health and that of others.

The Regional Initiative contributes to the establishment of equitable social relationships between the sexes, encouraging civic spirit and democracy, and strengthening the traditions of solidarity and community spirit. It advocates for the promotion and protection of human rights and fundamental freedoms in schools, according to the general norms and international standards of human rights which protect children, adolescents, and young
adults*, especially those who are more vulnerable (for example, children and youth with mental or physical disabilities, or in forced displacement situations).

3.2 OPERATIONAL STRATEGY OF THE ORGANIZATION FOR THE IMPLEMENTATION OF THE REGIONAL INITIATIVE

Since its formal launching in 1995, the operational strategy of PAHO/WHO for the Initiative’s implementation in the Americas has targeted its efforts at the following priority lines of action.

- **Advocacy of comprehensive school health programs and dissemination of the concept of Health-Promoting Schools** in the countries of the Region, through regional and subregional meetings, preparation and dissemination of informative and promotional materials, and participation in international forums;

- Technical collaboration to the countries to consolidate mechanisms of intersectoral coordination (National Commissions including representatives of health, education and other sectors), to promote comprehensive school health and implement the Health-Promoting Schools strategy;

- Technical collaboration to the countries to analyze and update joint policies of the health and education sectors and prepare the appropriate plans of action;

- Technical collaboration to strengthen the institutional capacity of the countries for the management of comprehensive school health programs and activities, through professional training activities in the health and education sectors;

- Support for the creation of National Networks of Health-Promoting Schools in the countries of the Region, as a mechanism to facilitate the sharing of information, knowledge, and experiences within the countries themselves;

- Creation of the Latin American and Caribbean Networks of Health-Promoting Schools to facilitate the sharing of information, knowledge, and experiences among different countries of the Region of the Americas, as well as to support the organization and development of Health-Promoting Schools and Networks in each country;

* Different international organizations have established special standards for the promotion and protection of civil, political, economic, social and cultural rights, and the fundamental freedoms of children, adolescents and young adults (Declaration of the Rights of the Child, A.G. res. 1386 [XIV], 14 N.U. GAOR Supp [No. 16], p. 19, ONU Doc. A/4354 [1959] and the Convention on the Rights of the Child, A.G. res. 44/25, annex, 44 N.U. GAOR Supp. [No. 49] p. 167, ONU Doc. A/44/49 [1989], which came into effect on September 2, 1990. In general, these fundamental rights and freedoms include the right to life, name and citizenship, freedom of thought, religion and association, the right to personal integrity, judicial guarantees, health, education, etc.
• Support for the dissemination and inclusion of Life Skills education as a component of comprehensive school health education programs;

• Development and dissemination of and support for the application of instruments for the rapid assessment and analysis of the countries’ capacity to implement and evaluate comprehensive school health programs;

• Support for the development, validation, and application of instruments for research and monitoring of risk behaviors and protective factors in schoolchildren and adolescents;

• Support for the development of the Inter-American Consortium of Universities and Training Centers in Health Education and Health Promotion; and

• Creation of strategic partnerships with other international agencies and the private sector (for example, the “Joint Initiative of the Pan American Health Organization and the World Bank for School Health and Nutrition in Latin America and the Caribbean”, 1997) to support effective strategies for the management of comprehensive school health programs.

Although the implementation of the Health-Promoting Schools strategy by different countries of the Region has had different interpretations and adaptations—according to the profile of needs and problems of the school-age population, the available priorities, and resources—it has generally included the following major lines of action:

• Development of joint agreements and policies among sectors (mainly health and education), including social mobilization and communication activities to promote dialogue between the social sectors and the public on the priorities in school health, as well as to create consensus, alliances, and social pacts to support the dissemination of the Health-Promoting Schools strategy;

• Consolidation of mechanisms of intersectoral coordination at different levels, including the activation or creation of Mixed Commissions, for the joint preparation of situation analysis and work plans, and the monitoring and evaluation of activities;

• Management of school health programs;

• Training of teachers and health professionals on subjects related to school health;

• Development of educational materials, and advocacy of the strategy; and

• Implementation of coordinated actions among schools, health services, and community organizations, including: the promotion and facilitation of community participation in health promotion; the involvement of community leaders and local authorities; and the promotion of local participatory planning to incorporate health promotion into local development plans.
3.3
LATIN AMERICAN AND CARIBBEAN NETWORKS OF HEALTH-PROMOTING SCHOOLS

3.3.1 LATIN AMERICAN NETWORK OF HEALTH-PROMOTING SCHOOLS (LANHPS)

The Latin American Network of Health-Promoting Schools (LANHPS) originated at the European Conference on Health Education and Promotion, held in Strasbourg in 1990. Subsequently, the Congress on School Health, convened in Chile in 1995, agreed on its formal creation, which was carried out in 1996 in San José, Costa Rica, with the participation of representatives from Argentina, Bolivia, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, and Panama, as well as members of the Spanish Network and the WHO Collaborating Centers on school health (Education Development Center and the Centers for Disease Control and Prevention of the United States)28.

Twenty Latin American countries are currently members of the LANHPS; its second meeting, held in Mexico in 1998, was attended by all the countries of Latin America, including Cuba and the Dominican Republic. The third meeting, held in Ecuador, Quito, in September 10-13, 2002, was attended by representatives of all the countries in Latin America, with the exception of Argentina and Mexico, and included the participation of delegates from international agencies, non-governmental organizations, and the private sector.

The mission of the LANHPS is to support the organization and dissemination of Health-Promoting Schools and networks in each country of the Region, as well as to facilitate the sharing of experiences by supporting the opening and establishment of channels of multidirectional communication that are interconnected and converge on points of interest for the improvement of education and health in the school setting29.

The operation of the LANHPS is based on the following principles:

• It is an organization that brings together institutions and agencies from various sectors that promote the health of the members of the educational communities in all countries of the region;
• It is open to free membership by all institutions and by all countries;
• It responds to the special features of the Region and of Member Countries;
• It focuses on the needs of students and has a comprehensive vision of health education; and
• It is committed to the comprehensive development of children and adolescents.
The LANHPS aims to achieve the following goals:

- Dissemination of the conceptual and operational framework of the Health Promotion Initiative in the school setting.
- Promotion for the participation of the educational community, institutional personnel, the population, and local authorities.
- Health promotion in the school setting through health education, the creation and care of healthy spaces, and the delivery of health services.
- Impetus for the formation and operation of national networks of Health-Promoting Schools.
- Development of methodologies to evaluate processes of health promotion in schools.
- Creation and expansion of networks that promote and facilitate the sharing of knowledge and experiences with health promotion in schools and among national networks.
- Strengthening of intersectoral coordination mechanisms, including mixed commissions.
- Strengthening of national networks and expansion of Health-Promoting Schools among Member Countries.

The principal work strategies of the LANHPS are:

- To promote the development and training of human, technical, and educational resources in the areas of health promotion, health education, community participation, multisectoral project planning and management, and other actions that contribute to the health of those who study, teach, and work in the school.
- To promote applied research on health promotion, in conjunction with universities, government agencies, non-governmental organizations, union entities, and the private sector.
- To support the preparation of educational materials for health promotion in schools and to establish strategies for their analysis and sharing.
- To organize forums, workshops, working groups, seminars, and other events that facilitate the study, analysis, and debate of the content and methodology of health promotion in schools.
- To promote the sharing of experiences in health education and promotion in the school setting, as well as to disseminate successful programs and encourage critical debate.
- To stimulate the interest of politicians, the private sector, and civil society in Health-Promoting Schools.
- To promote the evaluation of school health promotion actions carried out within the context of the Network, as well as the process of development of the Network itself.
- To prepare a newsletter, with the collaboration of all Member Countries, that contains experiences and progress achieved in health promotion in schools and national networks.
With regard to the activities of the LANHPS, it is appropriate to summarize the perceived weaknesses in its operation, which were discussed during the First Constitutive Meeting of the Caribbean Network of Health-Promoting Schools, held in Bridgetown, Barbados, November 26 to 28, 2001:

- Lack of continuous financing sources;
- Difficulty in coordinating actions (requires sufficient time);
- High and frequent turnover of country representatives;
- Insufficient and unsteady support by the Governments;
- Limitations in access to effective communication;
- Insufficient knowledge of local experiences;
- Duplication of activities;
- Insufficient development of the national networks of HPS;
- Ignorance of the existence of the LANHPS in Member Countries;
- Limited participation of new actors (private sector, non-governmental organizations, universities) in the process;
- Concentration of responsibility in one or two focal points in a single country;
- Limitations in access to training and continuing education; and
- Lack of experience with the networking dynamic.

