

# Promoting Health in Second Level Schools in Europe: A Practical Guide

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**PROMOTING HEALTH IN SECOND LEVEL SCHOOLS IN EUROPE:  
A PRACTICAL GUIDE**

**OVERVIEW OF GUIDE**

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**CONTRIBUTORS & ACKNOWLEDGEMENTS**

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## **INTRODUCTION**

### **Purpose of the Guide**

This Guide is designed to help school health education project managers. It aims to support them in developing, planning, implementing and evaluating health promotion programmes in second level schools in Europe. It could be used as a form of resource material for the development of health promotion in schools generally, but it is of particular use in supporting programmes which address the issue of cancer prevention.

The Guide will provide school project managers or health education coordinators with:

- a discussion on the basic concepts and principles underpinning contemporary health promotion.
- definitions of some of the key terms in health promotion.
- help in understanding the management of change within the school environment.
- an indication of the need to develop coordination and means to implement new programmes.
- support in short and long term goal setting.
- guidelines on the audit and review process.
- an understanding of the main principles of evaluation.

At certain points throughout the guide we have included practical activities. These could be used just by you, the reader, to help clarify your thoughts and priorities. However they are probably best used with colleagues, either informally or in a meeting, to make sure that everyone is starting from the same base, to discuss differences in opinions and values, and to make effective action plans.

1

2

In addition the Guide illustrates seven practical case studies relevant to cancer education.

These case studies highlight how individual schools across member states in Europe have developed, implemented and evaluated projects in health promotion. Key learning points are identified. We hope these case studies will offer you ideas for projects in your own school.

The Guide carries a limited list of references and suggested reading for coordinators, project managers and teams to follow up ideas in more detail.

The concept of the health promoting school was born at a European Seminar in 1980, and has grown in popularity such that it is now a widely accepted model for school health education. The 'Health Promoting School' embraces three essential elements -teaching programmes, the school environment and the wider community. Because of this wide spectrum, schools can choose from a variety of starting points and alternative actions. This guide offers examples.

Readers of this Guide should be aware of three current parallel projects which support the idea of promoting and researching the health of young people in Europe.

1. The European Training Manual
2. The European Network of Health Promoting Schools
3. The Health Behaviour in School Children Study

These are referenced at the end of the Guide.

### **Background to the Guide**

The Europe Against Cancer Programme was launched in 1985 as an initiative of the European Community, its major goal being the organisation of preventive actions against cancer throughout its 12 Member States.

In February 1990, the Europe Against Cancer Programme organised its first European Conference on Health Education and Cancer Prevention in Schools. This conference in Dublin proved to be a watershed for European School Health Education, bringing together experts in school health education and cancer prevention from each Member State. One of its fundamental and unanimously agreed resolutions was that cancer prevention should be set firmly within the broader framework of school health education and the health promoting school. In particular it was recommended that school programmes should emphasise those key elements of lifestyles open to influence during the pubertal and adolescent years such as the use of drugs - particularly tobacco and alcohol, nutrition, protection from sunlight and sexual behaviour.

A key recommendation of the Dublin Conference was that the Europe Against Cancer Programme should support the development of guidelines in the management of health promotion in secondary schools. These guidelines would address the planning, implementation and evaluation of school programmes and projects. Cancer related issues, such as tobacco and nutrition, would be used, where possible, to illustrate some of the basic principles of health education and the health promoting school.

A second European Conference on Cancer Prevention and Health Education in Schools was held in Dublin in November 1994. This Conference recommended in particular "the development of materials which provide concepts, frameworks and guidelines, rather than complete and finished works. These would provide common starting points for national experts to develop materials best suited to their own culture and needs.

The present Guide is the outcome of these conferences and associated discussions.

## **Adaptability**

This Guide is the product of a team of practitioners from different Member States of the Community. Because of our different backgrounds, roles, and cultures, it has been important to clarify the concepts and terms which we used. This has been no easy task!

Educational systems vary from country to country. Schools are organised differently. The role of teachers may vary. The way that health education is carried out will differ. Not all countries in Europe have a statutory health education curriculum. It follows that schools will have different starting points and priorities as regards health promotion. The illustrations or case studies, included in this guide, give a flavour of these variations.

Although you may at times be surprised by the use of an unfamiliar term or practice, we hope that you will not be put off by this. You may need to change a few words or terms (e.g. curriculum to programme, or co-ordinator to project manager), but we hope that the sense of the Guide will remain true for practitioners throughout Europe.

**Our major concern is to encourage you to think about how the ideas in the Guide can be applied, bearing in mind your own local conditions, practices and cultural norms.**

## **The "Europe Against Cancer" Programme and Health Education in Schools**

More specifically, as regards cancer prevention, the European Code Against Cancer has been developed as a synthetic and scientifically valid series of preventative messages, validated by the European Union High-level Committee of Cancer Experts. The ten messages of the Code are set out below. An information note on the Code is set out in Appendix 2 to the Guide.

## EUROPEAN CODE AGAINST CANCER

**Certain Cancers may be avoided and general health improved if you adopt a healthier lifestyle.**

1. Do not smoke. Smokers, stop as quickly as possible and do not smoke in the presence of others. If you do not smoke, do not experiment with tobacco.
2. If you drink alcohol, whether beer, wine or spirits, moderate your consumption..
3. Increase your daily intake of vegetables and fresh fruits. Eat cereals with a high fibre content frequently.
4. Avoid becoming overweight, increase physical activity and limit intake of fatty foods.
5. Avoid excessive exposure to the sun and avoid **sunburn** especially in childhood.
6. Apply strictly regulations aimed at preventing any exposure to known cancer-causing substances. Follow all health and safety instructions on substances which may cause cancer.

**More cancers may be cured if detected early.**

7. See a doctor if you notice a lump , a sore which does not heal (including in the mouth), a mole which changes in shape, size or colour, or any abnormal bleeding.
8. See a doctor if you have persistent problems, such as a persistent cough, persistent hoarseness, a change in bowel or urinary habits or an unexplained weight loss.

**For women**

9. Have a cervical smear regularly.
10. Check your breasts regularly. Participate in organized mammographic screening programmes if you are over fifty.

From its inception the Programme has targeted young people, particularly those of school age and especially in the context of tobacco use, nutrition and protection against the harmful effects of the sun.

## **CHAPTER 1**

### **CONCEPTS**

#### **Summary**

This chapter, having enabled the reader to clarify various concepts related to the health promoting school, explains why the school is a relevant place for this work to be implemented.

The focus shifts to the importance of both pupils' participation and the nature of interaction between the school and the community it serves.

This leads finally to a consideration of the importance of coordination in health promotion work.

#### **The First Step**

The first step in developing any initiative is to clarify the values on which it is based. Are you clear about the beliefs which underpin your view of a health promoting school and how do these compare with those of your colleagues? Unless this is discussed, you may find that you are pulling in separate directions, with no clear vision or sense of purpose.

It is important to explore your values and concerns about health, health promotion and education and the role of the school. For example, you may wish to discuss with colleagues:

- do people in your school share common values about health?

- how does health promotion fit with the values and ethos of the school?
- can your school (or you!) tolerate differences in views on the importance of health or on ways of promoting it in the school ?
- does your director or headteacher share a common vision with teaching colleagues on how to develop the school as a health promoting institution?

The following activities are designed to be used with colleagues to help address issues such as these.

### **What is a health promoting school?**

The health promoting school is a term which we often hear used nowadays. But what is meant by it? Different people will interpret it in different ways.

#### **ACTIVITY**

Here are a series of statements made by various teachers about "a health promoting school." Please indicate the extent to which you agree or disagree with each statement, by ticking the scale from 1 to 5.

**A health promoting school...**

**AGREE**

**DISAGREE**

**1**

**2**

**3**

**4**

**5**

**"gives pupils the opportunity to influence the health education curriculum of the school"**

**" gives pupils good information about how serious the health problems are in society"**

**"should enable pupils to influence factors that affect health"**

**"should use all the means at its disposal to ensure that pupils behave in a healthy way"**

**"ensures that all subjects of the curriculum will teach about health"**

**"is one which seeks to empower young people to make informed choices about their lifestyles"**

Which of these statements comes closest to your idea of a health promoting school?

How would you complete the following sentence?

**"A health promoting school is....."**

## **The Aims of Education**

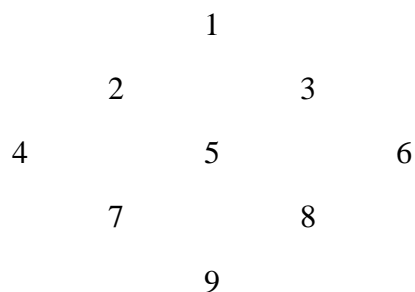
Your view of a health promoting school will be influenced by your attitude to the general aims of school education. If a person considers that education is primarily about the academic and intellectual development of pupils, to the exclusion of matters related to health and well-being, this will obviously have repercussions on their commitment and willingness to be involved in health promotion.

### **ACTIVITY**

### **A DIAMOND NINE**

This activity can help you to prioritise the aims which are important to you in school education and to discuss this with your colleagues. For each person taking part in the activity, photocopy figure 1 and cut it into nine small diamond shapes. Eight small diamonds each contain one possible aim of school education. The ninth diamond is left blank for participants to complete with another aim.

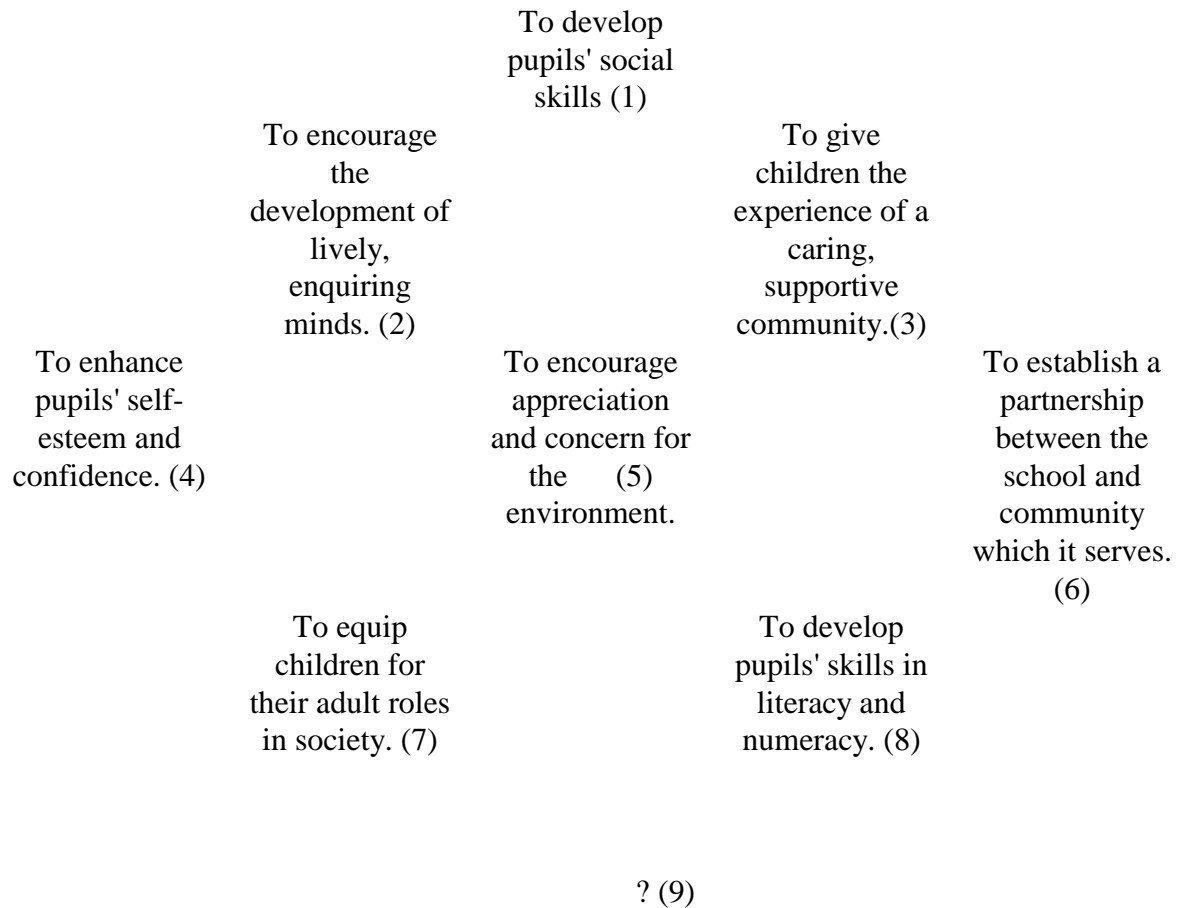
Each person should rearrange these into a large diamond shape, ranking them so that the aim which they think is **most important** is at the top and the aspect which is of **least importance** is at the bottom.



