This book presents an international perspective on health education and specifically the influence that context has on this aspect of education. The focus includes both formal and non-formal health education and the factors that impact upon its effectiveness, particularly in non-Western and non-English-speaking contexts (i.e., outside the UK, USA, Australia, NZ, etc.). An important feature of the book is that it draws upon the experiences and research of local experts, representing the perspectives of an extremely diverse cohort across the world (22 countries and 2 regions in total). The book addresses topics such as: the development and implementation of health education in different countries; the influence of political, cultural, societal or religious mores; governmental or ministerial drives; economic or other pressures driving curriculum reform; and the influence of external assessment regimes on health education. By embedding discussions of health education in local contexts and representing a diversity of perspectives on this important topic this book highlights both barriers and enablers to improving health education across the globe.
Health Education in Context
Health Education in Context: An International Perspective on Health Education in Schools and Local Communities

Editors

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# TABLE OF CONTENTS

Preface and Overview
1 Health education in context: An overview, and some observations  
*Neil Taylor, Frances Quinn, Michael Littledyke & Richard K. Coll*

Pacific
2 Whole school approaches to health promotion: The Pacific journey  
*Sereana Tagivakatini & Temo K. Waqanivalu*

Middle East and Gulf
3 Health education in the Sultanate of Oman: Towards sustainable health for students  
*Abdullah Ambusaidi & Sulaiman Al-Balushi*

4 Health education through extracurricular activities in Lebanon: Process and challenges  
*Mayada Kanj*

Europe
5 Health education in Portuguese schools: The contribution of the health and education sectors  
*Graça S. Carvalho*

6 The possibility of health education in an education-based society: The case of Hungary  
*Magdolna Chrappán*

7 An overview of formal and non-formal health education in Turkey  
*Muammer Çalik & Gamze Çan*

8 Education for healthy lifestyles in the European north of Russia: Developments and dilemmas  
*Marina Gvozdeva & Valentina Kirilina*

9 The role of education in preventing diseases: A case study from Poland  
*Joost Platje & Krystyna Slodczyk*

Africa
10 Lifting the lid on HIV/AIDS and tuberculosis in Malawi  
*Gilbert R. Phiri*

11 Medical research in South Africa: Education and ethics  
*Francesca Conradie*
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Author(s)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>The development of the school health policy and curriculum in Nigeria</td>
<td>Olawale A. Moronkola</td>
<td>107</td>
</tr>
<tr>
<td>13</td>
<td>The child-to-child curriculum in East Africa (Kenya and Tanzania):</td>
<td>Henry Sammy Wanyama &amp; Kalafunjia Mlang’a O-saki</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Strengths, challenges, and weaknesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Health education in Ethiopia: Practices, challenges, and prospects</td>
<td>Frehiwot Wubshet &amp; Temechegn Engida</td>
<td>123</td>
</tr>
<tr>
<td>15</td>
<td>The status of health education in Namibian schools</td>
<td>Choshi D. Kasanda, Maria Charlotte Keyter, &amp; Donovan Zealand</td>
<td>133</td>
</tr>
<tr>
<td>16</td>
<td>Environmental problems and their impact on people’s health: The Nigerian context</td>
<td>Josiah O. Ajiboye &amp; Folashade Afolabi</td>
<td>145</td>
</tr>
<tr>
<td></td>
<td>South Asia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Promoting healthy ageing: Experience from tea estate communities in</td>
<td>Wendy R. Holmes &amp; Jennifer Joseph</td>
<td>153</td>
</tr>
<tr>
<td></td>
<td>Sri Lanka</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Educating Indian children about the impact of climate change on health</td>
<td>Shyamala Mani, D. K. Banerjee, Divya Pant, Priyanka Porwal, &amp; Shefali Godura</td>
<td>163</td>
</tr>
<tr>
<td>19</td>
<td>Health education in primary schools in Pakistan: Perils and promises</td>
<td>Sadia Muzaffar Bhutta</td>
<td>171</td>
</tr>
<tr>
<td>20</td>
<td>Health and sex education in India: The collapse of a policy</td>
<td>Mala Sharda &amp; Mike Watts</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>East Asia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Malaysian traditional knowledge and herbal gardens: Informal education on plant resources for health</td>
<td>Noor Azlin Yahya &amp; Nor Azah Mohd. Ali</td>
<td>191</td>
</tr>
<tr>
<td>22</td>
<td>Supporting health education in Thai contexts: Conceptualizing and evaluating the change</td>
<td>Tussatin Kruatong &amp; Chanyah Dahsah</td>
<td>199</td>
</tr>
<tr>
<td>23</td>
<td>Priorities for health education in Hong Kong in relation to non-communicable diseases</td>
<td>Emmy Man Yee Wong &amp; May May Hung Cheng</td>
<td>211</td>
</tr>
<tr>
<td>Page</td>
<td>Title</td>
<td>Author(s)</td>
<td>Page</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>24</td>
<td>Working towards a healthier Brunei</td>
<td>Irene Poh-Ai Cheong</td>
<td>223</td>
</tr>
<tr>
<td>25</td>
<td>Integration of Health Education for Sustainable Development: Sabah’s Initiatives</td>
<td>Mohd. Zaki Ishak &amp; Hamzah Md. Omar</td>
<td>235</td>
</tr>
<tr>
<td>26</td>
<td>Mental health education and training in Vietnam: The role of clinical psychology</td>
<td>Hoang-Minh Dang &amp; Bahr Weiss</td>
<td>243</td>
</tr>
</tbody>
</table>
1. HEALTH EDUCATION IN CONTEXT