During the third meeting of the LANHPS, held in Quito, Ecuador, it was agreed to strengthen the LANHPS management, based on the analysis of critical aspects regarding its operation, and taking into account the following important recommendations:

- To include other sectors convergent with the proposal—governmental or non-governmental—as well as the health and education sectors, in the Latin American and Caribbean Networks of Health-Promoting Schools structure and the national networks of Health-Promoting Schools;
- To modify the LANHPS organizational structure to allow the Presidency of the General Board to be chosen from a list of three countries proposed by the participants in each meeting of the network;
- To modify the LANHPS structure, functions, and responsibilities. The country in charge of coordinating the necessary activities for this restructuring will be the one chosen by the Assembly to assume the Presidency of the General Board;
- To strengthen the sense of belonging and institutional identity of the LANHPS, through a strategy that includes the development and dissemination of its corporate image, and the promotion of interpersonal and interprofessional ties between its members, within a framework of respect for cultural diversity;
• To mobilize financial resources allowing the adequate operation of the LANHPS; and

• To develop the plan of action of the LANHPS according to the general guidelines established in Quito, and to create work groups or committees in the areas of human resources training, communication, and connectivity.

Puerto Rico was chosen by the majority of the representatives of the 19 countries attending the Third Meeting of the Latin American Network of Health-Promoting Schools to host the Fourth Meeting and to assume the Presidency of the General Board of the LANHPS. This appointment was accepted by the official delegates from Puerto Rico.

3.3.2 CARIBBEAN NETWORK OF HEALTH PROMOTING SCHOOLS (CNHPS)

In an effort to continue supporting the countries of the Caribbean with the dissemination and strengthening of school health programs, within the specific context of their characteristics and cultural identity, resources, and priorities, the constitutive meeting of the Caribbean Network of Health-Promoting Schools was held in Bridgetown, Barbados in November 2001, with the participation of representatives from the Bahamas, Barbados, Dominica, Grenada, Guyana, Jamaica, Puerto Rico, Saint Vincent and the Grenadines, Saint Lucia, Saint Kitts and Nevis, Suriname, and Trinidad and Tobago.

The objectives of the Caribbean Network are:

• To support the countries of the subregion with the improvement of health conditions and development of the school-age children and adolescent population;

• To support the countries of the Caribbean with the implementation of healthy policies in the school setting;

• To strengthen ties through community organization and participation;

• To increase the participation of parents in the health and well-being of children and adolescents, in order to facilitate the acquisition and maintenance of healthy lifestyles;

• To disseminate knowledge and successful practices in health promotion and education with regard to: smoke-free schools, sex education, food and nutrition, physical activity, prevention of addiction, Life Skills education, healthy spaces (free from violence), prevention of suicide, mental health, healthy lifestyles, etc.;

• To provide incentives for closer collaboration between the Ministries of Health and Education with a view to achieving the healthy development of children and adolescents;

• To advocate and promote the added value that the existence of a Caribbean Network of Health-Promoting Schools has among all the strategic partners, especially those already working in subjects related to health promotion in the school setting; and

• To strengthen the capacity of the Ministries of Health and Education to promote the Health-Promoting Schools Initiative.
Health-Promoting Schools networks in Latin America and the Caribbean offer opportunities to continue the dialogue about health promotion and health education in all settings, and to facilitate the sharing of ideas, resources and experiences to nurture the commitment and enthusiasm of all interested parties.  

3.4 ACCREDITATION OF HEALTH-PROMOTING SCHOOLS

Based on the general directives of the Health-Promoting Schools Regional Initiative, countries have moved forward with the process of defining criteria and procedures for the accreditation of Health-Promoting Schools. In general, the procedures include minimum requirement standards, certification by the Ministries of Health and Education, activities for monitoring and follow-up, information requirements, and periods of accreditation, with schemes varying from country to country. The following table provides an example from Chile.

**CRITERIA FOR THE ACCREDITATION OF A HEALTH PROMOTING SCHOOL**

**Planning Process**

The School should have at least three of the following components:

- Defined advocacy process or document of commitment for implementation of the Initiative;
- Working group for implementation of the Initiative and coordination with other sectors, that includes the participation of representatives of school administrators, teachers, parents, students, and parent-teacher associations;
- Needs assessment or plan of action for at least one year; and
- Inclusion of the school health program in the community plan of action, institutional education project, or regular national plans.

**Health Promotion Activities**

The school should have at least one program in three of the following priority areas:

- Healthy nutrition (healthy cafeterias, snacks, or dining rooms);
- Physical education (expansion of hours devoted to physical activity, recreation and sports, improvement of physical spaces);

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* Example from Chile
Protective psychosocial factors (emotions and sexuality, Life Skills education, interpersonal relationships);

Use of tobacco, alcohol, and drugs (declaration of smoke-free spaces, educational activities, prevention);

Oral health promotion (provision of toothbrush holders, educational activities); and

Healthy school environment (improvement of physical spaces, environmental education, creation and conservation of green areas).

Program participants

The school should incorporate the participation of representatives from at least three of the following groups:

- School administration personnel
- Teachers
- Students
- Parents
- Community
CONCEPTUAL FRAMEWORK
The goal of the Health-Promoting Schools Regional Initiative is the strengthening of sustainable human development of children, adolescents, and young adults in the school setting. The conceptual framework that serves as basis for the Initiative has two important foundations. The first are the Declarations and Orientations on Health Promotion*, which provide the main general framework for the Health-Promoting Schools approach. The second includes relevant considerations about the health and education collaboration, as well as with other social sectors; the context and experiences of the countries in Latin America and the Caribbean; current school health programs; and, in particular, scientific and technical knowledge about health and education at a global level, including educational theories, models and actions that allow the identification of appropriate, effective and efficient practices for the development of comprehensive school health programs at regional, national, and local levels.

The development of strategies and lines of action proposed for the strengthening of the Regional Initiative, from 2003 to 2012, is based on networking and community participation, especially of the educational community, which are channeled through the three pillars of Health-Promoting Schools: health education with a comprehensive approach; healthy school environments; and health and nutrition services and active life. Continuous work with healthy public policies is being proposed, to facilitate sustainable human development as a common and transversal element to the three components of the Regional Initiative.

The figure shown in the next page illustrates how the principal elements of the conceptual framework of the Regional Initiative are articulated, which are described in detail later in this section of the document.

4.1 WHAT IS A HEALTH PROMOTING SCHOOL?

The Health-Promoting Schools (HPS) model, disseminated by the Pan American Health Organization in the Region of the Americas through the Regional Initiative since 1995, is a health promotion strategy in the school setting, based in the articulated and synergistic development of three main components*

- Health education with a comprehensive approach;
- Creation and maintenance of healthy school surroundings and environments; and
- Delivery of health and nutrition services, and active life activities.