Compare the diamond rankings and try to reach a consensus.

## THE AIMS OF SCHOOL EDUCATION

### Example of a Diamond Nine Ranking



The term education refers not only to the learning and teaching in the classroom, but to the powerful informal education processes which take place outside the classroom in the total life of the school. These overlap within the social environment of the school as well as the physical environment.

## **The Aims of a Health Promoting School**

In the European Network of Health Promoting Schools, a participating school is encouraged to work towards meeting the following 12 criteria:

1. active promotion of the self-esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school;
2. the development of good relations between staff and pupils in the daily life of the school;
3. the clarification for staff and pupils of the social aims of the school;
4. the provision of stimulating challenges for all pupils through a wide range of activities;
5. using every opportunity to improve the physical environment of the school;
6. the development of good links between the school, the home and the community;
7. the development of good links between associated primary and secondary schools to plan a coherent health education curriculum;
8. the active promotion of the health and wellbeing of school and staff;
9. the consideration of the role of staff as exemplars in health-related issues;
10. the consideration of the complementary role of school meals (if provided) to the health education curriculum;
11. the realisation of the potential of specialist services in the community for advice and support in health education;
12. the development of the education potential of the school health services beyond routine screening towards active support for the curriculum.

This manual is based on a broad concept of a health promoting school which could be summarised as follows:

**"A health promoting school aims to enable pupils, staff and the community it serves to take action for a healthier life, school and society".**

### **Why Schools as a Setting?**

Health education and health promotion can occur in a variety of settings, such as hospitals, schools and workplaces. It is important to reflect on the special value of schools as key settings.

\*Timing. Young people attend school at an important stage in their lives through childhood and adolescence when behaviour patterns relating to health and concepts of health are being established.

\*Duration. The length of time young people attend school varies in different European countries, however it is at least 15,000 hours for most young people in Europe. This allows schools to plan long term, coherent and progressive programmes of health education which take account of the needs and conceptual development of young people as appropriate to their stage of development.

\*Literacy and Education. A strong association exists between the number of years of education a woman has at school and the life expectancy of her children. Health and education are inextricably linked and schools provide a universal setting for achieving both.

\*Parents and Families. Schools provide a setting for actively involving parents and using parents as a resource to promote the health of their children and active parental involvement has been shown to increase the effectiveness of school health promotion activities .

\*Communities. A school is a community where the health of all staff and students can be promoted if a positive and caring ethos is created and actively nurtured. In addition, schools have the potential to be the focus for health promotion activities for the wider community surrounding the school.

\*Nature of health education in schools. School health education offers the opportunity of going beyond the information-giving and awareness-raising role of the mass media to enable young people to develop action competencies for life. This is described in more detail later in this chapter.

The strengths of school health education have been recognised by a wide variety of international bodies. For example the Council of Ministers of Education of The European Communities in 1988 and the Ministers of Health in 1992. The American Public Health Association also fully recognised the potential of schools to educate in this domain a large proportion of a population over a significant time period when it stated:

The school as a social structure, provides an educational setting in which the total health of the child during the impressionable years is a priority concern. No other community setting even approximates the magnitude of the school education enterprise.'

### **What do we mean by health?**

Before we begin to consider further the issues involved in school health promotion, it is important to ask the question: **What does health mean? What determines whether one is healthy?**

## **ACTIVITY**

Below are several statements about good health. Which one do you prefer? If possible, share your ideas with a colleague.

"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." (World Health Organisation, 1947)

"Health is not an entity but a concept used to characterise a process of man adapting to changing demands of life and the changing meaning we give to living." (Rene Dubos - The Mirage of Health 1959)

"He who has health has hope and he who has hope has everything." (Arabian proverb)

"Well-being is possible only to the degree to which one has overcome one's narcissism; to the degree to which one is open, responsive, sensitive, awake, empty. Well-being means to be fully related to man and nature affectively, to overcome separateness and alienation, to arrive at the experience of oneness with all that exists.....Well-being means to be fully born, to become what one potentially is." (Erich Fromm)

"When you are strong and healthy  
You never think of sickness coming,

But it descends with sudden force

Like a stroke of lightening.

When involved in worldly things,

You never think of death's approach;

Quick it comes like thunder

Crashing round your head."(Milarepa)

"A man too busy to take care of his health is like a mechanic too busy to take care of his tools." (Spanish proverb)

"By health I mean the power to live a full, adult, living, breathing life in close contact with what I love - the earth and the wonders thereof. I want to be all that I am capable of becoming." (Katherine Mansfield, just before she died of tuberculosis in 1923)

"Health is the quality of life that enables the individual to do most and serve best." (Jesse Feiring Williams, Columbia University, 1940's)

Much has been written about concepts of health. More important than academic discussion, though, is the need for anyone involved in health promotion to define for themselves what health means.

## ACTIVITY

What do you understand as "being healthy"? In column 1, tick any statement which seems to you to be an important aspect of your health. When you have finished this, tick in column 2 the six statements which are for you the **most important** aspects of being healthy.

<b>Being healthy means</b>	<b>Column 1</b>	<b>Column 2</b>
1. Being able to run when I need to without getting out of breath.		
2. Never suffering anything more serious than a slight cold or upset stomach.		
3. Being able to get on well with people.		
4. Eating the "right" foods.		
5. Being able to express my feelings.		
6. Feeling concern for others.		
7. Not smoking.		
8. Being in touch with my spirit or soul.		
9. Being the ideal weight for my height.		
10. Taking regular exercise.		
11. Being concerned about the environment.		
12. Being able to make choices and decisions.		

	<b>Column 1</b>	<b>Column 2</b>
13. Feeling that deep down, I'm OK.		
14. Being able to adapt and make the best of the situation I'm in.		
15. Living to be 80 years old.		
16. Accepting my vulnerability.		
17. Liking my body.		
18. Being able to ask for help, if I have a problem.		
19. Feeling that I have a right to exist.		
20. Limiting my work and social engagements to allow myself time to rest.		
21. ....		
22. ....		

If possible, compare your answers with those of a colleague. From your replies, on which aspect of health do you seem to place a greater emphasis: physical, mental, emotional, social, environmental or spiritual?

### **Holistic Health**

The broad concept of health which is the basis for the Health Promoting School is also called holistic. Holistic health encompasses both physical and psychological dimensions, the body and the mind. The two are closely connected. For example, a psychological imbalance (such as stress) may increase your risk of infection, while it is known that physical exercise may

encourage emotional well-being and mental health. We should avoid treating the body and mind in isolation.

Holistic health embraces all the factors affecting health. This includes, not only the person, but the person in his or her environment. It involves a person's lifestyle and also his or her living conditions.

### **Lifestyle and Living Conditions**

The idea of lifestyle includes our attitudes and values, and our behaviour in areas such as exercise, diet, tobacco and alcohol. The term living conditions includes both the social and physical environments and the cultural and economic framework affecting people's lives.

Lifestyle is not something vague that can be changed at will. On the contrary, lifestyle develops in close interaction with living conditions. And, as expressed in WHO's document, *Targets for Health for All*,

"There are limits to the choices open to individuals - limits imposed by their physical, social and cultural environments and by their financial means."  
(WHO 1986, p.53).

Both lifestyle and living conditions are dynamic rather than absolute concepts. For example, lifestyles change in relation to an individual's development over time and may also vary according to cultural factors. Similarly, living conditions vary over time and place.

## **ACTIVITY**

Ask your students or colleagues:-

**What can you and I do so we ourselves, and others can have a healthier life?**

You could categorise the responses into personal lifestyle factors and living conditions.

Exploring what action we can take to influence both lifestyle and living conditions is a key task in the "Health Promoting School".

### **Involving pupils**

Health education must take account of pupils' living conditions and lifestyles (including their pre-existing beliefs, values and attitudes), if it is to be effective and relevant to the young people. We need to "start where the pupils are", to think about how we can involve pupils and encourage them to take action.

### **The concepts of action and action competence**

What is action? The first element is that the pupils actively decide themselves to do something, whether it is a question of a change in behaviour or an attempt to influence the conditions of life. It is very important that, on the one hand, they experience that living conditions - and society - affect what they are able to do and that, on the other hand, they are made aware that they can help to change the social framework. Secondly, an action must be goal-oriented towards solutions of a particular problem.

It is possible to work at two different levels to develop pupils' action competence :

**Level One: direct or concrete action through projects or teaching programmes.**

Pupils can try to change aspects of their personal lifestyles, aspects related to the physical and social environment of the school; or they can try to influence aspects of communities at a local and global level. Some actions involve small steps, others large steps - all leading to an influence on the future.

**Examples of actions**

- \* Write a proposal addressed to the headteacher and the school board or management for improving play-grounds in the school
- \* Build a compost heap on the school ground to bio-degrade waste
- \* Write a letter to local politicians asking for better traffic safety on roads near the school
- \* Agree to say at least one nice thing to each other in class everyday
- \* Start a water saving campaign in the school and later on encourage its development in the local neighbourhood
- \* Plan a debate evening for pupils, parents and people from the local area to discuss issues relating to health and environmental conditions

**Level Two: Action ideas developed by pupils.**

Pupils discover potential modes of action without necessarily carrying them out. We sometimes underestimate the value of pupils seeking out and developing their potential for action. It is important that they understand the whole range of possibilities for change in a democracy. In a democratic society it is accepted that in addition to individual rights there is a requirement to balance these with responsibilities to self and community.

### **Examples of action ideas**

- \* Encourage pupils, through discussion and role play, to consider what actions are feasible in a democratic society. Try to promote a vision for future action.
- \* Using a specific issue, such as local traffic conditions or unemployment among young people, as a starting point, encourage pupils to consider new action possibilities such as lobbying for change, development of consumer groups, organising boycotts etc.
- \* Encourage pupils to discuss what helps and hinders relationships in the school.  
What actions would help everyone in the school to feel good about themselves?

Level two ideas should feed action at level one.

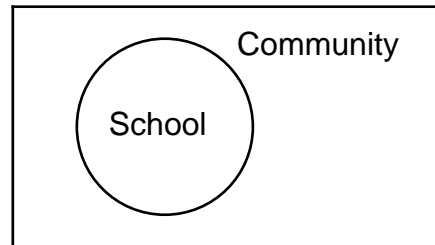
### **The School and Community**

There is no doubt that increased cooperation between the school and the local community could contribute to and facilitate more fruitful health education and health promotion activities. This cooperation can be of benefit to both the school and the local community.

### **ACTIVITY**

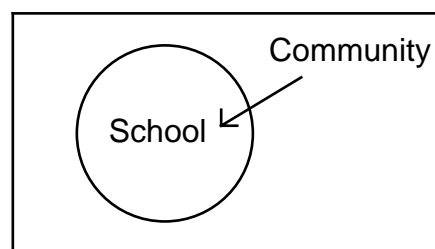
If possible, work in small groups with colleagues. Give each small group one of the following case studies to consider. They represent four different models of the relationship between the school and the community. List the strengths and weaknesses of that model and discuss your results. Which model is most like your own school?

## School 1



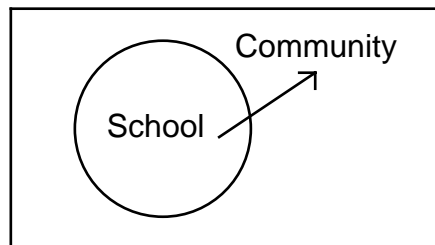
There are watertight doors between the school and the local community. The school can be regarded as an island. Teaching about matters concerned with society is done in the classroom. Without contacts in the local community, it remains abstract and theoretical.

## School 2



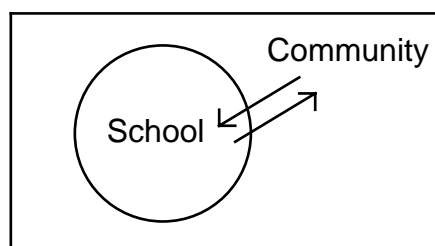
The school makes use of various key people from the community outside. They can be parents, politicians, people from the health sector or other agencies. These "visitors" provide practical examples of work being carried out in the classroom. The school is not an island, but the contact between the school and the community is only one way, i.e. from the community to the school.