An Overview and Some Observations

INTRODUCTION

This book presents a range of international perspectives on the development and implementation of health education. It is the third in a series that has previously explored science education and environmental education in largely non-Western contexts, particularly those in developing countries. The obviously strong links between science, the environment, and health mean there is considerable overlap in aspects of education relating to these three areas. Also, because health is influenced by lifestyles and the environment people live in, and because people’s lifestyles and consumer habits directly affect the environment, health is a key aspect of sustainable development.

Despite enormous advances in health and medicine in recent times, significant challenges still exist, especially in developing countries where resources are often limited. Since the advent and recognition of HIV/AIDS in 1981, the disease has spread to infect more than 33.3 million people worldwide, with the greatest incidence of infection occurring in sub-Saharan Africa (United Nations, 2010). The enormous social and economic toll that this epidemic exacts on countries means that it tends to receive a high profile in the media. However, HIV/AIDS sometimes overshadows other important health issues of much longer standing. For example, more than one billion people are infected with soil-transmitted helminthes, for example, hookworms, while about 200 million people are infected with parasitic waterborne worms (schistosomes), which cause the chronic and debilitating disease known as bilharzias (Focusing Resources on Effective School Health, 2011). About 225 million cases of malaria occurred worldwide in 2009, with associated deaths of about 781,000 people, many of whom were children from sub-Saharan Africa (World Health Organization, 2010a). Much of the disease burden in developing countries is associated with wider problems, including poor environmental hygiene, poverty, and inadequately resourced or staffed health services (World Health Organization, 2010b).

Furthermore, the growing middle class in many developing countries is associated with the emergence of more chronic health issues related to lifestyle choices. Over the past few decades, diabetes, heart disease, and obesity have become much more prevalent as individuals move away from traditional
low-energy diets and embrace high-energy convenience foods. This change is often accompanied by an increase in more sedentary lifestyles. These lifestyle changes are also affecting children in these countries, with Southeast Asia, the Pacific Islands, the Middle East, and China facing the most serious threat (Hossain, Kawar, & El Nahas, 2007). Moreover, issues relating to mental health and wellbeing are receiving increasing attention outside of Western contexts.

A considerable body of research highlights the relationship between children’s health and their social and educational outcomes. The literature also notes the reciprocal benefits of access to quality education on individual and family health status (see, for example, Basch, 2010). While medical advances can play a significant role in improving health outcomes, education at the school and community level is also crucial in promoting the measures that are so important in preventing and thereby reducing the incidence of many diseases and other health problems.

Against this background, this book explores developments in health education in the formal and non-formal sectors of non-Western countries (loosely interpreted to include countries outside of the English-speaking block of the UK, USA, Canada, Australia, and New Zealand). The intention is to provide the reader with a picture of the developments that are taking place in health education across a range of countries and about which little has been written.