CONCEPTUAL FRAMEWORK
HEALTH-PROMOTING SCHOOLS REGIONAL INITIATIVE

SUSTAINABLE HUMAN DEVELOPMENT

CHE: Comprehensive Health Education
HS: Health Services

HEALTHY PUBLIC POLICIES

NETWORKS AND COMMUNITY PARTICIPATION

STRATEGIES AND LINES OF ACTION 2003-2012

DECLARATIONS AND ORIENTATIONS
Health education with a comprehensive approach

Systems of formal education in the countries are ideal settings for the implementation of educational actions among the school population during the very important formative stages of their lives, recognizing that children, adolescents, and young adults are the social actors of tomorrow and that schools are the places where students can have access to information, knowledge, example, and support necessary to develop healthy habits and lifestyles.

There is sufficient scientific evidence that demonstrates that disease prevention programs focusing mainly or exclusively on the transmission of information and knowledge are largely ineffective, and that educational interventions for health promotion in the school setting should take into account the wide diversity of factors that influence human behavior. They also need to be based on a comprehensive and multidisciplinary vision of health that includes the analysis of social, political, and economic factors affecting daily life.

Therefore, this component of the strategy aims to strengthen the capacity (“empowerment”) of children and adolescents, through structured educational processes in the school setting that make it easier for them to acquire and use the knowledge, attitudes, values, skills, and competencies necessary to promote and protect their own health and that of their families and communities.

One of the major challenges for educators and public health professionals is to surpass the traditional approaches to health education often characterized by the teaching of isolated contents of health subjects that bear little or no relation to the reality of students, within their family and community environment; emphasis on the cognitive and didactic aspects of the educational process, with limited appreciation or complete disregard for affective processes and emotional intelligence; lack of participation by students and other members of the educational community in the selection of topics and the evaluation of the teaching and learning process; and lack of interactive and participatory techniques that help make the educational experience a more enjoyable process, with greater impact for all people involved.

School health education programs are comprehensive when:

- They are based on a paradigm that regards health as a source of well-being and sustainable development and not as the mere absence of disease;
- They use all available opportunities—inside and outside the educational community, formal and non-formal education, traditional or alternative methods—to implement health education processes;
- They strengthen the capacity of students (“empowerment”) to transform the conditions that determine health;
- They promote interaction among the school, community, parents, and local health services; and
- They promote the development and conservation of healthy school environments.
In the New Millennium*, children and adolescents require a true education for life aimed at the development of their innate capacity to learn to be, learn to learn, learn to do, learn to live with others, and learn to undertake actions, and strengthening the various skills and competencies necessary to successfully meet the demands and challenges of an increasingly complex world.

They require a participatory and liberating education to develop their analytical and investigative capacity in a positive and creative environment, and to strengthen the principles of respect for human rights, equity, and collective values, thereby contributing to the creation of men and women with self-esteem, autonomy, awareness, and social commitment.

In this regard, the Life Skills approach—with its emphasis on the development of skills and psychosocial competence—is gaining increasing acceptance and dissemination in the countries of the Region and constitutes a valuable tool to continue supporting processes of school health education.

The main purpose of Life Skills education is the development and strengthening of a generic group of psychosocial skills that can be applied in a wide variety of situations.

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* The Millennium Development Goals (MDG) adopted in the 55th U.N. General Assembly represent a global commitment in the fight against poverty and inequity in income distribution within and among the Member States. The health sector is involved in the achievement of three important goals: reduction of maternal and child mortality (MDG No. 4 and 5), and reduction of HIV-AIDS and other communicable diseases (MDG No. 6). Additionally, the health sector has the responsibility of collaborating with other sectors in the achievement of the other goals.

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**A Health-Promoting School**:  

- Implements policies that support dignity and individual and collective well-being and offers multiple opportunities for the growth and development of children and adolescents within the context of learning and success of the school community (including educators, students, and their families);

- Implements strategies to promote and support learning and health, utilizing all means and resources available for this purpose and involving personnel from the health and education sectors and community leaders in the implementation of planned school activities (e.g., comprehensive health education and Life Skills training; strengthening of protective factors and reduction of risk behaviors; facilitation of access to school health services, nutrition, and physical education);

- Involves all members of the school and community (including teachers, parents, students, leaders and non-governmental organizations) in decision-making and the implementation of interventions to promote learning, encourage healthy lifestyles, and carry out health promotion projects in the community;

- Has an action plan to improve the physical and psychosocial school environment and surroundings (e.g., standards and regulations for school environments, free from smoking, drugs, abuse, and any form of violence; access to safe drinking water and health facilities; nutrition services), trying to set a good example through the creation of healthy school environments and the implementation of activities that extend to outside the school setting and toward the community;

- Implements actions to evaluate and improve the health of students, the educational community, families, and members of the community in general, and works with community leaders to ensure access to nutrition, physical activity, counseling, and health and referral services;

- Offers relevant and effective training and educational materials to educators and students; and

- Has a local committee on education and health with the active participation of parents associations, non-governmental organizations, and other organizations in the community.
situations characteristic of the lives of children and adolescents. Although there are various ways to classify these skills, the World Health Organization originally proposed that the following ten are perhaps relevant in any socio-cultural context:

<table>
<thead>
<tr>
<th>Self-knowledge</th>
<th>Empathy</th>
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<tbody>
<tr>
<td>Effective communication (assertive)</td>
<td>Interpersonal relations</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Problem-solving</td>
</tr>
<tr>
<td>Creative thinking</td>
<td>Critical thinking</td>
</tr>
<tr>
<td>Management of emotions and feelings</td>
<td>Management of tension and stress</td>
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</tbody>
</table>

To know how to make better decisions or being able to “say no,” for example, are important psychosocial skills that can help children and adolescents to resist pressure from peers or friends to start using psychoactive substances or smoking. However, these same skills can also act as a protective factor in the case of risky situations relating to sexual activity among adolescents and young adults.

Some of the personal characteristics that have been identified in resilient children—for example, autonomy, empathy, control of emotions and impulses, or the ability to understand and analyze situations—can be developed or strengthened through Life Skills education in schools.

The fact that a single intervention—Life Skills education—makes it possible to address multiple objectives, interests, and priorities common to various social sectors, such as health promotion (development of personal abilities), prevention of psychosocial problems, and promotion of comprehensive human development, is one of the main strengths of this approach.

Current school health education programs should also be aware of issues related to health literacy* and its potential to contribute to the objectives of health promotion and disease prevention in the various stages of the developmental cycle.

Among the possible thematic contents of health literacy in the schools, it is appropriate to include education on basic human rights and fundamental freedoms of all children and adolescents in general, and especially of those in the most vulnerable or excluded groups—for example, children with chronic disorders or disabilities of any type, victims of armed conflicts, or refugees, among others.

It is essential to educate children and young people for a healthy life, based on the knowledge and appropriation of basic human rights and freedoms. Educational institutions provide an ideal setting for this purpose. There are very important ties to be explored between human rights, health promotion, and education within

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* There are several definitions of the concept of “health literacy”—of relatively recent application in the area of public health—, like the one adopted by the US Healthy People 2010 goals, where it is stated that health literacy is “the ability to obtain, interpret and understand basic information on health and services, and the ability to use such information and services to improve health conditions” (US Healthy People 2010 Objectives). During the Fifth World Conference on Health Promotion (Mexico, 2000), it was agreed to include other dimensions of community development in the concept, and to emphasize that health literacy is not only a personal characteristic but also a determinant factor in public health (Ilona S. Kickbusch. Health Literacy: Addressing the Health and Education Divide. February 2001).
the context of empowerment and social participation of Health-Promoting Schools.

School health education activities that involve the use of methods and strategies for participatory and interactive learning, such as Child-to-Child or Youth-to-Youth approaches, stimulate students to take an active role in health promotion and protection among children of their own age, their families, and their communities, including children and adolescents outside the school system.