### School 3



There is an attempt to break down some of the barriers between the school and the community, but here the school directs its activities outwards, towards the community. Examples of this approach are the pupils deciding to write a letter to the editor of the local newspaper, or sending a petition to local politicians with a request to do something about matters that are important for health (for example traffic conditions around the school). In this case, too, pupils are encouraged to apply classroom learning within the community and it is directly action oriented. But the contact is still one way, from the school to the community.

### School 4



The school draws on the knowledge and experience of key people in the local community, while the school and pupils for their part try to influence and change conditions in the community. This approach could be called the dialogue model. It gives the greatest

application and real world experience because it is extended to include the whole local community. In this model the teacher is more like a `consultant' rather than a traditional educator.

These four models each have their strengths and weaknesses, and require different conditions before they can operate. In any case, it is important to be clear which model will be used when planning strategies for health promotion in schools.

## **Co-ordination**

### **The Need for Co-ordination**

The purpose of co-ordination is to ensure that all the school's efforts to promote health are managed effectively. The manner in which this is done will depend on the size of the school and the ways in which health promotion and health education can be organised and delivered within it.

In the context of the health promoting school it is essential to ensure that health activities in the classroom are linked with actions in the school as a whole and with developments in the community of which the school is part.

### **A Co-ordinated Approach Makes it Easier:**

- \* to realise goals concerning the school population and the surrounding community;
- \* for all concerned to work with greater consistency of purpose and message;
- \* for the school to identify and report its activities and achievements;
- \* to use resources effectively;
- \* to recognise and support the wide ranging nature of health topics and learning, and to integrate them into school programmes, e.g. subject areas, project work and tutorials.

### **Co-ordination of Programmes of Study**

This perhaps merits particular attention, as for many teachers planned health education sessions may be what first comes to mind when they hear the words "health promotion". Health topics can easily arise through the subject matter of various disciplines and through the spontaneous questions and interests of pupils. Wherever the organisation of health education extends beyond a single subject or course there will be a need to cooperate with others. Schools will recognise a variety of forms for co-ordination of programmes of study. In reality, as the case studies show in part 2 of the guide, there will be a variety within as well as between schools.

There tends to be two main patterns of coordination:

**Specialist:** Health is taught through a single subject or course and the responsibility for co-ordination remains with those who deliver the work concerned. The strength is in clarity and simplicity, the weakness may be in an inability to influence the curriculum and the school as a whole.

**Cross-curricular:** Health is taught through several subjects and courses. The strengths are the breadth of coverage and the opportunity to interlink the work of different disciplines. The weaknesses may lie in the size of the task of co-ordination in a large, complex second level school.

### **ACTIVITY**

Below are four different models of delivering health education taken from schools throughout Europe. List the possible advantages and disadvantages of each. To what extent do you think each school has addressed the issue of coordination?

#### **School 1**

This school decided that for one week all teaching staff, no matter what their subject, would make a contribution to a specific health topic. The health topic chosen was **drugs** to include tobacco and alcohol, as well as the illegal varieties. Each teacher researched and planned how they could best include a drug related topic in their teaching scheme. Pupils, parents and community health workers were also alerted and the momentum produced an impressive teacher / school / family / community project. Because of its success, the school decided that they would repeat the exercise every year.

## **School 2**

At this school a teacher of biology was so inspired by an in-service course on HIV/AIDS education that he planned a programme of sex education for his subject throughout the school. He discussed the matter with his headteacher who suggested a meeting of staff and parents to discuss the whole issue. As a result the teacher was invited to run an in-service course for other teachers and parents.

## **School 3**

After an inspiring talk by a visiting speaker on the subject of young people's perceptions of health and health behaviour, this school decided to find out what their pupils thought. Teachers in several classes asked their pupils to bring to school artefacts which for them in some way represented or had associations with health or health related behaviour. The pupils responded enthusiastically and the teachers were so amazed by the richness of the responses and the discussions that they decided to put on an exhibition for the whole school. Parents, School Governors and other teachers were impressed by the response and "Health" was put firmly on the agenda of the school.

## **School 4**

This school was dismayed to learn, following a survey amongst its pupils, that over 50% of them came to school without breakfast. The school doctor and nurse responsible for the survey discussed the matter urgently with the headteacher and convinced her that lack of breakfast was responsible for inattentive and listless behaviour during the mid-morning classes. With the help of parents and the pupils themselves, a special school breakfast was organised every morning at break time. In addition teaching about the importance of nutrition to health was instigated throughout the school.

## **CHAPTER 2**

### **STARTING OUT**

#### **Summary**

The main focus of this chapter is the process of choosing a project manager or coordinator and forming a team or action group.

In any change aimed at creating a healthy school, the mobilisation of resources will be more successful if everyone likely to be affected understands what is involved. Communication at all levels of the school is essential.

Any project is more likely to be effective if it makes the most of the complementary nature of people and the cooperation of all.

**"We want our school to be a *health promoting school* - we will go for it!"**

### **Initial Questions**

#### **Is the School Ready for Change?**

In our enthusiasm for an innovation, we can sometimes forget all the other changes which are occurring simultaneously and vying for people's time and attention. Staff and pupils in many schools are faced with major transitions, often outside the school's control. Some examples would be major political changes, the introduction of new programmes of work and changes in teachers' terms of employment . All these put great pressure on individual teachers and the school generally. If we are adopting a whole school approach, we cannot ignore the effect of this stress, and should work towards alleviating rather than exacerbating it.

#### **Do People Understand What is Involved?**

If you are developing a 'health promoting school' people need to understand what might be involved. One starting point is to increase understanding, by giving information to all concerned. The ways in which you do this will vary according to the position or personality of the people involved. Some may prefer a formal written paper, others will welcome discussion at a more personal level.

You may find some of the information and concepts in Chapter 1 useful for triggering discussion with your colleagues.

It is important to remember the existing channels for communication, for example in meetings of the school staff, as well as informal contacts in the teachers' room or elsewhere in

the school. There may be numerous opportunities to raise awareness in the school about health. You might talk about a TV programme, newspaper headline, a recent health promotion campaign, or local events.

Increasing understanding should also go hand in hand with gathering information. It is a two way process. The more people feel they have a say at an early stage, the more likely they are to feel some ownership of the change rather than feeling it is being imposed on them.

### **The Appointment of a Project Manager or Co-ordinator**

The work of developing a health promoting school is probably best achieved by a reasonably experienced and influential member of staff, working with a group of committed colleagues.

#### **Example of a group in a French school**

Deputy Director or Headteacher	Biology teacher
School Doctor	Physical Education teacher
Social worker	School Nurse

In order to achieve certain outcomes or tasks, a project manager or co-ordinator may need to be a director and facilitator, a creator of ideas and a diplomat in solving problems. However besides these task functions, there are also the qualities needed in creating and maintaining an effective group or team, and in managing the personal needs of its members.

A project manager plays an important maintenance role. This is likely to involve discerning the different qualities of individual members and building on their strengths. A project manager will need to be able to motivate people. To fulfil this role, she or he needs:

1. to be sensitive to others, in listening, watching and responding to their feelings;
2. to be able to analyse and synthesize communication processes.

The ideal project manager is able to keep the task and maintenance functions of the team in balance, not forgetting either the wanted outcomes or the personal needs of team members. If she or he is successful in this, the team is likely to become increasingly self-supportive.

And last, but by no means least, she or he needs to have time to give to this work.

To summarise, in choosing the project manager you need to bear in mind the main tasks that he or she is likely to perform. These are outlined in the box below.

**Leadership:**

Ensuring the development of a common vision, shared sense of direction, and providing a clear voice within the school to champion health.

**Co-ordination:**

Ensuring effectiveness and avoiding duplication.

**Building a group:**

Encouraging and building a skilled and committed group.

**Managing Change:**

Ensuring that innovation and development are managed positively.

**Winning Resources:**

Identifying human and other resources to achieve health tasks .

## **Teams**

### **How to select a team, or put together a group**

Varying with the size of the school population, a team is likely to be more effective if it has no more than ten members.

How to select these members depends largely on the school's long-term aims and the tasks appropriate to achieve them. In an ideal world, a school would have a health policy. The team would then develop an implementation strategy to support this, laid down in a plan of activities.

To give an example:

A school may have as a general health policy: "the promotion of the social, physical and emotional well-being of pupils", and it may set the following objectives to match the overall aim:

- \* to structure and channel the communication between different professionals involved in the health and well-being of pupils ;
- \* to plan and organise activities/projects to promote health and well-being at school;
- \* to promote co-operation and communication between the team and the school as a whole, and between the team and relevant external organisations.

Team members should be willing to subscribe and contribute to these long term aims. Review and audit activities will be necessary to clarify the problems and needs of your particular school. As a result you will be able to draw up more specified objectives, for

example in relation to different school programmes (see Chapter 4). You may need to form sub-teams to meet these objectives, for example a team from subject areas to look specifically at integrating health education into teaching programmes.

In deciding whether someone would be an asset to a team, another important factor is their position and personality. For one thing members will need to communicate with different groups of people: the school management, teaching and non-teaching staff, parents, the community and pupils.

You are likely to want to include people on the team:

- who can represent or influence policy-makers;
- who are specialists on particular health subjects;
- who are involved in counselling;
- who are responsible for personnel management .

They will also need to be able to give their time, which might mean meeting twice a term.

The method of selecting a school team may vary depending on the style of leadership of the school. If this is predominantly autocratic, people may not be used to changes involving 'democratic solutions'. A good strategy is to stress the voluntary nature of participating in the team. You may find that team members tend to be the 'idealists' in the school, and this makes it all the more important for someone from school management to direct the team. It is probably best to keep the teams plan of activities 'small-scale' and directed at urgent needs in the school. Aim at concrete results within a relatively short period (see Chapter 5).

In the case of more democratic leadership, with a more positive attitude to change, it is important to tap into this enthusiasm for innovation. Paradoxically, it may be more difficult to find team-members, as the 'healthy school concept' may be one topic amidst several others. One strategy is to discuss openly the changes and goals needed to bring about a healthier school. The manager or co-ordinator may then ask for volunteers to fulfil these goals.

### **How to build an effective team**

The success of healthy school projects is largely dependent on how the team works together. Therefore it can be useful at the beginning of the project to give members a chance to discuss what they hope to gain from involvement in the team, their hopes and expectations, to share their values and explore how they are going to co-operate. It is important to create a climate where everybody feels comfortable and accepted.

Team-building is a process, which includes four vital steps:

1. Feeling accepted (forming): new team members are concerned about whether they fit in the team. They may wonder if they have sufficient knowledge and experience.  
What is expected of them?
2. Exchanging information and opinions: this can often lead to conflict (storming), and involves issues such as "What position do I take on this?" "How will others react to what I say?" There is often a testing out of others on the team and of the leader.
3. Goal setting and value clarification (norming): this concerns the process of defining aims and deciding on priorities. Through this process, the team is clearer about its needs and wishes, the paths to be pursued and the best courses of action. It concerns questions such as "How do we want to be as a group?"

4. Process management (performing): this concerns the 'pecking' order in a team: the division of power and influence and of different roles. It involves valuing the differences in team members and using their strengths to perform a task.

These processes not only play a part in the beginning of the team building process, but also in later stages of team development.

### **Winning Resources**

Any change is likely to need resourcing, both in human and material terms. What you are able to achieve may be dependent on the funds available and the number of hours which people have to spare for the task. Besides resources within the school do you have access to any outside? Maybe official departments can help or you could look for sponsors within the community.

Involve others as much as possible in the process of change. Successful management is a collaborative process, in which there is open two-way communication with all who are involved in or affected by what is being proposed. This includes not only staff, teaching and support staff, but also pupils, parents and the wider community. It applies to all stages: review, audit, goal and target setting, implementation and evaluation.

**CHAPTER 3**  
**IDENTIFYING NEEDS**

**Summary**

This chapter explores three areas for review:

- \* **the school environment**
- \* **the community**
- \* **teaching programmes.**

The reader is offered suggestions for ways of discovering the real needs of pupils, in order to make a diagnosis and draw up plans for future work.

There is material with which to reflect on the teaching to be given in school to encourage a healthy lifestyle. Suggestions are offered for a progressive learning process and teaching conditions favouring a better acquisition of knowledge and skills in the area of health.