THEORETICAL BASIS OF THE BOOK

As with the previous publications in this series, the theoretical basis to this book is derived from sociocultural theories of learning championed by authors such as Vygotsky (1986) and Wertsch (1991). Sociocultural views of learning place considerable emphasis on the social component within the particular context or situation in which learning occurs. The basic tenet of a sociocultural approach is that human mental functioning is inherently situated in social-interactional, cultural, institutional, and historical contexts. This, to some extent, explains the various taboos associated with many health issues in both Western and non-Western contexts. Beliefs about how diseases are contracted can often be scientifically inaccurate but may be advocated by large sectors of societies and cultures. Furthermore, what is accepted as treatment practice in one context may be rejected in another.

ABOUT THE CONTRIBUTORS

The book draws upon the experiences and research of local experts from an extremely diverse cohort across the world. It is intentionally diverse in its approach to health issues and education. Most authors provide a broad overview of the major health challenges specific to their country or region. Some continue this overview approach by examining the major national developments in formal and non-formal health education, while others focus on specific health education case studies. Some chapters take the form of a story or narrative; others draw from particular
research inquiries conducted by authors and their colleagues. Many of the stories contained in this book highlight the interplay between social, political, economic, and environmental matters and the health issues people are experiencing. That they do makes evident the need for policymakers and practitioners to attend to these interlinked aspects of the health context when determining interventions and education aimed at improving health outcomes, and when securing funding for these initiatives.

Between them, the book’s authors address many topics. The following list is but a sample: the content of health education (HE) and its integration into national and school curriculums, the impact of formal and non-formal HE programs, the influence of political, cultural, societal, and religious mores on HE, and tensions between government ministries (in particular health and education) for ownership of HE.

We (the book’s editors) have made a conscious effort to allow the contributors’ own voices to be heard. This book represents their stories, not ours.

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2. WHOLE SCHOOL APPROACHES TO HEALTH PROMOTION

The Pacific Journey

The Pacific region consists of 22 countries and areas (excluding Australia, New Zealand, and Hawaii). Its total population is approximately nine million people, living on land masses encompassing 551,684 square kilometers and situated within a vast area of ocean. The number of people per country range from around 1,500 in Niue to approximately six million in Papua New Guinea (PNG), which has the largest population in the region.

![Pacific Islands Map](http://www.tropicalresortjobs.com/map)

Source: [http://www.tropicalresortjobs.com/map](http://www.tropicalresortjobs.com/map)

The Pacific is plagued with lifestyle and non-communicable diseases such as obesity, diabetes, heart disease, and cancer, which together are responsible for 75% of all deaths, most occurring prematurely (before people reach age 60). There is a high prevalence of risk factors for these diseases. In some countries, up to 95% of the population in the 25- to 64-year-old age group is overweight, more than 50% smoke cigarettes, and most people do little physical activity (WHO NCD STEPS Survey in the Pacific 2002–2009).

Health and health education in Pacific schools was traditionally left to visiting school clinic nurses and dental teams, who carried out inspection and

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monitoring activities, and to classroom teachers, as a curriculum subject. As such, little was done to ensure that the health of students was actively supported and promoted in schools and the wider school community. This situation changed with the introduction of the health promoting schools (HPS) concept to the Pacific in the early 1990s, a concept that gained credibility because of increased understanding that children’s health is a major factor affecting their capacity to learn.

The HPS concept is thus seen to offer advantages. One is that health promotion is more effective if it targets children before (hopefully) they have opportunity to develop unhealthy habits. The second is that because schools are a central part of Pacific communities, access to those communities and significant proportions of Pacific Islanders is made relatively easy. Schools in the Pacific typically bring parents, government agencies, school authorities, and key health and education stakeholders together in the interests of the education of their children. Hence, it is not surprising that many Pacific countries chose schools as settings for “healthy islands” within the context of the World Health Organization’s (WHO) themes in the late 1990s of Preparation for Life and Protection of Life (Erben, 1998).

WHO’s definition of a health promoting school as “a school that is constantly strengthening its capacity as a healthy setting for living, learning and working” (WHO, 1998, p. 2) positioned schools as a place where all members of the school community could work together to promote and protect health among students, staff, families, and the members of wider societies. The principles and practice of HPS also aligned with application of international declarations such as Health for All by Year 2000 and Education for All, sentiments that Pacific nations embraced.

The HPS concept furthermore supported proactive and preventative measures that many ministries of health in Pacific countries were beginning to welcome. These measures included, amongst others, raising awareness about non-communicable diseases, conducting anti-smoking campaigns, and providing information about HIV/AIDS. However, ownership of these initiatives tended to remain exclusively with the health sectors. Partnerships between ministries of health and ministries of education were the exception rather than the rule. This disjunction has been acknowledged in more recent years, and efforts have been made at regional and national levels to address it.