It is evident that in a continent like the Americas, with such extraordinary cultural diversity and innovative pedagogical experiences, there cannot be only one way to plan and carry out health education activities in schools. Nevertheless, the design and development of a comprehensive health education program generally require the assessment of needs; curriculum development; preparation of educational material; education, training, and updating of teachers; research; monitoring and evaluation; and dissemination of information.

It is recommended that these programs:

- Be part of a school curriculum, based on national, regional, and local public health priorities conceived in terms of the knowledge, attitudes, values, and skills necessary for the development of healthy lifestyles;

- Emphasize protective factors (including the promotion of resilience) and risk behaviors and factors;

- Include the component of education in psychosocial skills and competence (Life Skills);

- Apply new health teaching methods that complement classroom learning through transcurricular strengthening and activities in the school setting and the community.

Although physical education has traditionally been part of health education and focuses on the practice of sports and development of motor skills, an international movement to improve physical conditions at all stages of the life cycle has gained momentum in recent years. Physical education and recreational activities offer additional opportunities for the promotion of active life and physical and mental health in schools.

Creation and maintenance of healthy school surroundings and environments

The creation of healthy environments is another basic component of school health promotion and involves two different and complementary dimensions:

- Physical dimension. This refers to the physical environment in which teaching and learning take place, which must guarantee minimum conditions of safety and environmental sanitation—water, sanitary services—conducive to the health, well-being, and development of the maximum potential of children and other members of the educational community. The conditions of the physical environment at school, the conditions supporting the care of the environment,

and the policies related to its use—e.g., smoke-free spaces, types of food sold in the school cafeteria—can have a powerful reinforcing or contradictory effect on other health promotion messages fostered in the school setting.

- **Psychosocial dimension.** A Health-Promoting School aims to foster a climate of interaction that is harmonious, kind, respectful of human rights, equitable, and free from any form of violence among its members, through the teaching of tolerance, democracy, and solidarity. There is increasing evidence on the enormous impact of the quality of the psychosocial microclimate in the classroom—harmonious relations, absence of fights, formation of peer groups—on the academic performance of students and the performance of the teachers themselves.

**Delivery of health and nutrition services and active life activities**

There is a long history of health service delivery in the school setting in the Region of the Americas. Over the years, approaches and models in this regard have been characterized by enormous variation from country to country, reflecting changes in public health trends and the different ways in which nations have moved forward in the reform of their health systems. The “school hygiene” model, derived from European experiences at the beginning of the last century, evolved into school programs that included wide vaccination campaigns and health education topics, and subsequently into the design of more comprehensive interventions in which health and education became active partners in the achievement of common objectives and goals.

The delivery of health and nutrition services, and active life activities for schoolchildren should be organized according to the policies, mechanisms, models and relevant contents responding to the needs of students, and resources allocated in each case—country, region, or municipality—for the healthcare of the population in general. In this regard, a Health-Promoting School:

- Guides the educational community to ensure that schoolchildren have timely access to all prevention actions—including immunization, vision and hearing screening, oral health, mental health, and counseling—and disease treatment, food, and nutrition services to which they are entitled to within the mechanisms anticipated in the current health system;

- Organizes, in conjunction with the network of services available locally, the direct delivery of health services—including food, nutrition, and active life services—within the school setting, should this be deemed appropriate and in accordance with the established policies, the current model for the delivery of health services, the resources available for this purpose, and the socio-cultural context;

- Supervises the quality and timeliness of health services—including food, nutrition, and active life services—received by the students and other members of the educational community;

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* Results of the First International Comparative Study of Language, Mathematics and Associated Factors, developed by the Latin American Laboratory for The Evaluation of the Quality of Education (UNESCO, 1988). For more information, see UNESCO-OREALC Web site: [www.unesco.cl](http://www.unesco.cl).
• Informs and educates the school community on the rights and responsibilities of schoolchildren and other members within the health system to which they belong, and

• Participates in the epidemiological surveillance of risk conditions and protective factors to which the educational community is exposed.

4.2 INTERNATIONAL DECLARATIONS AND THEORETICAL APPROACHES AS A BASIS FOR THE HEALTH-PROMOTING SCHOOLS REGIONAL INITIATIVE

Health-Promoting Schools are, in essence, a health promotion strategy in the school setting and represent the application, to the specific setting of the educational communities, of the theories, scientific bases, models, and tools on which health promotion is based. Thus, to refer to the conceptual framework of Health-Promoting Schools involves the consideration of the most important elements of the conceptual framework of health promotion itself.

As a public health strategy, health promotion deals with a broad range of social sectors that are critical for the improvement of the health of the population, human development, and the quality of life. Health promotion expands the operational framework of the primary care strategy and helps achieve the objectives of “Health for All,” by strengthening people’s ability to choose and maintain healthy lifestyles and to participate in those community actions that are necessary to live healthy lives.

Health promotion is fundamentally, although not exclusively, inspired by the essential proposals of the Ottawa Charter (1986) and subsequent international and regional conferences, in which various aspects, critical to improving the conditions of health and development of people and communities, have been analyzed. Thus, for example, the Second Conference, held in Adelaide (Australia, 1988), emphasized the key role of healthy public policies, and the Third Conference, held in Sundsval (Sweden, 1991), emphasized the interdependence between health and the environment in its various dimensions—physical, cultural, economic, and political.

During the Conference held in Bogotá (Colombia, 1992), the importance of solidarity and equity as indispensable conditions for health and development was discussed and the impact of violence on the health of individuals and communities was condemned. The Caribbean Conference on Health Promotion (Trinidad and Tobago, 1993) emphasized health promotion and protection, identified strategies for the organization of intersectoral activities, and called for renewal of the commitment to community participation in the decision-making processes, social communication, and greater equity in health.
Subsequently, the Jakarta Conference (Indonesia, 1997), the Fourth International Conference on Health Promotion after Ottawa, proposed the need to move forward in the struggle against poverty and other determinants of health, in developing countries. Similarly, the mobilization of the private sector and the creation of strategic partnerships were emphasized.

The Fifth International Conference on Health Promotion, held in Mexico City (2000), considered the promotion of health and social development to be a fundamental duty and responsibility of governments, shared by all other sectors of society. It concluded that health promotion should be a basic component of health policies and programs in all countries in the search for equity and better health for all, proposing, among other things, the following actions:

- to make health promotion a fundamental priority of local, regional, national, and international health policies and programs;
- to exercise leadership in ensuring the active participation of all sectors and civil society in the application of health promotion measures;
- to support the preparation of action plans at the national level for health promotion; and
- to establish or strengthen national and international networks that promote health.

In order to move from theory to practice and to achieve the objectives of health promotion, the Ottawa Charter (1986) proposed that promotion actions be based on the implementation of the following five major strategic areas:

- Formulation of public policies that promote health in all sectors and at all levels of society (healthy public policies);
- Creation of supportive environments (physical, social, economic, political, cultural) for health and well-being;
- Strengthening of community actions and public participation in decision-making and health promotion actions;
- Development of personal skills necessary to live a healthy life; and
- Reorientation of health services to place greater emphasis on health promotion.

The application of this general strategic framework, which is the base of health promotion, to the context of specific settings or environments has been used to guide the implementation of important international public health initiatives such as “healthy cities or municipalities” and “healthy schools or Health-Promoting Schools.”

Conceptually, health promotion is fueled by an enormous diversity of theories and models based on scientific research stemming from various disciplines and latitudes, especially the United States and Europe, with
such notable exceptions as the research in the field of participatory action (Fals Borda 1988-91) and the theory of participatory education (Freire 1970-74), that were developed in Latin America. Nevertheless, it is clear that much more research is needed to develop theories, models, and processes for health interventions in the specific social, economic, and cultural context of Latin America and the Caribbean.