## **A review as a starting point**

Having set up a team to manage effective health promotion you now need to find out the situation in your school in order to work out where to start:

- \* **What are your school's problems?**
- \* **What are your school's needs?**
- \* **What are your school's constraints?**

### **Pupils Needs**

You will need to undertake investigations to be sure to begin from "where pupils are" in terms of their feelings, lifestyles and health knowledge. There are a whole range of methods at your disposal, including:

- \* a box for ideas
- \* questionnaires
- \* interviews
- \* discussions with classes and with parents

You might want to ask pupils questions about specific issues, such as those in the box below.

**Examples of questions**

Do you think the food available in the school is healthy?

Do you eat breakfast before coming to school in the morning?

What do you feel about the support that you get from teachers outside the classroom?

List three things which you would like to know more about, to do with health and feeling good.

List three things which you would like to be able to do better or differently, which would help to make you healthy and to feel good about yourself.

Is there anything about yourself that you would like to change, which may make you feel healthy, happy and good about yourself?

**Staff needs**

There may be specific questions which you want to ask teachers and others working in the school . Examples would be:

What gets in the way of you developing health promoting activities in the school?

What opportunities do you have for health promotion in the school?

What support do you think you would have for health promoting projects?

**Needs of all concerned**

However, as a starting point it could be useful, to think of questions that you could give to pupils, colleagues in school, parents and people in the community. It may be preferable to keep the questions as open as possible:

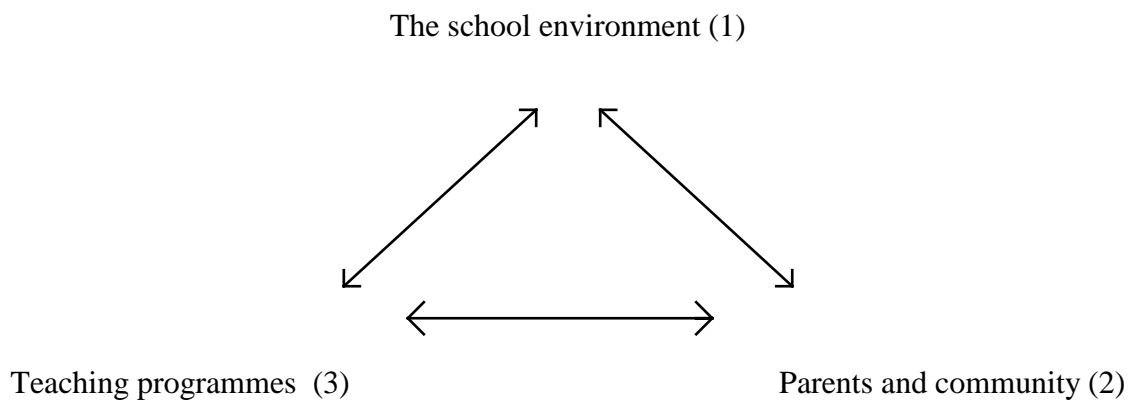
In what ways can our school be made health promoting?

How can our school help to make our community more health promoting?

How can the community help our school to be more health promoting?

**What might you review?**

Don't forget that the health promoting school ideally should be put in to practice at three levels:



You could review and analyse the responses across all three dimensions. This next section explores these three in more detail.

**The School environment**

Children not only learn from classroom teaching but also from the "hidden" teaching of the school milieu - from the way in which a school is managed, from the observed relationships between the staff, and teacher and pupils, from the customs and traditions of the school, from

the physical appearance of the school environment, and from older pupils and teachers as role models. Clearly, if what is taught in the classroom is not supported by what pupils see and experience in the body of the school itself, then the classroom message can become so diluted and weak that it loses its significance to influence decisions which pupils make about their lifestyles. The school environment can affect the health of everyone who works there - pupils and staff. For example, attractive, cared-for surroundings will affect people's sense of well-being and of being valued. How healthy is the food available in your school? Are you encouraging healthy eating?

As a school co-ordinating team you can encourage strong support for teaching programmes through relevant school policies, and the building of a school milieu which reflects good relationships, good management and the valuing of each individual. Many schools have felt it timely to establish a "School Council" or "School Parliament" where the teaching staff, each year group, and parents are represented through a democratic system of voting. School policies over a wide range of issues can be discussed - including those related to the health and wellbeing of pupils and staff.

Some of the issues which you may need to consider as a co-ordinating team or group are suggested below:-

- \* Developing and monitoring health related policies e.g. bullying, nutrition, smoking, pupil-punishments, safety and accident prevention, and physical education
- \* Reviewing and developing the pastoral support systems of pupils - Do pupils know where they can go for help?
- \* Enhancing the physical environment of the school - Are there improvements to be made? How can pupils/parents help?
- \* What are the in-service training needs of teachers? \* Is there a need for health promotion for teachers e.g. stress reduction workshops, smoking cessation etc.?

- \* How can the school health services best be utilised within the context of the total school programme?
- \* How can the support of parents and the community best be mobilised and utilised?
- \* Design "peer teaching" materials involving older pupils working with younger children in the same school.

### **The wider community**

Often the health related knowledge, skills and attitudes taught and learned in the school are in danger of remaining just "school-business", and remain unconnected with the real world beyond the school gates. Lifestyle behaviours often have to be legitimised by the family, close friends, peers or community institutions of different kinds.

Another significant task for the school, therefore, is of ensuring that the relevant influences which exist beyond the school gates are, more or less, in harmony with those of the school itself. While the family remains an anchor for most young people during adolescence, it is important to recognise the growing influence of peers and close friends who come, more and more, to supplant the values of the family. Determined schools have shown that it is possible to maintain harmony between themselves and families and community by thinking about:-

- \* Asking parents with particular interests or skills to support the school by providing workshops on their country's cookery, first aid care, arts and crafts, safety at work etc.
- \* Arranging meetings where the neighbourhood and school can discuss violence, bullying and safety in the surrounding area.
- \* Planning and implementing a school/community project related for example to:

- environmental issues such as litter, collection of bottles, preservation of wild-life, restoration of forest, gardens or waterways
  - people at risk such as elderly folk or very young, the handicapped
  - a nutrition project such as a 'healthy breakfast' project
  - special events such as 'National No Smoking Day'
- \* Making an inventory of the health promotion projects, environmental projects or any others that are being implemented in the wider community. Informing the school community of the objectives and methods of the projects, in order to encourage involvement.

### **Teaching programmes**

#### **Start from where pupils are**

Finding out where pupils are in their perceptions provides a starting point for teaching and learning. Young people do not come to their secondary school "tabula rasa". The knowledge, attitudes and skills they bring to school are often a mixture of truths, half truths and myths, and it is important to clarify what they know and feel in order to establish what teaching/learning needs to be done.

#### **The content**

One of the early decisions for a school co-ordinating team relates to the vexed question of health education content - what are the key areas of a healthy lifestyle? A recent study of school health education in the 12 Member States of the European Community identified 10 areas of common concern. These were:

1. **Personal health care including personal hygiene and dental health.**
2. **Mental and Emotional Health - including personal and human relationships.**
3. **Sex Education.**
4. **Family Life Education.**
5. **Nutrition Education.**
6. **The use and abuse of addictive substances (legal and illegal).**
7. **Physical Activity.**
8. **The Environment .**
9. **Safety Education and Accident Prevention including First Aid.**
10. **Consumer Education.**

In an ideal situation, all these areas might be addressed in each school year-group, but, because of the constraints on available curricular time, this is unlikely to occur. Schools may wish, therefore, to establish priorities for specific year groups which can be determined by:-

- (i) Particular local health needs/problems such as:
  - \* frequency of accidents of various kinds
  - \* a drug abuse problem - perhaps smoking
  - \* bullying - a problem in or out of school?
- (ii) Stage of adolescent and sexual development of pupils
- (iii) What pupils themselves feel they want and need

### **The spiral approach**

The principle of the spiral curriculum is based upon established practices in curriculum design, where key concepts of a subject or topic are revisited at intervals throughout the school life of pupils, in order that knowledge and understanding is successfully achieved through a progressive chain of learning. It is important to emphasise that each visitation needs to build upon previous learning, introducing new facets of the topic through teaching methods appropriate to the development of the pupils concerned. For this to be achieved it is necessary to identify a spiral of relevant aims and objectives.

## Methods of teaching

Experience shows that health knowledge and skills are most effectively acquired when teachers:-

- \* show genuine concern for the welfare of pupils without dictating what they should do
- \* are able to demonstrate the relevance of the topic to the present or future lives of pupils
- \* employ a variety of participative teaching methods
- \* help and support pupils to set goals for themselves and to take action

### **ACTIVITY**

#### **HEALTH PROMOTING SCHOOL - 30 POINT CHECKLIST**

Read through the checklist and mark the place on the line which best represents your opinion on your school's current position.

**To what extent does your school attempt to:**

<b>THE SCHOOL ENVIRONMENT</b>	<b>A little</b>	<b>A lot</b>
<b>The physical environment</b>		
1. have attractive, cared for surroundings - interior and exterior?		
2. provide good quality physical work conditions?		

	<b>A little</b>	<b>A lot</b>
3. provide "healthy choices" in catering?		
4. have adequate facilities: e.g.a quiet room, rooms for recreation and exercise?		
5. offer access to a smoke-free environment?		
6. have facilities which can be used by the community?		
<b>The school ethos</b>		
7. have clear social aims?		
8. develop and monitor health related policies e.g. bullying, nutrition, smoking, pupil-punishments, safety and accident prevention, and physical education?		
9. have clear and consistent methods for policy -making?		
10. actively promote the self-esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school?		
11. have effective consultations with parents, teachers and pupils?		
12. encourage staff/pupil contact beyond teaching-related commitments?		
13. consider the role of staff as exemplars in health-related issues?		
14. develop organisational procedures and management strategies which are geared to recognise and reduce stress?		
15. provide a counselling service for pupils and staff?		
16. have health guidance accessible to all?		
17. have effective internal communications for and with pupils as well as staff?		

<b>TEACHING PROGRAMMES</b>	<b>A little</b>	<b>A lot</b>
18. provide stimulating challenges for all pupils through a wide range of activities?		
19. integrate health education across educational disciplines?		
20. have planned programmes of study which show continuity and progression?		
21. revisit subjects and issues?		
22. demonstrate a commitment to active learning strategies?		
23. include education to develop pupils' personal effectiveness and action competencies?		
24. offer a range of recreational and exercise options?		
25. offer staff development programmes to enable quality delivery of the above?		
<b>PARENTS AND COMMUNITY</b>		
26. develop good links between the school, the home and the community?		
27. develop good links between associated primary and secondary schools ?		
28. realise the potential of specialist services in the community for advice and support in health education?		
29. develop the education potential of the school health services beyond routine screening towards active support for the curriculum?		
30. identify with local issues and relate to national and international perspectives?		

**CHAPTER 4**  
**AN AUDIT OF HEALTH EDUCATION**  
**IN TEACHING PROGRAMMES**

**Summary**

This chapter aims to provide the reader with various tools to enable him or her to discover what areas are covered or to be taught in the area of health in terms of:

- \* knowledge
- \* skills
- \* attitudes

On the basis of these preliminary investigations and results, there is naturally a need to consider what follow-up there will be and to select teaching methods which will achieve the determined objectives

Few European Countries include Health Education as a subject in its own right. You may need to consider how health topics might be best integrated with other subjects or teaching programmes. There is a natural affinity between health education and some subjects such as the sciences, home economics, physical education, geography, and language where the objectives of both might appear to be complementary.

An audit of health education can give you a firm baseline. It can provide you with information about what is taught, in which subjects and when. It may also provide more detailed information about the depth of coverage, whether the coverage is planned or incidental, which teachers are involved and which classes/pupils they teach. In this way it will identify areas of omission and of duplication. Acquiring such information is an important step in co-ordinating health education in the school.

It may be a good idea to only collect information on one or two areas of health in an audit so that the workload is not too great. The aim should be to act on the information gained as soon as possible.

### **What information should be collected?**

Schools may have received guidance on appropriate health education topics, or they may need to decide the content themselves.

When you are deciding on the information to be collected, it is important to remember that health education involves more than knowledge about health related matters. At the heart of the "health skills" are those of listening and communicating successfully, being able to set achievable goals for one's own lifestyle, and acquiring a basic understanding of the social pressures and influences to which we are all prone.

For example, you may decide that pupils should be taught about smoking. The areas to be covered could be:

- \* knowledge about tobacco use;
- \* attitudes to smoking;
- \* skills to deal with pressure to smoke.

You could use an audit to discover if these areas are being covered. These three objectives are used as examples in the rest of this section.