The focus on health promotion received considerable support from the WHO Regional Office for the Western Pacific (WPRO), which outlined three key strategies for maintaining the initiative over the long term:

- Build supportive policies and links to other health initiatives;
- Collaborate with countries in order to advance the development of HPS; and
- Facilitate training directed at ensuring implementation, monitoring, and evaluation of activities and establishment of HPS-related networks and partnerships, especially with the United Nations and regional organizations.
DEVELOPMENT OF HEALTH PROMOTING SCHOOLS IN THE PACIFIC REGION

At the regional level, the Pacific states are grouped with Asian countries under the WHO Regional Office for the Western Pacific (WPRO) banner. In 1993, the health promotion program for the Pacific region focused on settings through which the program could be supported and implemented. The Pacific states, especially, endorsed schools as settings for this initiative, given that schools are, as noted above, such an integral part of their communities. The policy document *New Horizons in Health*, developed in 1994 by WPRO (WHO, 1995a), assisted member countries to clarify and position health promotion and protection as central features of health programs. A discernible shift in focus from curative to preventative approaches was soon apparent in relation to health initiatives. It may even be fair to say that because of this paradigm shift, every citizen in the region can now find a foothold that will allow him or her to take more responsibility and action with respect to health promotion.

The publication of the *New Horizons in Health* document was followed by a workshop on school health promotion in 1994 in Sydney, Australia (WHO, 1995b). The workshop created urgency and impetus for the development of HPS within the Pacific member states of the region. A similar workshop held soon after in Singapore focused on developing HPS in the northern part of the Western Pacific region. Parallel to and in support of these initiatives, the ministers of health in the Pacific countries expressed their commitment to the Healthy Islands concept via the Yanuca Island Declaration (WHO, 1995c), thereby raising the platform for priority national action in member countries.

Participants at the Sydney workshop welcomed and supported the development of HPS proposed by WHO under the theme *New Horizons in Health, Preparation for Life*. Twenty-seven countries in the Pacific region expressed interest in collaborating to promote school-based health. The outcome of the workshop was an eight-point proposal for guiding further work on the HPS initiative. The following recommendations were put forward:

1. Gain a better understanding of the needs of school students;
2. Engage in effective teaching for health;
3. Foster a healthy school community;
4. Create a supportive school environment;
5. Reorient school health services;
6. Engage families and communities;
7. Develop and implement health-supportive public policy; and
8. Draw on international support and develop networks.

Donor agencies were encouraged to support the implementation of the recommendations, especially in terms of helping build local capacity and expertise, sponsoring country coordinator positions and projects designed to establish HPS, supporting the development of a clearinghouse for health-promotion resource materials, and conducting in-country research.

In October 1995, WHO/Manila and the Institute of Education at the University of the South Pacific (USP) jointly organized and hosted a follow-up workshop,
which was held in Suva, Fiji. Twenty-three participants representing health and education ministries from 17 countries in the region attended. The workshop resolved to:

- Develop national HPS committees and identify national focal points;
- Develop a HPS manual to assist in implementing HPS; and
- Establish national networks and a regional network to support HPS.

The workshop participants appointed the University of the South Pacific’s Institute of Education as the focal point from which to coordinate the regional HPS network. The Fiji-based steering committee that was subsequently formed included representatives from regional organizations and key stakeholders in health and education in Fiji. Representation on the committee also came from the United Nations Children’s Fund (UNICEF), WHO, the Secretariat of the Pacific Community (SPC), the Fiji Ministries of Health and Education, the Fiji Trilateral Health Project, the Fiji National Food and Nutrition Committee, and the South Pacific Action Committee on Human Ecology and the Environment.

New Zealand’s Official Development Assistance Programme provided the seed funding necessary to set up the regional support network for HPS and to assist the network implement its planned activities. These activities included in-country workshops and purchase of resources. The network’s primary focus was to enhance implementation of HPS in the region. It therefore sought to provide professional and material support to its members.