Some of the most important theoretical approaches and their relationship to the strategic areas of health promotion are presented in the following table*:48:

<table>
<thead>
<tr>
<th>Frame of reference</th>
<th>Emphasis</th>
<th>Strategic area of health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Political theories on participatory community development</td>
<td>• Explain capacity building, democratic organization, and administrative styles</td>
<td>• Creation of surroundings or environments to support healthy life</td>
</tr>
<tr>
<td>• Networks of community-based social support</td>
<td>• Facilitate interpersonal communication and consensus on healthy lifestyles</td>
<td>• Strengthening of community action</td>
</tr>
<tr>
<td>• Theories on learner-centered cognitive development</td>
<td>• Describe and explain the process of acquiring and updating values, knowledge, and skills</td>
<td>• Development of skills or abilities necessary for a healthy life</td>
</tr>
<tr>
<td>• Theories on behavior modification</td>
<td>• Describe and explain the process of adopting healthy lifestyles at the individual and community levels</td>
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</tbody>
</table>

**Political theories concerning participatory community development**

Empowerment is a fundamental concept in the practice of community organization and participatory development, and refers to people’s ability to make decisions and carry out actions, individually and collectively. It implies access to and control over the necessary resources.

**Individual empowerment** refers to psychological characteristics such as self-esteem, self-confidence, and a good

* The table is based on information included in the document “Communication, Education and Participation: A Framework and Guided Action”, prepared by Dr. María Teresa Cerqueira and Dr. Gloria Coe in 1996. At that time, Dr. María Teresa Cerqueira was Regional Adviser in Social Participation, Health Education, and Dr. Gloria Coe was Regional Adviser in Social Communication.
dose of self-control to achieve a personal goal or interest. Community empowerment refers to characteristics of social organization, contacts, and alliances among interest groups, and influence at the political and economic decision-making levels, to achieve a goal or interest of the group or community.

Within the framework of health promotion, the term “empowerment” also refers to the process of social action that promotes the participation of people, organizations, and communities in achieving goals of increased individual and community control, political effectiveness, improvement of the quality of life in the community, and social justice.

The process of empowerment implies the development of competencies and training in the skills necessary to negotiate, handle conflicts, build consensus, and form strategic alliances.

To the extent that communities strengthen their capacity to make decisions and solve problems through collective action, this change will be reflected in an increase in the quality-of-life indicators and a reduction in the rates of social and health problems. The communities that have been strengthened in this way can work efficiently toward the modification of risk factors and conditions that underlie many health problems. These communities are the force behind the promotion of public policies that facilitate healthy lifestyles.

**Networks of community-based social support**

The development of competent communities frequently involves the application of principles and approaches derived from theories of social support and formation of community-based networks, which techniques are used to identify natural leaders in a community; understand community patterns; identify high-risk groups; and to involve network members in evaluating the needs of their own communities so they can undertake the actions necessary to improve the quality of life and create supportive environments in the community.

Social support networks perform a vital function in promoting individual and collective healthy lifestyles, by either encouraging or discouraging behavior toward health and well-being.

**Theories on learner-centered cognitive development**

Many of the current mainstays on cognitive development are the result of Jean Piaget’s pioneer work, who in the 1930s postulated that cognitive development in human beings progresses through a series of stages—sensorimotor, pre-operational, concrete operational, and formal operational—as a result of the permanent interaction between biological factors and experience, and that in each one of them the individual acquires the capacity to understand the world in an increasingly complex and sophisticated way.

It is evident that seven decades later many of Piaget’s original statements have been reviewed and updated in the light of recent scientific research results. For example, the six stages in which the author originally subdivided the sensorimotor stage are currently classified in four, with critical transitional points at 3, 8, 12 and 18 months of age, all of which seem to coincide with changes in the process of brain maturation related to brain waves, sleep...
cycles, and perception, which had not been elucidated by Piaget’s time49.

Although it is necessary to put into context Piaget’s scientific work, it is clear that his contributions to the development of the theory of knowledge were countless, and that many of them served as basis for the development of educational theories. First, Piaget pointed out clearly that the function of knowledge is to transform reality, not only to acquire information. Secondly, he highlighted that behavioral psychology and cognitive science greatly denied the importance of feelings. Human experience involves thought, cognition, action, and the psychomotor and affective domains. Piaget indicated that it is only when these three dimensions are considered as a whole, that the learning of each experience acquires meaning, and enriches and empowers the individual50.

For years, involving people in constructive learning experiences has been considered an essential aspect for the improvement of individual and collective quality of life. The frames of reference for learner-centered cognitive development, based principally on the theories of adult education (Knowles 1981-1984), critical pedagogy (Freire 1970-1974), and social learning (Bandura 1986), are key to the capacity strengthening in the local environment.

Popular health education models, based on critical pedagogy, focus on empowering community members to identify problems and implement the solutions necessary to improve the quality of life.

To a great extent, the theoretical basis for health education and the training of health workers has been derived from the field of adult education. The most effective models assume that a well-motivated learner can benefit from an abundance of life experiences, and therefore many programs emphasize the importance of a climate of mutual respect, collaboration, reciprocity, confidence, support, openness, and authenticity.

Theories on behavior modification

The understanding of what determines whether or not a person chooses a healthy lifestyle has been a topic of scientific research in various disciplines. Some of the theories frequently used to explain this process are those relating to the models of behavior modification by stages and theories of persuasion.

Theories of behavior modification hold that the adoption of healthy behaviors is a process by which people move through several stages until the new behavior becomes part of daily life.

Theories and models of persuasion offer a broad frame of reference for understanding human behavior and its determinants, and have served as a basis for scientific research in disciplines related to health sciences, and to planning, implementation, and evaluation of communication and health education activities. Within this area, two models, that are quite solid and have been widely disseminated across cultures, are worth emphasizing.

The Health Beliefs Model was formulated in the 1950s, based on an experience of public participation in a tuberculosis screening program. Analysis of the various forces and factors that affected participation resulted in the development of the model, based on three essential factors:
legislation. This model stresses that health and behavior are determined by multiple factors, and that multisectoral and multidisciplinary actions are essential to achieve behavioral changes.

The model consists of five assessment stages, one implementation stage and three evaluation stages. The assessment stages include:

1. Social assessment of needs, desires, and perceptions;
2. Epidemiological assessment of the health situation and its most prevalent problems;
3. Assessment of behaviors and the environment;
4. Assessment of predisposing behavior conditions (knowledge, attitudes, beliefs, values, and perceptions that promote or limit the process of change), which strengthen (rewards and feedback), facilitate, and impact behavior (social skills, available resources, barriers that can promote desired behavior or limit undesirable behavior); and
5. Assessment of the administrative and political environment, evaluating the organizational and management capacity, and available resources for program development and implementation which can impact desirable behavior factors.

The great challenge for those working in school health promotion lies in the creative application of these theoretical frameworks, as well as many others, to improve the quality of life and the opportunities for learning and healthy development of the school-age population.
5.

STRATEGIES AND LINES OF ACTION

2003-2012
The Health-Promoting Schools Regional Initiative is a strategic mechanism of social, multisectoral, and inter-agency advocacy, coordination, and mobilization of resources, to strengthen the regional, national, and local capacities needed for health promotion, the creation of conditions conducive to learning and comprehensive human development, and the improvement of the quality of life and collective well-being of children, adolescents, and other members of the educational communities.

This strategic plan for strengthening the Initiative during the period of 2003 to 2012 was formulated taking into consideration the current status of school health programs and the degree of progress achieved in implementing the strategy in the Region, within the general framework of the Organization’s priority areas of technical cooperation for the same period, and those established by the Health Promotion and Protection Division (HPP) to create and strengthen technical capacity regarding health promotion.