**How do you collect the information?**

**(a) Breadth of coverage**

In its simplest form you could present the audit as a grid listing the desired health education content. Ask individual subject departments to indicate if they mention the areas listed as shown in the following example.

**A simple audit grid**

Name of Subject Department:					
Please tick if you cover any of the health education issues listed below					
Health education content	School Year				
	1	2	3	4	etc
Knowledge about tobacco use					
Attitudes to smoking					
Skills to deal with pressure to smoke					

(b) **Depth of coverage**

The grid shown above gives an indication of the breadth of coverage, but not the depth. You may need to ask supplementary questions in order to gain additional information. These additional questions can be asked when performing the audit. A more detailed audit questionnaire, developed in Wales, is illustrated on the next page:

Example of audit questionnaire

AUDIT OF HEALTH EDUCATION ACROSS THE CURRICULUM

Subject \_\_\_\_\_

Name of teacher \_\_\_\_\_

There are several columns on the grid. The information needed for each is as follows:

Coverage - the depth in which you cover it, i.e. x = not at all, 1 = mention, 2 = in depth

Year group.

Course - title of the course being taught.

Term of teaching.

Classes - which particular classes in the year are taught the topic.

Could staff please look at their schemes of work and indicate whether any of the topics listed on the attached grid are being, or will be, covered by their courses.

Topic	Coverage	Year Group	Course	Term	Class/es
Knowledge about tobacco use					
Attitudes to smoking					
Skills to deal with pressure to smoke					

### Specific areas or topics

You might want the audit to be much more detailed. In relation to sex education, for example, you might want answers to specific questions to gain a comprehensive understanding of its coverage in the school.

The following questions were asked in a questionnaire for teachers in a project in the Netherlands, to determine the nature of teaching relating to sexuality/sexual harassment .

1. In your lessons do you cover?

	no	sometimes	yes,structurally integrated
Education about relationships and sex			
STD/AIDS information			
Breaking down role stereotypes			
Prevention of sexual harassment			
Emancipation of homosexuality			

	yes	no
2. Do you - in addition to `technical' information - give attention to feelings, intimacy and relationships? to communication skills, and to norms and values concerning sexuality?		
3. Do you in your lessons give attention to differences between boys' and girls' experience of sexuality, and to the experience of one's own body and that of the other?		
4. Do you give attention to the formation of girls' and boys' social images? to sexual roles and stereotypical behaviour and to the assumptions that go along with these?		
5. Do you give specific attention to sexual intimidation in your lessons about sexuality? to the "grey area" between making advances and sexual intimidation? to the distinction between flirting and making intrusive "jokes"? to behaviour that goes too far?		
6. Do girls at your school have the opportunity to follow a course in self-defence?		
7. Are lessons in self-defence a regular part of the course offering at your school?		
8. Does your school offer lessons or a course for boys with the specific intention of making them conscious of behaviour that goes too far?		
9. Do you talk specifically about sexual abuse in the lessons? about the occurrence of sexual abuse by family members (incest), rape and assault?		
10. Do you tell students in your lessons what steps to take in the case of assault or rape? how to report it? what to do to leave possible proof on and to your body?		
11. Do you talk in your lessons about standing up for yourself (assertiveness)?		

**Teaching and informational material  
about sex education**

	yes	no
12. Do you use material specifically developed for teaching sex education during your lessons?		
13. Are you informed regarding the current teaching material about sexuality/sex education?		
14. Is informational material about sexuality/sexual harassment available for school personnel for example in the teachers' lounge?		
15. Is informational material about condom use, contraception, sexual harassment etc. available for the students, for example in the library or the documentation centre?		

**Who should be involved?**

It is suggested that the health education coordinator should manage the data collection. Individual heads of department or coordinators of different disciplines could be requested to complete the audit grid in discussion with colleagues in their department or discipline. It may be easier if heads of department are approached during an appropriate meeting. In this way the idea of an audit can be given status as an important whole school issue. It also allows discussion of the issues and the answering of any questions. It is important to put a deadline for the return of the audit forms, preferably within two or three weeks of their distribution.

**How should the data be collated?**

The person managing the data collection will need to collate all the information on a summary sheet. For each statement a note is made of the subjects claiming coverage.

The most appropriate way of collating information may be in a summary grid as illustrated below:

**A summary grid**

Health Education Topic	Year 1			
	Science	Language	Maths	History
Knowledge about tobacco use	2	X	1	1
Choosing a healthy diet	2	1	X	X
Understanding of sexual harassment	X	X	X	X

Within the grid a key could be used to indicate depth of coverage, e.g.:

- Mention = 1
- Cover in depth = 2
- Not at all = X

**What happens next?**

**You could:**

consider the importance of informing staff involved of the results of the audit in appropriate group meetings

start to work as a team to set goals for health education which will be included in a school health education policy (see chapter 5)

consider on-going monitoring of health education provision (see chapter 6)

decide how you are going to teach relevant programmes. You may need to use a

variety of participative teaching methods which might include:

- \* Class or small group discussion
- \* Brainstorming
- \* Role play
- \* Task-groups
- \* Projects
- \* Specialist Visitors etc.

**CHAPTER 5**  
**ACTION PLANNING AND MANAGING CHANGE**

**Summary**

Having clarified the difference between aims and objectives, this chapter encourages readers to analyse the situation in their schools in order to locate the strengths and resistances to change.

Next, this change, seen in terms of power and influence, leads to the drawing up of strategies aimed at convincing both those with power and those without.

A strategy of managing change in the context of the school and community finally reveals the necessity of starting 'small' and making use of training.

## **Goal setting**

Goal setting is indispensable, both to map your way forward and to help you to evaluate your work. If you don't know where you're going, how can you know you've arrived?

As mentioned in chapter 3, it is important to know the situation in your school, taking into consideration any problems, needs and constraints so that you have a solid framework upon which to set your goals.

It is useful to define goals in three areas: cognitive, affective and skills(or action competencies). All goals need to be realistic and clear.

The differences between long and short term goals are mainly related to their breadth, scope and, of course, the timeframe for achievement. Long-term goals are usually referred to as aims, and short-term goals are objectives.

## **Aims**

Aims are more ambitious than short-term objectives.

Examples of Aims:

- To develop pupils' ability to influence their own lifestyles.
- To create a health promoting workplace for staff
- To improve pupils' skills to make responsible choices.
- To promote the school as an agent for change in the community

They have a global and unifying nature, and their purpose is to guide the daily practice of all people in the school and thereby be a frame or a perspective for objectives.

If you have identified your aims and the priority areas to work on in your school, you have found your starting position, and it will not be difficult to design the short term goals or objectives.

**ACTIVITY**

**FORCEFIELD ANALYSIS**

The purpose of this activity is to help you to identify the factors which might help and hinder the achievement of your aims. You need to be able to see both sides of the picture in order to make realistic plans and to prioritise factors or forces that it is important to take action on. If possible do the activity with a small group of colleagues.

**Choose an aim to work on**

**Write down as many PRO forces as you can - those that help you reach your aim**

**Write down as many CON forces as you can - those that are against you reaching your aim**

**Quickly, rate the relative importance of each force from 1 - 5, where 5 is very important and 1 is of little importance.** Do not spend too long discussing this. Give your initial reactions.

### Example of Forcefield Analysis

**Aim = to improve pupils' ability to influence the health of the community.**

<b>PRO FORCES</b> (Helping you reach the aim)		<b>CON FORCES</b> (hindering you from reaching the aim)	
5	Our contacts with the community	4	Lack of time
3	Pupils' enthusiasm	5	Teachers' attitudes
3	Support of the Network of Health Promoting Schools	3	Social problems seeming insurmountable
4	School Health Services	2	Money
4	Link with different subject areas or educational disciplines	3	Parental concern
3	Parental concern	2	Pupils' communication skills
5	Our commitment	3	Pressure of exams

This can help you to make decisions about where to start. You may find it useful to add up the scores of the pro and con forces. If the con forces, or negatives, far outweigh the pro forces, or positives, you may need to either rethink your aim, or work on ways to reduce the negatives.

**Underline the forces rated 3 and above that it is important to act upon.** If possible choose forces which will use the strengths and interests of your team or group. Make sure that you choose both pro and con forces, as you need to work on reducing the negatives as well as building on the positives.

Turn these underlined forces into objectives.

In the example on the previous page, some objectives might be:

- \* to consult contacts in the community over the way forward
- \* to increase teachers' understanding of the benefits of this type of work

For advice on writing objectives, read on!

## **Objectives**

Objectives are the stepping stones which help you reach your long-term aim.

### **Objectives should be:-**

- very concrete and objective
- realistic
- quite easy to achieve
- able to be measured or assessed
- indicators that allow allocation of responsibilities and tasks
- time-related

In order for a school to be health promoting, objectives have to be carefully designed to cover the three levels we have spoken about several times in this manual:

- \* the classroom
- \* the school (milieu) environment
- \* the surrounding community.

It is important that all staff and pupils are aware of these objectives.

The box below shows the type of objectives which you might have for the classroom, the school environment and for the surrounding community.

<p><b>For the classroom</b></p> <p>knowledge</p> <p>attitudes</p> <p>skills</p>	<p><b>Examples</b></p> <ul style="list-style-type: none"> <li>* to know that a varied diet is needed to be healthy</li> <li>* to explore misconceptions and stereotypes linked with smoking</li> <li>* to develop and practise simple ways of keeping safe outdoors</li> </ul>
<p><b>For the school environment</b></p> <p>interpersonal relationships at school</p> <p>pupils' guidance</p> <p>physical environment</p>	<ul style="list-style-type: none"> <li>* to develop pupils and teachers skills in giving praise and encouragement</li> <li>* to develop teachers' counselling skills through training</li> <li>* to ensure that all school toilets are clean and pleasing</li> </ul>
<p><b>For the surrounding community</b></p> <p>parental and social links, improvement of relationships</p> <p>school environment activities</p> <p>links with community health projects</p>	<ul style="list-style-type: none"> <li>* to set up a working group of parents, pupils and teachers to improve communications</li> <li>* to reduce the amount of litter in the school and its immediate environment</li> <li>* to organise a 'health day' for the community in cooperation with local health services</li> </ul>

## **Managing Change**

### **What helps?**

The way in which change is managed can have a crucial impact on the health of those concerned, both at an organisational and personal level. A project in England, working with teachers and other educational professionals, explored ways that the individual, other people and the school might help in the management of change. Common themes emerged:

\* At an individual level, personal and interpersonal skills were considered important. These included self-awareness, relationship-building, goal-setting, assertiveness, relaxation techniques and time management.

\* Other people, such as colleagues or friends, helped by listening and showing empathy, giving praise and encouragement, providing information, allowing space and time, giving feedback when asked, and helping to have fun and relax.

\* The school could help by providing the necessary resources to tackle the change, by setting clear goals and boundaries, offering training and opportunities for professional development, giving information, induction for new staff, regular review and above all by creating a positive, supportive climate.

### **Who might be affected by any change which you initiate?**

In many models of organisational change, there are often two sides identified: the supporters and the opposers to change, or the drivers and resisters of change. The John Elliott- Kemp

Matrix offers a structure for mapping the people in an organisation who are affected by your proposed change, and for identifying supporters and opposers. You can then plan how best to build on strengths and overcome resistance.

In thinking about people affected by a proposed change, there are two issues to be considered: the level of **power or influence** each person is thought to have and their degree of **interest or concern** for the proposed change.

**Level of power or influence:** this can take many different forms. A person who is able to restrict, reduce or limit alternatives to others has power. Power usually comes from status or position (for example from being headteacher or deputy director, although a caretaker or the person in charge of catering could hold a lot of power to block your initiative). However a person may have relatively low power but high influence, so that although she or he is not in a position to order or command, they may achieve results by persuasion, through their special personal qualities or expertise.

**Interest or concern:** this involves the level of commitment to the change. To what extent does a person care about the innovation? Are they enthusiastic supporters, fairly keen, apathetic or strongly resistant?

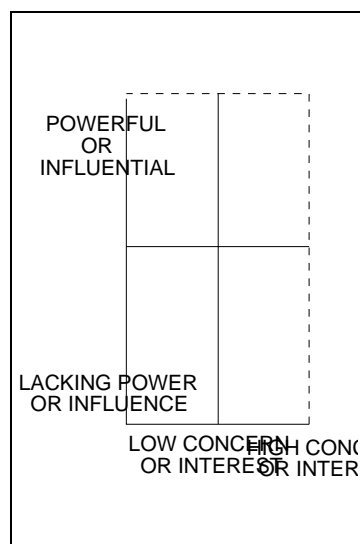
These two issues form the axes of the matrix, with each axis being a continuum, with high power or concern at one end and low power or concern at the other. Four quadrants can be formed, into which you could write the names of people in the school according to how they stand on these two dimensions.