After a decade of activities across the region, an opportunity to scale up the HPS work occurred when WHO officials were invited to give a presentation at the Forum of Education Ministers meeting in October 2006 in Nadi, Fiji. During this forum, the ministers passed resolutions promoting health as an essential element of growth, learning, and education. More specifically, they endorsed the following initiatives:

- Adoption and implementation of HPS in their respective countries as a mechanism to strengthen the inextricable link between health and education and to take advantage of the considerable opportunity for health and education ministries to work together to meet the common goal of ensuring generations of youth who are healthy and productive;
- Establishment of HPS as a workshop discussion theme during the next Forum of Education Ministers meeting, with this work being conducted in collaboration with the Pacific Regional Initiative on Development of Basic Education (PRIDE), and with WHO personnel acting as facilitators;
- Incorporation of health as an additional benchmark indicator in the educational strategic plans of Pacific countries, with this process being exercised through the PRIDE project;
- Close collaboration and partnership between the ministries of education and health in the participating countries in order to realize national strategies;
- Ongoing advocacy for closer collaboration between education and health agencies at the country level as well as at the regional level in association with
personnel from WHO, the SPC, and the PRIDE project, as well as from other regional agencies;

- Encouraging donors, governments, and non-governmental organizations to work toward operationalizing regional and country-level cooperation.

The sub-regional workshop was conducted at Griffith University in Brisbane, Australia; 15 country representatives from the education and health sectors attended. The workshop resulted in most countries strengthening the partnerships between their respective ministries of health and education. It also led to the establishment of a memorandum of understanding between the two ministries in the Cook Islands, Fiji, the Marshall Islands, the Federated States of Micronesia (FSM), and Nauru. Soon after, increasing numbers of schools from the 15 countries began adopting the HPS concept and creating plans for implementation. Networking was strengthened further through dissemination of regular newsletters and establishment of the Pacific Health Promoting Schools (PacHELPS) website (http://www.pachelps.org/).

HEALTH PROMOTING SCHOOLS MANUAL

The HPS manual (Pacific Network of Health Promoting Schools, 1997) for the Pacific region that was written and distributed after the 1995 workshop provided practical suggestions for getting HPS programs underway at both national and school levels. The manual also provided guidance on actions relating to six key areas identified during earlier HPS work in other regions of the world, namely, school health policies, the physical environment, the social environment, community relationships, personal health skills, and school health services. Some of the procedures featured in the manual follow. The first set of items given here relate to national actions, with ministries and departments of education and health asked to:

1. Jointly endorse the HPS concept and regional guidelines for action;
2. Select a national coordinator (preferably from the education sector);
3. Select a national advisory committee consisting of representatives of the education and health sectors, the unions, WHO, UNICEF, SPC, non-governmental organizations, and other agencies as appropriate;
4. Select schools within which to pilot HPS or invite schools to apply to be a pilot school;
5. Identify goals and objectives for the national committee;
6. Conduct a survey of the national health status of school children;
7. Declare a health day or health week.

This next set of items covers school-based actions. Each participating school was asked to:

1. Have the head teacher/principal, teacher, or national HPS coordinator explain the HPS concept to staff, student representatives, members of the school committee, and parents;
2. Elect a coordinator;
3. Widely communicate the decision to become a HPS;
4. Form a HPS committee comprising representatives from the school and the community;
5. Set goals and guidelines for the school;
6. Write an action plan;
7. Draw up a school health calendar;
8. Implement the action plan and monitor and publicize progress;
9. Evaluate action plan outcomes;
10. Enter Phase 2 of the project.

SUPPORTING THE COUNTRIES

WHO consistently continued to support the Pacific countries in their effort to implement HPS throughout the schools of the region. This support included the development of materials such as the regional guidelines, which were finalized in 1996 (WHO, 1996) and distributed to Pacific schools. The regional HPS network coordinator visited Kiribati, Nauru, FSM, the Marshall Islands, the Solomon Islands, Vanuatu, and Fiji to assist the establishment of national HPS committees and to provide training in formulating and integrating projects into school activities and/or to revitalize national or school efforts.

A survey of the extent to which the participating countries were building on or linking up with existing programs and activities revealed that much was already happening but that the efforts were largely being carried out in isolation and without consultation with other key players in school health. Accordingly, WHO increased its efforts to support countries in their efforts to secure links with existing programs and to limit duplication of (i.e., consolidate) activities.

One key initiative that the HPS national programs were able to capitalize on was that of the Australia–South Pacific (ASP) 2000 Sports Program, which at least eight Pacific nations adopted. However, the cessation of the coordinator position slowed down the momentum in regards to networking and activities.