The plan is based on the development of six main strategies and their corresponding lines of action, which are described below and presented in a brief summary in a table at the end of this section.

5.1 ADVOCACY FOR SCHOOL HEALTH PROGRAMS AND THE DISSEMINATION OF THE HEALTH-PROMOTING SCHOOLS REGIONAL INITIATIVE

One of the most significant achievements of the Health-Promoting Schools Regional Initiative, has been the promotion of a greater visibility of the comprehensive needs of the child and adolescent school-age population on the political, socioeconomic, and public health agendas of the Member States. Similarly, the Initiative has promoted increased understanding in the Continent of the indissolubility of the health-education nexus and the strategic potential for schools to promote health, sustainable development, and socioeconomic and spiritual growth of populations.

Nevertheless—and not withstanding the progress achieved—, advocacy of comprehensive interventions in the school setting should continue to be one of the priorities of the Health-Promoting Schools Regional Initiative. A persistent challenge in consolidating the Initiative in the Region is to involve society as a whole, international agencies, public and private sectors, communications media, political decision-making entities, educators, and parents in the definition of priorities and the mobilization of human and material resources required to carry out the activities.
Therefore, over the next ten years, the Initiative will continue to support regional and subregional strategies designed to increase the social value of comprehensive school health programs, political commitment, and resources available for these programs. Moreover, the Initiative will focus the Organization’s technical collaboration in strengthening the capacity for advocacy in the countries themselves, especially by the National Commissions and other important partners responsible for promoting the cause for comprehensive school health programs.

Supporters of school health need a clear vision of these actions and how to implement them within the specific context of each country, as well as technical tools to develop proposals and manage resources and information based on scientific evidence. The broad dissemination of such information and the results of research have a considerable impact on the determination of priorities and on the work of the various institutions and agencies.38

Principal lines of action:

• To strengthen the awareness of political leaders and officials of the Member States responsible for decision-making at the Ministries of Health, Education and other sectors, opinion leaders, and strategic actors linked to non-governmental sectors*, about the importance of continuing to move toward the objectives of the international policies “Health for All” and “Education for All” (EFA-2015) and the potential of Health-Promoting Schools to contribute effectively to the achievement of these common objectives.

• To strengthen the technical capacity of National School Health Commissions to promote effectively the Health-Promoting Schools strategy.

• To support the development and dissemination of social information, education, and communication (IEC) strategies and innovative programs for advocacy of school health programs and promotion of the Health-Promoting Schools strategy.

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* Institutions of higher education and human resources training centers; scientific and professional associations; teacher unions; mass media; non-governmental organizations; and other advocacy groups.
5.2 SUPPORT FOR THE INSTITUTIONALIZATION OF THE HEALTH PROMOTING SCHOOLS STRATEGY AND FORMULATION OF HEALTHY PUBLIC POLICIES IN EDUCATIONAL COMMUNITIES

In the sociopolitical and administrative context of growing decentralization processes and reform of the health and education sectors in Latin America, priorities are increasingly established and redefined based on local settings, where adequate resources may or may not be allocated. The absence of clearly-defined policies that guarantee the priority of school health in the public and economic agendas of the countries, provinces and municipalities, or the educational communities themselves, frequently means that although successful experiences, these may not receive adequate financing as a consequence of the will of the administrations in power.

The sustainability of the Health-Promoting Schools strategy requires explicit commitment policies for health, education, and sustainable human development, through the educational communities, not only at the national governments level, but also through its inclusion in regional and municipal development plans. Similarly, it is important to move toward the institutionalization of the strategy through its coordination with the Institutional Educational Projects (IEP).

The Regional Initiative will continue to strengthen the technical capacity of the Member States so they can move ahead in the formulation and updating of multisectoral policies and plans of action, as well as the incorporation of comprehensive school health programs and the Health-Promoting Schools strategy into the institutional plans and projects of the educational communities.

In addition, the experience gained over nearly a decade demonstrates that Health-Promoting Schools are an effective strategy for promoting the dissemination, adoption, social auditing, and evaluation of healthy policies in the school setting. One of the main objectives of the strategy is to facilitate the convergence of complementary actions for the benefit of the health, education and quality of life of communities. To this end, the Initiative will promote the dissemination and participatory formulation of policies, contributing to the achievement of these goals with the Health-Promoting Schools, in coordination with other Divisions, Programs, and Centers of the Organization*, PAHO/WHO Collaborating Centers, Ministries of Health and Education, and other key actors.

Principal lines of action:

- To provide technical collaboration to Member States with the preparation of guidelines and tools that pro-

* CPC, CLAP, CFNI, INCAP, and CEPIS.
mote multisectoral consensus-building and the strengthening of policies and plans of action aimed at school health promotion and the dissemination of the Health-Promoting Schools strategy.

- To support the preparation and dissemination of guidelines and instruments that promote the incorporation of the Health-Promoting Schools strategy into the institutional plans and projects of the educational communities.

- To advocate, in coordination with other Areas, Units, Representative Offices, and Centers of the Organization, PAHO/WHO Collaborating Centers, Ministries of Health and Education, and other sectors, the dissemination, adoption, social auditing, and evaluation of healthy policies in the school setting.

5.3

STRENGTHENING THE PARTICIPATION OF KEY ACTORS IN THE MANAGEMENT OF SCHOOL HEALTH PROGRAMS

Improvement of health conditions, quality of life, well-being, and opportunities for learning and development of the school-age population and other members of the educational communities is not the exclusive responsibility of a single sector. It requires the commitment and coordination of resources and efforts by the community, various sectors and levels of public administration (especially at the local or municipal level), non-governmental organizations, and international cooperation agencies. Multisectoral action is indispensable for the mobilization of commitments, the definition of solutions, and the implementation of actions5.

Although more than 65% of the countries of the Region already have intersectoral coordination mechanisms5, these need to be consolidated and strengthened. Over the next ten years, the Organization’s Initiative will seek to encourage Member States so that these mechanisms and strategies include all sectors responsible for health, education, and development of schoolchildren, and not only the health and educational sectors. It is expected that this should lead to the capacity to negoti-
ate and coordinate common agendas, conceptual and operational frameworks shared by and relevant to all, and convergent and complementary interventions.

The creation of networks has proven to be an effective strategy for the promotion of comprehensive school health programs at the regional level (Latin American and Caribbean Networks of Health-Promoting Schools) and at the national level (National Networks of Health-Promoting Schools). For this reason, the Initiative will continue to support their dissemination and the mobilization of the necessary resources to strengthen their management.

**Principal lines of action:**

- To support the creation or strengthening of the management capacity of the National School Health Commissions in the countries of the Region that have not yet established them and consolidate those that already exist, through training strategies, dissemination of relevant information, and sharing of knowledge and experiences.

- To provide technical collaboration to the countries of the Region for the development of guidelines that facilitate multisectoral consensus-building on shared conceptual frameworks and strategic plans for the design, implementation, and evaluation of school health programs that are applicable at the national, regional, and municipal levels.

- To promote the creation of National Networks of Health-Promoting Schools and strengthen their management through strategies that promote dissemination of relevant information, sharing of knowledge, documentation and dissemination of successful experiences, and health promotion applied research in the school setting.

- To strengthen the management of the Latin American and Caribbean Networks of Health-Promoting Schools (LA&CNHPS), through the dissemination of successful programs and intervention models in schools, promotion of debate and sharing of knowledge and experiences, promotion of applied research, and promotion of human resources development and training in areas critical to school health.