An example of how this might be done follows on the next page.

## ACTIVITY

Either on your own, or preferably with a colleague or small group of colleagues:

1. List the key people in your school who would be affected by the change which you are proposing. Remember also to include yourselves.
2. Consider how long you wish to make the list. Will the envisaged change affect non-teaching staff and pupils? Are there any key people who could be involved from the community?
3. Draw the matrix below on a large sheet of paper and on it plot the people you have identified.



### **Different Strategies**

Each type of person is likely to need handling in a different way.

### **Convincing those with power - Quadrant 1**

Convincing those with high power is crucial to the success of an initiative. For one thing, you are unlikely to get the resources which you need, in terms of time, money or staffing. Without their active backing the innovation is likely to fail.

If someone with very little power, but a lot of commitment to an idea, tries to persuade a powerful, but opposed or uninformed headteacher, experience suggests that they would have little success. Far better for someone with high power and concern to approach the headteacher (for example someone from Quadrant 2). In order to get the backing of a senior member of staff, it can be useful to bring in outsiders who are seen to have expert power or status in the community. Advisers, inspectors and consultants can all play an important role. Similarly any written evidence may give credibility to your case.

### **Convincing those without power - Quadrant 4**

These are often the people who you need to implement health promotion at grassroots level. In this case, the most effective strategy may be for those who have relatively low power, but are highly motivated towards the notion of the health promoting school to work with their colleagues to help them to understand and accept what is involved. If a powerful supporter of the innovation tries to influence them, they may feel pressurised or coerced. The result might seem to be compliance, but it is likely to only be short term. Sabotage and non-cooperation may soon follow!

### **Empowering those who are committed, but relatively powerless - Quadrant 3**

This strategy is often the most important. In many schools innovation may be limited to "top-down" change. Decisions come from on high, and often leave people feeling powerless and resentful. How can people who are highly committed to an innovation, but with little power,

bring about any change? This would apply not only to staff, but also to pupils. The tactic here is to encourage the group of individuals to become a team.

When a number of isolated individuals become a fully functioning group with a sense of identity and a mission, the effect of the whole is greater than the sum of the parts. The collective power of the group may be sufficient to influence those at a higher power level.

### **Starting small or the Trojan Mouse**

Unfortunately, there may be some schools where all change is resisted by people in key positions. Those who attempt to bring about "bottom-up" change are frustrated by lack of support from the top.

A typical case would be where people with high commitment, but relatively little power, have tried helping others' understanding of the proposed change. They have formed a team, with shared values and a clear sense of direction. But they are still unable to find a way through the wall of resistance and apathy. They need a new strategy.

Underpinning this strategy are the ideas that:

- \* There is sometimes resistance because a change is seen as something new - the name or title or terminology is off-putting.
- \* People find it easy to criticise something which does not yet exist on the grounds such as "It would never work here" or "It's just not feasible".
- \* It often helps to reassure people if they can see the innovation in action, even on a small scale.
- \* That sometimes it is better to talk about an experiment, rather than an innovation.

This strategy involves identifying one aspect of the desired change and concentrating all efforts on this small scale version - a mouse rather than an elephant. For example, if your aim was to improve alcohol education by the use of active learning methods throughout the school; you would initially organise an experimental short course, with selected participants, taught by a small group of highly committed, competent staff. The course would have limited objectives, and be so planned that its success would be more or less guaranteed. This would act as a demonstration, to convince others of its value and practicality, in order to organise more, and similar courses.

Like the Trojan horse, the mouse enables you to break through the walls, and once you have gained access, you are more likely to have longer term success!

### **Staff Training**

You will need to consider the training needs of staff, and how to meet these needs.

It is likely that some many staff will feel lacking in confidence to take on board health education. They may worry that they have not the relevant expertise, that their knowledge is inadequate or that they will not know how to respond in certain situations.

It is important that they have a chance to explore what is involved in health education and to experience it for themselves. They may need an opportunity to clarify their own values and to consider their motivation in becoming involved in health education.

Training may be necessary on individual health topics, or on methods and approaches for use in school. The aim should be to develop techniques which take the teaching beyond knowledge gain, and which work to develop attitudes and skills related to health issues.

Further assistance in the formation of training programmes can be found in the European Network of Health Promoting Schools manual " Promoting the Health of Young People in Europe".

**CHAPTER 6**  
**EVALUATING SCHOOL HEALTH**  
**PROMOTION PROJECTS**

**Summary**

This final chapter, before presenting actual case studies from schools in Europe, explains why assessment should be a essential systematic process, governed by precise methodological rules.

Key elements are elaborated upon with regard to: investigation, indicators, and methods to be used. This strict methodology (rarely implemented) is illustrated by presenting some of the tools which could be used.

Finally, the chapter stresses the need to process the results of the evaluation in order to compare them to the objectives which were originally drawn up and to produce new proposals for future work.

Evaluation is an important and integral part of any health promotion project or programme. It may be useful to think of evaluation in terms of measuring impact in some way. More specifically: **evaluation is a systematic, continuous process of objectively assessing the extent to which a project has achieved the pre-set goals. It is a set of methodological procedures to appreciate the adequacy and efficiency of an action.**

Given this definition it is critical that you develop an appropriate evaluation 'tool kit' to monitor change and outcome or goals, and to interpret results.

## **Key questions**

In designing a strategy for evaluation it is helpful to ask a number of key questions at the outset.

1. **What are the purposes of the evaluation?**  
or Why do we want to evaluate our health promotion provision?
2. **Who is the target audience?**  
or Who needs to know the result of the evaluation?
3. **What is the focus of the evaluation?**  
or What specific topics/ issues/activities should be evaluated?
4. **What are the specific objectives of the health promotion project or programme?**
5. **What performance indicators will be used?**  
or How will we recognise that we are achieving our objectives?
6. **What information sources and data-collection methods will be used?**
7. **What evaluation instruments will be used?**  
or How can we encourage a consistent approach to evaluation?
8. **How can the data be analysed and used to aid future project development?**  
or What judgements can be made based on the information collected, and how can these be reported effectively to aid the review process?

Some possible responses to these questions are explored in the following sections.

### **What are the purposes of the evaluation?**

It is important to decide at the very beginning why you are evaluating. This will have implications for the type of evaluation to be undertaken.

The primary purpose of any evaluation should be to improve the quality of the education provision and monitor progress towards a health promoting school. It is important to involve teachers, pupils and others in the evaluation process.

From time to time, schools may wish to review the overall effectiveness of their health promotion programme, and the appropriateness of its goals. Such a major review is more manageable when more limited evaluations have been a regular feature of the school practice, and have provided a sound information base on which to draw.

For example, if you wanted to evaluate health education teaching programmes, the purpose might be to :

- determine progress in pupils' knowledge, understanding and skills in specific topics of health education;
- note any changes in pupils' attitudes, values and health behaviour in response to a unit of work;
- assist with future planning and management of the curriculum;
- acknowledge success and encourage the extension and replication of successful activities.

### **Who is the target audience?**

In planning and designing an evaluation process it is important to identify at the outset the audience or audiences for whom the evaluation is intended.

Audiences might include individual teachers, subject departments, local health services, headteachers and parents. Different audiences will have different concerns. For example, individual teachers may want to focus on the effectiveness of their own teaching in terms of pupils' interest, development and achievements. Senior staff may be more concerned with the efficient deployment and use of resources. Clearly the audience will affect all elements of the evaluation design.

### **What is the focus of the evaluation?**

It is unlikely that there will be sufficient resources and expertise to tackle all aspects of your health promotion work in a single evaluation process. At the outset, therefore, you will need to establish priorities. What are you going to evaluate?

Evaluation is more manageable if it deals with a specific component for a specific group (eg. a year group or a particular group in the community). The evaluation could be undertaken on the basis of a rolling, progressive programme. Decisions have to be made as to which components or issues should be evaluated in some depth, and in which order.

### **What are the specific objectives of your health promotion project?**

A major purpose of evaluation is to measure the progress made towards general AIMS or GOALS, since these are the guiding lights of all health promotion.

Details on defining aims and objectives have already been discussed in Chapter 5.

### **What performance indicators will be used?**

Measuring progress towards a specific objective and aim is helped if you have devised performance indicators. These are 'markers' or 'signals' which indicate movement towards the achievement of the objective. They are not themselves objectives or general statements but are the means by which teachers can recognise success (or failure).

The performance indicators define the sort of evidence that needs to be collected. For example:

**Aim:** To provide pupils with accurate information about health matters.

**Specific Objective:** To develop pupils knowledge and understanding of the facts about smoking including its effects.

**Performance Indicator:** Percentage of pupils' whose assigned work on the subject is completed to a satisfactory standard (or better) measured against agreed criteria.

**Source of Evidence:** Sampling and scrutiny of pupils' completed work.

Written work is not the sole indicator of pupils' knowledge and understanding. It is possible to see evidence of achievement in oral or practical work. However, the quality of written work is an important indicator of pupils' success in learning, and thus is suitable for evaluation purposes.

Performance indicators, and indeed the objectives to which they relate, may need to be refined throughout the evaluation planning process. Each stage in the process often raises queries about earlier decisions so that, for example, framing data collection questions may require a redefinition of the performance indicator or clarification of the objective. This refining process helps sharpen, not just the evaluation, but also the educational objectives, and hence has benefits beyond the evaluation itself.

### **What information sources and data-collection methods will be used?**

A wide range of data collection methods may be used , for example:

- \* interviews;
- \* questionnaires
- \* quizzes;
- \* observation of activities and behaviour in the classroom and elsewhere;
- \* videos;
- \* scrutiny of pupils' work (course work, diary, draw and write work);
- \* analysis of test/examination results.

The choice of which method(s) to use will depend greatly on the precise nature of what is to be evaluated. However, it will be important to weigh this choice against practical considerations - what information could be collected without any disruption of normal practice?

It is important to consider whether the instruments devised for data-collection will actually measure what they are intended to measure. The validity of the method is basically the extent to which the data collected is what the evaluator set out to record. One way of strengthening validity of data is to employ more than one data-collection method or to collect data from

more than one source. This is known as triangulation. It is recommended that whenever possible a mixture of data-collection methods and information sources should be used.

Although the choice and design of data-collection methods falls largely to the evaluation team, the actual data-collection may be carried out by many other staff. This requires sensitivity, recognising others' existing workloads, and gaining co-operation. It helps if existing recording procedures are incorporated where possible to avoid additional work.

### **What evaluation instruments will be used?**

To encourage a standard approach it is helpful for all those concerned to use shared evaluation instruments. These need to be practical, user-friendly tools for the people who will have to work with them.

It will help if a specific proforma is developed, and used for each area targeted for evaluation. This proforma should define the aim and specific objectives being evaluated and also one or more relevant performance indicators. It should also indicate the information source, i.e. where and how the data can be obtained; and the data to be collected.