REGIONAL NETWORKING

The regional HPS network was also represented at subsequent workshops, notably the SPC’s Development of Indicators for Health Promotion workshop held in Noumea (New Caledonia) in December 1998, and the Healthy Islands Meeting workshop organized by WHO and held in Suva (Fiji) in February, 1999. The inclusion of HPS network representatives in forums that had traditionally been limited to health personnel and health programs was a positive sign of sector collaboration between health and education in the region.

By this time, information sharing had become an added dimension of the HPS network. For example, countries were now documenting their experiences for circulation to others through a newsletter and gaining greater awareness of and ideas for resources and activities, such as the comprehensive school program in the Republic of Palau, which included school health screening, dental care,
development of a health curriculum, coordination of health promotion, in-service training for teachers and nurses, and sports training.

EXAMPLES OF HPS INITIATIVES FROM SELECTED COUNTRIES

Fiji

Fiji signaled its commitment to the HPS concept in the mid-1990s by setting up school health teams charged with planning and monitoring HPS activities in the country’s 374 kindergartens, 700 primary schools, and 147 secondary schools. The activities included health-based advice, inspection and monitoring of school lunches, personal hygiene, dental health, height to weight ratios, environmental sanitation, school gardening, and district workshops. During the late 1990s, Fiji also extensively revised its senior primary school curriculum, a process that provided an excellent opportunity for including HPS issues and concepts in classroom programs.

Another initiative implemented around the same period was the Australia–Fiji Healthy Islands program, which subsumed the Kadavu Rural Health Project that ran from 1994–1997 (Roberts, 1997). Even though the project was embedded in the activities of the Ministry of Health, its primary health care approach meant its reach extended into rural administrative systems and communities, providing much needed support for HPS to build on. The health and safety awareness policies and campaigns that the government ran under the program helped keep schools free of health risks for those attending them.

In 2009, teachers from selected schools were invited to attend a national HPS workshop in order to help them implement the program in their schools. The Ministry of Education and Ministry of Health also signed a memorandum of understanding to strengthen the implementation of HPS in Fiji.

More recently, national school nutrition policy and canteen guidelines have been produced for use in participating HPS schools. Another pleasing development is that of schools that had volunteered to take part in research focused on obesity prevention in the community signing up for the HPS program.

Republic of the Marshall Islands

At the time the HPS program was being promoted throughout the Pacific region, the Republic of the Marshall Islands already had in place a policy regarding school education on HIV/AIDS and sexually transmitted infections, and it was field testing modules containing information on these matters in selected schools. As such, it was already attuned to issues of school health.

In July 1996, the nation’s Ministry of Health and Environment introduced the HPS concept to 40 school principals, school supervisors, and elementary school teachers, in the presence of assistant secretaries of education. The initiative was immediately taken up by the Ministry of Education as a priority area of focus for schools. In August 1996, health education officers presented their HPS
groundwork to the Pacific Educational Conference 1996, thereby generating interest in sharing information with other Pacific nations and territories. At the beginning of the 1996/1997 school year, staff from the Ministry of Education and Ministry of Health and Environment visited schools where they distributed fluoride tablets and Vitamin A capsules, conducted a de-worming program, measured students’ heights and weights, and conducted programs designed to raise awareness of health issues. Schools also started clean-up activities in their grounds and their communities. These nationwide health initiatives provided good entry points for implementing HPS in each school. Somewhat later, seven schools on the atolls of Majuro and two on Ebeye began developing and implementing health plans of their own, with these encompassing issues particular to these communities.

**Niue**

At the time the HPS concept gained the attention of Pacific nations, Niue had a number of initiatives running that complemented HPS very well. The WHO-supported ASP 2000 Sportstart program called Junior Sports had been in place since 1995. Niue was also one of the participants in the Australian Government’s Overseas Aid Program, the AusAID-funded Healthy Islands program. Members of the nation’s eventual HPS committee, drawn from Niue’s two schools, also participated in the national committee for that program.

Under the HPS umbrella, Niue carried out compulsory health checks of all students and instituted healthy food policies in the country’s two schools. Action plans drawn up for the schools were implemented at both schools. Niue also completed the Global School-Based Student Health Survey, a surveillance tool developed by WHO in order to aid evaluation of HPS activities. Niue was the first country to conduct the survey.