- To form and consolidate strategic partnerships with various agencies of the United Nations, the Organization’s Centers, PAHO/WHO Collaborating Centers, non-governmental organizations, and other institutions, to strengthen the Health-Promoting Schools Regional Initiative in the Member Countries.
5.4 STRENGTHENING THE CAPACITY OF MEMBER STATES TO MANAGE THE HEALTH-PROMOTING SCHOOLS STRATEGY

In response to the profile of needs and problems identified by the countries of the Region, for the successful management of comprehensive school health programs and the Health-Promoting Schools Initiative, the Initiative will support the training of human and institutional resources (facilitating centers) in the Member States and strengthen associations for technical collaboration among the different countries and subregions.

The chronic scarcity of personnel (professionals in the health and education sectors) with training in school health, the high turnover of staff and workers, and the high costs of training processes, also necessitate the search for and the evaluation of strategies that are innovative and of high cost-benefit to enable the countries to increase the availability of human resources.

The healthy development of the child and adolescent population requires the satisfaction of basic needs and the acquisition of skills and competence necessary—including psychosocial skills—to negotiate with the social environment and to assume roles as adults, meaning that the dissemination and strengthening of the technical capacity to design, implement, monitor, and evaluate interventions aimed at the promotion of psychosocial competence and education in skills for life are also a priority within this Regional Initiative.

Principal lines of action:

- To identify institutions in the countries—academic institutions, government agencies, non-governmental organizations—with credibility, leadership, and experience in school health promotion to strengthen their technical capacity, management, and coordinated work as facilitating centers in their own countries and subregions.

- To promote the inclusion of the school health promotion component in the curricula of the institutions that train human resources in health and education in the Member States.

- To support the development, implementation, and evaluation of programs and innovative methodologies for the continuing education of professionals—in the health, education, and other related sectors—in the conceptual, technical, and operational aspects of school health programs.

- To establish, in collaboration with international agencies*, the Organization’s Centers, PAHO/WHO Collaborating Centers, academic institutions (Inter-American Consortium of Universities and Training Centers in Health Education and Health Promotion—CIUEPS), and other potential partners, mechanisms for higher education of health and education professionals in school health.

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* UNESCO, UNICEF, WFP, World Bank, Inter-American Development Bank, etc.
• To provide technical collaboration to the countries to improve systems and mechanisms for the accreditation of Health-Promoting Schools, based on their own criteria, priorities, and resources.

• To support the dissemination, inclusion, and evaluation of the psychosocial skills component (Life Skills) in health education programs of Health-Promoting Schools.

5.5 RESEARCH SUPPORT FOR THE DEVELOPMENT OF SCHOOL HEALTH PROGRAMS

Other priorities in this strategic plan include the promotion of research geared toward the evaluation (process and impact) of school health programs with a comprehensive perspective, the monitoring of risk behaviors and protective factors in students, and the periodic analysis (survey every two years) of the degree of progress achieved in the Health-Promoting Schools Regional Initiative in the countries.

From the standpoint of research, the expanded coverage and quality improvement of school programs in the Member States should be sustained on the broad dissemination of information based on scientific evidence, analysis and rational use of the available information at the different decision-making levels (especially the municipal level), and greater participation by the educational communities themselves in the processes of evaluation. Determining which interventions in the school setting yield the greatest benefits at the least cost is a priority, as is the dissemination of this information to support the ongoing task of advocacy and decision-making.

With this purpose of promoting and supporting school health field-applied research, the Initiative will promote mobilization of resources, creation and strengthening of strategic partnerships with different partners and potential allies, and development of research protocols.

Principal lines of action:

• To define and promote a regional agenda of priorities in applied research to comprehensive school health programs and the Health-Promoting Schools Regional Initiative, in close coordination with the countries; other Areas, Units, Representative Offices and Centers of the Organization; international cooperation agencies; academic institutions (Inter-American Consortium of Universities and Training Centers in Health Education and Health Promotion); and other potential partners.

• To collaborate with the United Nations system*, non-governmental organizations, and academic institutions for the collaborative development of research protocols and instruments to monitor risk behaviors and protective factors of the school-age population.

• To provide technical collaboration to the countries of the

* UNESCO, UNICEF, WFP, WHO, FACO, CDC, UNFPA, etc.
MOBILIZATION OF RESOURCES

Promotion of school health involves complex actions and responsibilities that are beyond the capabilities of a single sector or agency. It requires the ability to mobilize commitments and resources and negotiate multisectoral proposals.

The mobilization of resources for school health programs is closely related to the task of advocacy and the positioning of such programs in the public agenda and at the center of interest of society in general. There is a common area between these lines of action, in which innovative strategies for social communication and marketing are indispensable to increasing the global awareness of the value of health and education, as active elements in the promotion of sustainable human development, social stability, and the economic and spiritual progress of populations.

The Health-Promoting Schools Regional Initiative will continue to manage the mobilization of institutional and external resources allocated for the implementation of the strategies and lines of action proposed in this plan, for the support of the Initiative in the Member States, and for the regional management of the Initiative itself.

Principal lines of action:

• To prepare regional, subregional, and national proposals for the mobilization of international resources that contribute to the dissemination of the Health-
Promoting Schools Regional Initiative and the implementation of activities planned in the countries, based on their needs and the current status of the educational communities.

- To form and consolidate strategic partnerships with agencies of the United Nations, non-governmental organizations, the private sector, and other strategic partners, to mobilize the necessary resources to strengthen health promotion actions in the school setting in the Region and to minimize duplication of actions and overloading of professionals in the Member Countries.

### STRENGTHENING OF THE HEALTH-PROMOTING SCHOOLS REGIONAL INITIATIVE

**PLAN OF ACTION 2003-2012**

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Lines of action</th>
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| 1. Advocacy of school health programs. | • To strengthen the awareness of political leaders, those responsible for decision-making in different sectors, opinion leaders, and other strategic actors linked to non-governmental sectors, about the importance of school and health programs.  
• To increase the technical capacity of the National School Health Commissions to promote the Health-Promoting Schools strategy.  
• To develop and disseminate social communication strategies and innovative materials for advocacy activities for school health programs. |
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<tr>
<th>2.</th>
<th>Institutionalization of the Health-Promoting Schools strategy and formulation of school healthy policies.</th>
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<td>• To strengthen multisectoral consensus-building for the development of school health promotion policies and joint plans.</td>
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<td>• To promote the incorporation of the Health-Promoting Schools strategy into the educational institutions plans and projects.</td>
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<td>• To promote the dissemination, application, social auditing, and evaluation of healthy policies in the school setting.</td>
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<th>3.</th>
<th>Strengthening participation of key actors in the management of school health programs.</th>
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<td></td>
<td>• To support the creation or consolidation of the National School Health Commissions in the countries of the Region.</td>
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<td></td>
<td>• To promote multisectoral consensus-building of shared conceptual frameworks and strategic plans for the management of school health programs.</td>
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<td>• To support the creation and strengthening of the management of the National Networks of Health-Promoting Schools.</td>
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<td></td>
<td>• To strengthen the management of the Latin American and Caribbean Networks of Health-Promoting Schools.</td>
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<td>• To create and consolidate strategic interagency partnerships to strengthen the Regional Initiative.</td>
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<th>4.</th>
<th>Strengthening the technical capacity of the countries.</th>
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<td></td>
<td>• To identify available institutional resources in the Region and to strengthen their management as facilitating centers of school health promotion in different countries and subregions.</td>
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<td>• To promote the inclusion of the school health promotion component in the curricula of the institutions that train human resources in health and education.</td>
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<td></td>
<td>• To promote innovative programs and methodologies for the con-</td>
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<td>5. Research</td>
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<td>• To promote applied research about school health programs.</td>
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<td>• To develop, in collaboration with other agencies and institutions,</td>
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<td>research protocols and instruments to monitor risk behaviors and</td>
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<td>protective factors in the school-age population.</td>
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<tr>
<td>• To support the application of surveillance protocols of risk behaviors</td>
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<td>and protective factors in the school-age population.</td>
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<td>• To apply the Health-Promoting Schools regional survey in Latin America</td>
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<td>every two years.</td>
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<td>• To disseminate updated scientific research in the area of school health.</td>
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<td>• To validate the conceptual framework of the Regional Initiative,</td>
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<td>based on scientific evidence and information about the situation of</td>
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<td>school health programs in the countries.</td>
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<th>6. Mobilization of resources</th>
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<td>• To prepare regional and subregional proposals.</td>
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<td>• To develop alliances with strategic partners for the regional and</td>
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<td>subregional mobilization of resources.</td>
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BIBLIOGRAPHY