A possible proforma is given below:

**Evaluation planning proforma**

Aim	
Specific objective:	
Aspect of health promotion:	
Target group:	
Performance indicator(s):	
Information source (where and how the information can be obtained):	Data to be collected:

INFORMATION SOURCE	METHOD	MAJOR ADVANTAGES	MAJOR DISADVANTAGES
People e.g. staff, pupils, parents, employers	Questionnaire	<ul style="list-style-type: none"> <li>* Collects information from a large sample cost-effectively</li> <li>* Yields specific and comparative data</li> <li>* Allows respondents to remain anonymous</li> </ul>	<ul style="list-style-type: none"> <li>* Time consuming to write and analyse</li> <li>* Questions can be misinterpreted by respondent</li> <li>* Responses may be superficial; in-depth questioning difficult</li> <li>* Questions may miss some important facets</li> </ul>
	Interviews and conversations (one-to-one or group)	<ul style="list-style-type: none"> <li>* Follows up responses, checks initial information</li> <li>* May reveal interviewees' real perceptions/attitudes</li> <li>* More flexible and friendly than paper exercise</li> <li>* Group situation may encourage individuals to speak more freely</li> <li>* Groups allow the views of more individuals to be collected.</li> </ul>	<ul style="list-style-type: none"> <li>* Time consuming to plan, administer, write-up and analyse</li> <li>* The interviewer can influence the interviewee in a one-to-one situation</li> <li>* A group may be dominated by one or two individuals</li> </ul>
Statistics, reports and other records of past events.	Analysis of documentary/data base sources, including reported assessment of pupils' work.	<ul style="list-style-type: none"> <li>* Provides a record of events over a period of time</li> <li>* Provides a useful overview where data are readily available, and is a cost-effective source of specific and detailed information</li> <li>* Provides a longer-term view encompassing several weeks/months</li> <li>* Easily accessible with minimal disruption to normal practice</li> </ul>	<ul style="list-style-type: none"> <li>* Records may be incomplete, inaccurate, or out of date</li> <li>* May be difficult to collect, collate or analyse data presented in an inappropriate form</li> <li>* Limited in applicability.</li> </ul>
	Analysis of planning documents	<ul style="list-style-type: none"> <li>* May provide an indication of the state of development uninfluenced by the evaluator's presence/questionnaire</li> <li>* Gives rapid overview</li> <li>* Helps target aspects for in-depth evaluation and assists evaluator's understanding of the context.</li> </ul>	<ul style="list-style-type: none"> <li>* Reality may not match rhetoric</li> <li>* Detail may be insufficient for evaluation purposes</li> </ul>
Teaching /learning situation	Observation	<ul style="list-style-type: none"> <li>* Direct, 'first-hand' information</li> <li>* May reveal facts not anticipated by evaluator</li> <li>* May provide feedback from evaluator to teacher</li> </ul>	<ul style="list-style-type: none"> <li>* Observation may alter learning environment, inhibiting both staff and pupils</li> <li>* Observation and analysis are time-consuming</li> <li>* Risk of subjective judgements</li> <li>* Only provides a snapshot</li> </ul>

## **How can the data be analysed and used to aid development?**

The evaluator's role is to analyse, synthesise and present the data in a comprehensible form in order that specific judgements can be made. This process can involve some or all of the following stages:

(i) Analysis:

- \* immersion in the data - familiarisation with, and a preliminary organisation of, the raw data are important first steps in the analysis procedure;
- \* sorting and grouping the data - this sorting will very much depend upon the evaluation focus, but could include sorting by target group, gender, ability, linguistic background etc.

(ii) Synthesis:

- \* comparing and contrasting - looking for areas of commonality and agreement in the data and also areas of specific contrast and direct contradiction;
- \* drawing conclusions - patterns and trends which emerge from the evaluation data will provide the basis for making generalisations and should be translated into general findings and overall conclusion;

(iii) Presentation:

- \* providing a brief analysis and summary of the evidence collected through the evaluation;
- \* making recommendations accordingly or offering alternative courses of action in the light of these findings.

The evaluators need to adhere to the rules of confidentiality and anonymity in report writing. They should also be prepared to take feedback on the report as it is important that those affected by the evaluation agree a response to the report. The report should be viewed in relation to other information, much of which will have been gleaned in the daily business of working in or with the school. In this way the evaluation can be a tool to aid development.

**CHAPTER 7**

**CASE STUDIES**  
**EUROPE AGAINST CANCER**

## **CHAPTER 7**

### **CASE STUDIES**

As already mentioned, this guide is intended for those involved in health promoting schools in Europe. In this chapter seven case studies are presented, which reflect the diversity of our cultures and our approaches to education. Each is related in some way to one or more elements in the Europe Against Cancer 10 Point Code.

Each case study has the following structure:

<p style="text-align: center;"><b>Background</b></p> <p style="text-align: center;"><b>Objectives</b></p> <p style="text-align: center;"><b>Participants</b></p> <p style="text-align: center;"><b>Methods and actions</b></p> <p style="text-align: center;"><b>Outcomes</b></p> <p style="text-align: center;"><b>On reflection</b></p>
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These case studies are in no way intended to be presented as models. They are merely illustrations of the work done by people on the ground who, with their good sense, experience, hesitations or certainties, are all striving for the same aim - that of promoting health.

## **CASE STUDY 1**

### **NINE SCHOOLS IN FRANCE FIGHTING AGAINST DRUGS**

**"Moderate your consumption of alcoholic drinks, beers, wines or spirits "** (Point 2, European Code Against Cancer).

#### **Introduction**

In France there is a very acute drug problem and the idea that hashish consumption is common place is gaining ground, especially in the minds of young people.

There is one school of thought which seeks to legalise this type of substance and which would like to see a change made to the fairly strict law of 1970 on this issue.

In the face of these trends, those in charge of schools are having to manage difficult situations with consumers of toxic products (most often outside the perimeters of the school), with pupils whose behaviour is altered by taking substances, and with parents who are more often than not ignorant of their children's illicit practices.

In the face of these problems, which most often manifest themselves in the form of absenteeism and demotivation at school, all sorts of experiments are being carried out but the difficulty remains in assessing the validity of the action taken.

## **Background**

Tours is a large conurbation of more than 200,000 inhabitants situated on the Loire and linked to Paris, which is 220 kilometres away (less than one hour by TGV). Parisian dealers can very quickly supply their "stuff" and melt back into the capital.

Tours is a city cut in two by the Loire and with different aspects in the city centre, to the north of the Loire and to the south. North of the Loire, where the majority of the population is not well-off (manual workers and unskilled staff for the most part), there are 9 secondary schools made up as follows: 2 grammar schools, 2 vocational high schools and 5 middle schools. More than 6,000 pupils, including some from neighbouring fringe districts, attend these establishments, which are served by urban or suburban buses.

## **Objectives**

When school resumed in September 1992, having been recently appointed to a middle school in this area, and being very aware of the issues of drugs and health in general, the headteacher sought to convince the other heads in Tours-Nord that a large-scale preventive programme should be implemented in view of the constant increase in the circulation and consumption of toxic substances by pupils. The massive consumption of alcohol was another determining factor in this desire for action.

The essential objective of this joint mobilization of nine schools was to make all those involved with social life aware of these drug problems and to promote action tailored to the needs expressed by young people on this issue.

## **Participants**

A school brings together various participants (parents, pupils, teachers, administrative staff, head teachers) and works with partners within its environment. The first difficulty is that of mobilizing these very different groups to work on a joint preventive programme. To be able to carry out such unifying work, it is necessary in the first place to explain the objectives being pursued to those people within the school and their partners outside it.

In this initial step, the head teachers concentrated on their people whilst two school social workers canvassed all those who had close or distant contact with young people in their daily lives (associations, neighbourhood committees, traders, institutions, etc.)

## **Methods and action taken**

The very important consciousness-raising task constituted the initial phase. It was followed very soon after by a meeting intended to ensure that everyone was aware of the objectives of the plan, and by a discussion, led jointly by staff from the National Education Department and a psychiatrist specializing in drug-related issues.

A work plan was drawn up, divided into the following phases:

- details of the needs expressed by the pupils on these issues of how to prevent the consumption of toxic substances.
- analysis of these needs with regard to each establishment.
- establishing the main themes on the basis of the needs of all these establishments and determining the objectives of the plan.
- listing these objectives in order of importance.

- putting in place measures to be carried out jointly by all the establishments and those specific to each establishment, the roles being distributed according to those taking part, school staff or partners.
- assessment of the action.

## **Results**

At this stage it is too early to be able to speak of results as the needs analysis phase is still under way.

For the pupils in the five middle schools, the question posed is the following: "If today you had to say or shout something important to the adults, what would it be? You can write it, or you can draw it....."

The first results show major differences between the levels of the classes being studied, with the younger pupils in the 1st year of secondary school tackling fewer subjects than those in the 4th year. [\*1]

\*1 Normally, the French system for numbering school years is the reverse of the British system, ie 6ème = 1st year. However, in this case the context suggests that '1ère année' precedes '4ème année'.

Generally however, the main themes tackled by the pupils were as follows:

communication	living environment	natural environment
drug add	war	pollution
iction	ill-treatment	humanitarian aid
AIDS	will to live	violence
sexuality	unemployment	
racism		

We can already gauge the impact on young people of major social phenomena, but it is necessary to combine all the results (not yet obtained) in order to determine jointly in which direction the partnership work is to be conducted.

### **On reflection**

The work that has been started, to create a new relationship between pupils, families, partners and teaching staff, must be continued for at least three years. In the absence of an assessment, it is interesting to note the extent to which, in young people's eyes, the school acquires a new legitimacy, when co-operating with its environment on problems that affect them.

School is no longer the disembodied entity which is rejected. Instead, having become part of the social context of the city, it is better understood and therefore better viewed. In these circumstances the prevention messages will gain credibility.

The point on which the success of such a plan is fully dependent remains of course the level of involvement of the pupils in the whole process. If the needs are assessed by the adults without being those truly expressed by the young people, the plan will become a fiasco.

On the other hand if an honest attempt is made to provide responses to real questions, we will be able to proceed a long way with the prevention work and the pupils involved will surprise us with their ability to undertake things, to set things in motion and to strive to adopt responsible forms of behaviour.

This plan can be applied to all possible subjects, and of course we are thinking of the prevention of all behaviour which involves risk but also the acquisition of life habits which on their own are able to reduce certain diseases such as lung or throat cancer for example.

## CASE STUDY 2

### HEALTHY EATING IN SCOTTISH SECONDARY SCHOOL

**"Frequently eat fresh fruits and vegetables and cereals with high fibre content"** (Point 5, European Code Against Cancer).

**"Avoid becoming overweight and limit your intake of fatty foods"** (Point 6, European Code Against Cancer).

#### **Background**

The effect of a health promotion initiative relating to healthy eating on the knowledge, attitudes and behaviour of S2 pupils was investigated in three Scottish secondary schools. This was undertaken by comparing pupils in a case study school which had introduced a healthy eating policy, with pupils in two control schools. This case study features a school (school A) which had developed a healthy eating policy over a period of several years as part of a whole school approach to health promotion.

The school's initiative had evolved through discussions with pupils, parents, teachers, school meals staff, health education staff and dieticians. Over a period of time prior to the research being carried out, changes were made to the food and drinks available for snacks and meals in the case study school and these are summarised in Table 1.

The case study school was compared with two control schools which are of a similar size with approximately 900 students aged 12 - 18 years and have similar socio-economic profiles. The schools are all in the east of Scotland.

## **Participants**

The sample of pupils used for the study were mixed ability groups of 14 year old pupils in all three schools.

## **Methods**

The evaluation involved the following:-

- \* the development of a pupil questionnaire, on the knowledge, attitudes and behaviours of the pupils in relation to healthy eating, which was completed under classroom conditions;
- \* a structured interview with several staff in each school;
- \* the utilisation of education department census data on the uptake of school meals.

## **Outcomes**

Significant differences in eating behaviour were demonstrated with pupils in school A showing healthier snack selection at school and a higher level of uptake of school meals than the controls. There was evidence that wider factors outside the domain of the school, reduced the impact of the case study school's achievement.

The school meal census data revealed that the percentage of pupils choosing a school meal was consistently higher in school A than in the control schools and this difference was statistically significant. This was consistent with information supplied by the headteachers and a similar trend was observed in the sample of 14 year olds, although in this case the difference was not statistically significant .

Important differences were observed in the snacks taken between breakfast and lunch, with pupils in school A having fewer and healthier snacks than pupils in the controls.

### **On Reflection**

In all three schools the scores on the knowledge items were high and there was no significant differences between the means scores of pupils in the three schools. When these were analysed by gender, it was revealed that the girls in one of the control schools B performed significantly better than either boys or girls in the other schools. Most of this variance was due to the responses to the two questions on dietary fibre. Pupils in all schools who answered the knowledge question on dietary fibre correctly were more likely to have eaten a cereal breakfast that morning. This does not necessarily mean that the relationship between knowledge and behaviour is a causal one, and it does not indicate in which direction cause and effect might operate. Pupils might be learning about the fibre content of cereal from their packets or choosing to have a breakfast cereal because of their knowledge. Further qualitative work would be needed to try to tease out the nature of this association.

School A appears to have successfully influenced the type of snacks which the pupils consume during the time spent at school and this is a considerable achievement. However, there was no evidence that these behaviours were consistent in other settings. For example, although fewer pupils in school A consumed sweets or fizzy drinks at the morning interval there was no significant differences between the pupils in the three schools in the frequency of consumption over a week (which included time out of school).

School A only provided milk in the semi-skimmed variety and yet out of school the pupils in school A drank full milk more frequently than pupils in the control schools as indicated by their responses to the questions on what they consumed at breakfast that morning and their reported frequency of consumption over one week.