**Palau**

In Palau, the Ministry of Health and the Ministry of Education formally agreed to establish a HPS program. One of the program’s first activities was a survey of all high school students and 20% of elementary school students in order to provide baseline data for the program. Subsequent activities included training and certifying a “school-based” nurse to work with the national health promotion coordinator, establishing a “dispensary-based” nurse as a contact person for the outlying villages, and completing a computerized database containing health information on all students in Palau. The aim of the last of these three activities was to facilitate information exchange about immunization and other health matters between the Ministries of Health and Education. The first school audit and assessment of the HPS implementation and monitoring began in January 1997.
Samoa

Samoa already had a history of health education in schools, but this was reinvigorated by the prospect of developing this area of education into a HPS initiative. A national HPS committee was set up, with the national coordinator and chair selected from the senior ranks of the Department of Education, and with the chief health educator of the Department of Health assisting as technical adviser.

In September 1995, a week-long in-service training program for teachers was held under the banner, School Health in Transition to HPS. Key stakeholders in primary schools, school inspectors, and district nurses were trained and introduced to WHO’s HPS guidelines. Further workshops were held for HPS stakeholders, culminating in a national HPS symposium in May 1997.

Over time, the national HPS committee has organized a number of activities, among them the following:

- National School Boys’ Under-17 and Under-19 Smoke-free Rugby Tournament, May 1996;
- National School Girls’ Smoke-free Netball Tournament, May 1997, in collaboration with the Samoa Rugby Football (School Boys’) Union and the Samoa Netball Association; and
- The WHO-supported ASP 2000 Sportstart program called FiaFia Sport.

The committee was also instrumental in securing Samoa’s participation in the AusAID-funded Healthy Islands program, one focus of which was HPS. A significant milestone for Samoa with respect to HPS was the government’s decision to include funding for the initiative in the nation’s 1998/1999 national budget.

Tonga

Tonga has a long-standing health education program as well as involvement in school gardens and healthy school-compound projects. Health studies are compulsory for Forms 1 and 2 students in all schools. After Form 2, health is incorporated in home economics studies. A broad cross-section of people from government and community agencies are involved in school health promotion.

The Ministry of Health and the Ministry of Education agreed to jointly carry out a health behavior study of schoolchildren. Around the same time, Tonga’s parliamentary cabinet approved implementation of a “health and weight awareness program” as part of fitness instruction in Nuku’alofa primary schools. The program, which was initiated by Tonga’s Central Planning Department and Ministry of Education, included fitness instruction, health promotion (through the medium of television), aerobics competitions, and development and distribution of education materials.

Follow-on activities within primary schools since that time have included those aligned with Tonga’s National Weight-loss Competition and with information drawn from the country’s National Nutrition Survey. Tonga also went on to develop a National Food and Nutrition Policy and a National Plan of Action for
Nutrition. (UNICEF assisted this initiative in 1997.) The country also participated in the Healthy Islands project, which included HPS activities.

**Cook Islands**

The Cook Islands reinvigorated its HPS-related work when it conducted a curriculum review in 2004, commensurate with the signing of a memorandum of understanding between the Ministry of Education and the Ministry of Health. The memorandum resulted in development the Cook Islands Health and Physical Well-being Curriculum, the content of which is based on two key questions:

- What does being healthy mean to you?
- What makes it hard to be healthy in the Cook Islands?

All schools were required to develop a plan setting out how they would implement the two essential learning areas of the curriculum. They have also, since that time, been required to produce a biannual health education long-term plan and an annual physical education long-term plan.

As part of its implementation of the curriculum document, the Ministry of Education and the Ministry of Health have continued to work closely together in many different ways. One example is a pilot project which aims to address obesity through encouraging physical activity and sport at school.

**CONCLUSION**

The shift in approach from health education to health promotion across the island nations of the Pacific has placed greater responsibility on schools, teachers, and administrators to create environments, relationships, and policies that support HPS. The success of health promotion can be measured in terms of the extent to which it becomes integrated into national governments’ planning and funding, into ministry of education policies and priorities, and into school ethos, behavior, and activities. There is great hope throughout the Pacific Islands for the continued success of HPS. But this success relies on all participants, especially children, being empowered to make and act on decisions that promote their health and the health of those around them. Realizing this state of affairs should lead to generational changes that will ultimately help the Pacific nations achieve their vision of healthy islands populated by healthy people.

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