ANNEX
PARTICIPANTS IN THE
SCHOOL HEALTH
EXPERTS MEETING
WASHINGTON, DC, OCTOBER 2-4, 2002

Dr. Andy Thomas Anderson
Ontario Institute for Studies in Education
University of Toronto
252 Bloor Street West
Toronto, Ontario
M5S 1V6
Canada
Tel. 416-978-2992
E-Mail: aanderson@oise.utoronto.ca

Lic. Amanda Josefina Bravo
Coordinadora Pedagógica Nacional
Fe y Alegría Colombia
Diagonal 34 No. 4 - 94
Bogotá, Colombia
Tel. 323-7775
E-Mail: abravo@col-online.com

Mrs. Carmen Dardano Newman
Food and Nutrition Officer
Food and Agriculture Organization (FAO)
P.O. Box 631-C
Bridgetown, Barbados
Tel. 246-426-7110
E-Mail: carmen.dardano@fao.org

Dr. Carlos Dos Santos Silva
Gerente do Programa de Saúde Escolar da
Secretaria Municipal de Saúde Escolar do Rio de Janeiro/Brasil
Rua Afonso Cavalcanti, 455/850
Cidade Nova
Rio de Janeiro/RJ, Brasil
Tel. 55-21-250-32-222
Fax: 55-21-22734240
E-Mail: carlossilva@pcrj.rj.gov.br

Lic. Irene Diana Gojman
Directora de CASSA
(Centro de Asesoramiento en Salud Adolescente)
Peña 2709 7to. Piso
1425 Buenos Aires, Argentina
Tel. 4805-6217
E-Mail: irenegojman@hotmail.com

Mr. Charles Gollmar
Team Leader School Health/Youth Health Promotion
WHO/ NPH
Ave Appia 20
Geneva, Switzerland
Tel. 41-22-791-3581
E-Mail: gollmarc@who.int

Dra. María Paz Guzmán Llona
Encargada del Programa Nacional de Salud del Estudiante
Red de Apoyo al Estudiante
Ministerio de Educación (JUNAEB)
Antonio Varas, 153, Providencia
Santiago, Chile
Tel. 235-9898 ext. 226
E-Mail: mpguzman@junaeb.cl

Dra. Blanca Patricia Mantilla Uribe
Directora
Instituto PROINAPSA
Universidad Industrial de Santander
Carrera 32 No. 29-31 Piso 3º
Facultad de Salud
Bucaramanga, Colombia
Tel. 7-645-0006 - Ext.3156
E-Mail: proinaps@uis.edu.co
Sr. Alfredo Rojas-Figueroa
Oficial de Programas
UNESCO
Oficina Regional de Educación
Enrique Delpiano 2058
Santiago, Chile
Tel. 562-655-1050 ext. 43
E-Mail: arojas@unesco.cl

Dr. Antonio Sáez
Asociación Iberoamericana de Salud Escolar y Universitaria
C/Pilar de Zaragoza, No. 32-2º DCHA
Madrid, España
Tel. 34-91-725-0919
E-Mail: omepspain@ent.ucm.es

Dra. Aída Verónica Simán de Betancourt
Directora de Desarrollo Humano y Coordinadora Ejecutiva de Escuela Saludable
Secretaría Nacional de la Familia
Calle José Martí # 15, Col. Escalón
San Salvador, El Salvador
Tel. 503-263-4090
E-Mail: a.siman@primeradama.gob.sv

Mr. Kiene Werner
Representative
United Nations
World Food Programme (PMA)
2175 K Street, N.W., Suite 350
Washington, DC 20009
Tel. 202-653-2029
E-Mail: werner.kiene@wfp.org
OPS/OMS

Dr. Leonardo Mantilla
Asesor
Fe y Alegría Colombia
Carrera 8 # 49-25 Consultorio 705
Bogotá, Colombia
Tel. 2-219621
E-Mail: lmamtilla@cable.net.co

Sr. Juan Carlos Melero Ibáñez
Responsable de Prevención
EDEX / Centro de Recursos Comunitarios
Particular de Indautxu, 9
48011 Bilbao
España
Tel. 34-94-442-5784
E-Mail: prevencion@edex.es

Mrs. Paula Morgan
International Program Coordinator
Centers for Disease Control and Prevention
CDC/DASH
4770 Buford Hwy. N.E. MS-K-29
Atlanta, GA 30002
Tel. 770-488-6107
E-Mail: pmorgan@cdc.gov

Sr. Jesús A. Pérez-Aróspide García
Director del Observatorio Vasco de la Juventud
Presidente de la Fundación “Vivir sin Drogas”
Gregorio de la Revilla 22, entreplanta,
Dto. 3, 48011 Bilbao
España
Tel. 94-441-8582
Dra. María Teresa Cerqueira
Directora
División de Promoción y Protección de la Salud
Organización Panamericana de la Salud
525-23rd. Street NW
Washington, DC 20037
202-974-3243
Fax: 202-974-3640
E-Mail: cerqueim@paho.org

Dr. Ernest Pate
Coordinador
Programa de Salud de la Familia y Población
División de Promoción y Protección de Salud
525 Twenty-third St, NW
Washington, DC 20037
Tel: 202-974-3466
E-Mail: pateerne@paho.org

Dra. Josefa Ippolito-Shepherd
Asesora Regional en Educación para la Salud
Programa de Salud de la Familia y Población
División de Promoción y Protección de Salud
525-23rd. Street, NW
Washington, DC 20037
202-974-3639
Fax: 202-974-3631
E-Mail: ippolitj@paho.org

Dr. Lenor Amstrong
Student Intern
Health-Promoting Schools Regional Initiative
Family Health and Population Program
Division of Health Promotion and Protection
525-23 Street, NW
Washington, DC 20037

Ms. Christine Bocage
Nutritionist
Caribbean Food and Nutrition Institute
c/o UWI, Augustine
Trinidad
1-868-663-1544
Fax: 1-868-663-1544
E-Mail: cfni@cablenett.net

Ms. Patricia Brandon
Adviser in Health Promotion and Health Education
PAHO Office of the Caribbean Program Coordination
Dayrells, St. Michael, P.O Box 508
Barbados
246-426-3860
Fax: 246-436-9779
E-Mail: brandon@cpc.paho.org

Lic. Lourdes Mindreau
Asesora, Atención Primaria Ambiental
CEPIS/OPS
Los Pinos 259 Urb. Camacho-La Molina
Lima, Perú
511-437-1077
Fax: 511-437-8289
Lic. Veronika Molina
Gerente Educación
INCAP/ OPS
PO Box 1188
Guatemala, Guatemala
502-440-9722
Fax: 502-473-6529
E-Mail: vmolina@incap.ops-oms.org

Lic. Karina Cimmino
Consultora
Health-Promoting Schools Regional Initiative
Family Health and Population Program
Division of Health Promotion and Protection
525-23 Street, NW
Washington, DC 20037
Health Promoting Schools

Strengthening of the Regional Initiative

Strategies and Lines of Action 2003-2012