The reasons why significantly more pupils in school A choose full fat milk are interesting. They may relate to the fact that more pupils in that school live in small villages near to the town the school serves compared to the controls. The Scottish Milk Marketing Board's own data reveals that low fat milk consumption is lower in rural areas and that a higher proportion of people in rural areas get their milk from home deliveries and that the choice of semi skimmed is not always offered. It is plausible that other traditional cultural factors in rural areas may inhibit changes from full fat milk to semi skimmed. This is an important example, because changing from full fat to semi skimmed has been shown to be one of the most effective single changes which could be made to the diet of an adult group, if the target was a reduction in fat intake.

It is suggested that issues over which the school has little influence may limit the effectiveness of aspects of a schools' health promotion initiative such as this. School A has involved parents in its initiatives, but there are clearly limits to it or any other school's responsibility for health promotion, and also limits to the extent that a school would wish to intrude into areas that might be seen as restricting parental choice. Health promoting schools need a social and physical environment that shares their vision.

### **Questions to consider**

School A had communicated with parents through the schools' handbook, through several newsletters and at parents' nights. Yet there was evidence that wider cultural factors, beyond the influence of the school, remained important influences in pupils' food selection.

**Is this the school's business?**

**How could the school have more effect on eating behaviour?**

The school has attempted to 'make the healthy choices the easy choices'.

**To what extent is a school justified in restricting choice (e.g. by removing high sugar products) from its premises?**

School aged pupils in Scotland have the highest consumption of sweets and confectionery in Europe and yet knowledge levels relating to which foods are high in sugar were excellent in all three schools in this survey.

**Are there other aspects of public policy which are needed to support the work of schools?**

ONE SCOTTISH SCHOOL'S CALENDAR SHOWING THE IMPLEMENTATION OF A HEALTHY EATING PROGRAMME

DATE	DEC.JAN.FEB.	MARCH	APRIL	MAY
F I R S T	Informal discussion within school following the observation that pupils were restricting their choice of food thus having an unbalanced meal.	Further meeting between school staff involved and headteacher to discuss way forward.  Decision to do a small scale survey.	Survey of a random sample of 60 pupils across S1-3 over four days.  The results supported the view that pupils are eating a nutritionally unbalanced mid-day meal.	Meeting attended by representatives of Education Catering Service, Area Health Education Officer, the kitchen supervisor, those school staff involved and chaired by the headteacher.  Decisions taken:
S E S S I O N	Headteacher contacted Education Catering to discuss matters of general policy.	Materials prepared ready for work in classes.  SHEG approached for guidance.		1. To issue a letter with survey results to all parents.  2. To remove certain foods in stages from dining-hall and to introduce others gradually.  3. To adopt a whole-school approach to launch the Healthy Eating Campaign.
	Contact established with Area Health Education Department.	Parental approval sought.		

DATE	JUNE 3RD-15TH: HEALTH WEEKS		AUGUST	SEPT. OCT. NOV.	JAN. ON		
F	Dining Hall - all confectionery replaced by a range of crunch and fruit bars. Canned fizzy drinks removed, range and number of fresh juice cartons increased. Proportion of brown/granary bread rolls increased. Whole milk replaced by semi-skimmed (standard and flavoured). Increased availability of salads. Salt located on a side table only, i.e. not immediately available.	S	Meeting - regular liaison re-established with Assistant Area organiser School Meals service and kitchen supervisor.	Dining Hall - Deep fried pizza and chips now oven prepared. Portions of dried fruit, nuts and seeds available. Standard crisps replaced by low fat and wholewheat crisps. Increase number of baked potatoes and variety of salads. Cream buns replaced by puddings, yoghurt, purees etc.	The Future - Remove all fizzy drinks, increase range of healthy alternatives. Increase range of salad mixes. Use of whole meal flour for puddings, cakes, crumbles etc. Examine alternatives to sausages, pies, white puddings, etc.  Continue to provide education on a regular basis; repeat Health Weeks.  Conduct a second survey and tabulate results.		
I		E	Recognition that this will be a long-term project.				
R		C					
S		O					
T		N					
		D					
S		S				School-fresh impetus given to nutrition education at Assemblies.	Another newsletter to parents reminding them, in summary, of the campaign.
E		E					
S		S				New 1st year introduced to guidelines and school policy.	
S		S					
I	I	A copy of previous session's Newsletter sent to all new S1 parents.					
O	O						
N	N						

**CASE STUDY 3:**  
**TOBACCO PREVENTION IN A PORTUGUESE SECONDARY**  
**SCHOOL**

**"Do not smoke. Smokers, stop as quickly as possible and do not smoke in the presence of others."** (Point 1, European Code Against Cancer)

**Background**

The Miraflores secondary school administers the official national curriculum. In the school year 1988/89 there were 1,350 pupils - boys and girls.

Most of the teachers and students live around the school area, which is a help in carrying out projects and activities.

The school is built in a valley, having on one side a residential area with a tower and well aligned buildings, inhabited by the middle and high-middle classes and, on the other side, a slum representing high risk groups concerning drug use and several forms of delinquency. A large number of people here have returned from the ex-Portuguese colonies. The economic and social contrast of the two neighbourhoods is quite evident.

Even so, since the opening of this school a high consumption of tobacco has been evident. It is forbidden to smoke in schools according to Portuguese legislation which is one of the most advanced of the European Community.

As to the educational context a recently implemented reform of the educational system considers a curricular space designated "School area". This goes vertically through the curriculum, as well as complementary activities, and is dedicated to the development of projects in the school.

The Miraflores secondary school is one of those that created in this country a "Tobacco or health nucleus", to which teachers and students belong, if they can identify with its objectives and methods. The greatest challenge of the "Tobacco or health nucleus" lies in offering attractive and convincing alternatives, so that more and more young people will choose health instead of tobacco and other drugs.

In our society there are, among others, two organisations with the objective of preventing tobacco addiction:

- The "Council for the Prevention of Tobacco Addiction", an inter-departmental organisation which supports integrated and motivated action to prevent tobacco addiction, under the Health Ministry.
- The "Tobacco or Health Movement" a non governmental organisation recognised by the Education Ministry, which supports school activities with the same objective.

### **Objectives**

- To investigate the reality of tobacco addiction in the present world and the harm caused.

- To promote activities which interest young people motivating them not to start smoking.
- To help those who wish to stop smoking.
- To contribute to the application of legislation against tobacco addiction in the school and in the surrounding milieu.

### **Management/staffing**

Since the opening of the school several teachers and directors have been very much interested in developing a new pedagogical approach. The teacher that launched this project is particularly interested in ecology and health, and the project dynamics attracted three other teachers of different subjects.

As a consequence of an agreement between the Ministry of Education and the "Tobacco or Health Movement" some time allocation was given to the teachers' co-ordinating team.

Some of the students also have co-ordination responsibilities for each activity carried out by the club.

### **Methods and Actions**

A group of students from different school years joined the teachers and decided to start a project concerning the environment. After some reflection they concluded that the school environment, especially the air we breath, was the issue to work on.

The work has been developed in two ways:

(a) **All-year round activities:**

- \* Football, handball games, races, gymkhanas happen periodically and they are called "games without smoke". Besides and related with these games, the breathing capacity of the smoking and non-smoking students is evaluated and compared. Sometimes games between schools take place.
- \* Data-processing: the purpose of this is, not only to analyse numbers related with smoking, but also to prepare a newspaper which is delivered on certain occasions.
- \* Art: songs and puppet sketches are composed to improve written and oral expression. Contests and exhibitions of drawings and posters are organised.
- \* Research and communication: Awareness activities aimed at the different sectors of the school have taken place.

A non-governmental organisation was asked to give training on how to quit smoking. These strategies for pupils and teachers were highly successful.

Some research on smoking habits was undertaken in cafes and restaurants in the neighbourhood, trying to make people aware of the already existing legislation.

(b) **Special celebrations**

Activities have been prompted at several events of the school year such as the reception of new pupils, end of terms or of the school year. On these occasions key messages are spread stressing the advantages of a tobacco free school and healthy holidays.

National and international days related with health are always celebrated and balloons containing anti-tobacco messages or newspapers are launched. Some balloons have been found in different places of the country and abroad and their messages answered.

Besides the nucleus itself, there is also the so-called "nucleus friends group" made of friends, school staff and parents that support the club or build on the idea in the games.

The school project has also been helped by the "Tobacco or Health Movement", the local authority, the "Council for the Prevention of Tobacco Addiction", the local scouts and the P.L.A.C. that offers financial help and some equipment.

Once the activities are performed, the club evaluates them whenever possible.

**Outcomes**

- Once the activities have been carried out the club evaluates them whenever possible
- .- The first achievement is the noticeable increase of non-smoking students in the school.

- There was a similar success in students' families as a number of parents also quit.
- Young people and adults involved in this work found it extremely rewarding, it enhanced the self esteem as well as interpersonal relationships developed within and outside the school.
- The club assumed that the value of its work depends mainly on the strategies used to approach and motivate students.
- Students felt that they developed a network between schools and a feeling of being on the same "side" in the battle.
- 'Quit training' courses had a huge success. Even some sceptical teachers quit having decided to follow the strategy of these courses.
- The club and its work have been recognised by the school, media and other institutions.

### **On reflection**

Some teachers felt very tired with the increased work, since the time allocated for this work was insufficient for the number of hours they had to invest simultaneously with the launching of the educational reform.

Funds are limited in spite of the creativeness shown by the group, so they sometimes faced financial difficulties.

Although the country's legislation on smoking is the most advanced in the EEC, the club would like to see strategies aimed at really respecting it.

Teachers involved in this action, although recognising the difficulties of evaluating health education projects, have reflected on the need for more adequate evaluation tools.

**CASE STUDY 4:**  
**EDUCATION FOR RELATIONSHIPS AND SEXUAL LIFE STYLE**

**"Have a cervical smear regularly."** (Point 9, European Code Against Cancer).

The development of cancer and sexual behaviour are clearly linked. Point 9 in the code identifies measures a woman can take to reduce risk of cervical cancer.

**Background**

A college in The Netherlands has about 500 pupils in the 12-16 age group and 40 teachers. Forty per cent of the multi-ethnic school population is of North African and Caribbean origin. It is one of several schools in one of 15 regions in the country that has realised a partial health care policy regarding sex education.

A region is defined by the existence of a network of various institutions, generally co-ordinated by the health promotion unit of a local Public Health Institute. Up to December 1994 almost 25% of all Public Health Institutes in the Netherlands will be co-ordinating such a network with possibly more to follow. These regional networks include workers from the Public and Mental Health organisations, the local Family Planning organisation, emancipation and school advisory organisations, representatives from the schools, and others. The network supports secondary schools in introducing relationships and sexual issues in the school work plan.

Under the banner of a 'Living Together' concept, regional networks help schools to discuss with pupils several issues regarding relationships and sexual lifestyle. In addition to biological and technical information, it involves information on different expressions of lifestyle and (homo)sexuality, on sexually transmittable diseases and learning preventive techniques, and it includes communicating norms, values and skills. The Living Together concept also focuses on breaking down conventional role stereotypes and the prevention of sexual harassment, of which these role stereotypes are a major cause. Education on all this is considered necessary for pupils to develop a personal lifestyle, with respect and openness for other lifestyles.

The college started a relational and sexual lifestyle project more than five years ago, following an incident of assault in the school, and it successfully sought the systematic support of an external network co-ordinated by the Public Health Institute.

Now the school is integrating this particular project into a more comprehensive policy on school health: the project has been a first step towards a wider policy.

#### **Aims/objectives of this case study**

- to illustrate the intrinsic motivations and needs of schools to implement a school curriculum in relational and sexual lifestyle as a partial health care policy.
  
- to clarify the conditions in terms of school organisation, external (network) support and overall communication structure to make an implementation strategy of this particular health care policy successful.

- to demonstrate that a school's experience in one health care topic - such as relational/sexual lifestyle can generate and facilitate the step towards a more general school health policy.

### **Participants/partners**

After a timid and gentle hearted boy at the college had been bullied and assaulted by a group of others in the toilets, the school team decided to set up a project on relationships and sex. The project was to contribute to the principles of the school's guidance system, aiming at mutual respect and openness.

With the support of the school management, a work group of teachers was set up. It was decided that the whole school team should be involved in the activities. The group asked the health promotion unit of the local Public Health Institute for support and two workers actively started to participate in the school's project. At the same time the health promotion unit had taken the initiative to co-ordinate a network with various other institutions, to support all local secondary schools in a partial health care policy regarding 'Living Together' issues.

### **Methods and Actions**

At the college the work group formulated a policy and a plan of activities. It also kept the school management and the team informed about all the steps to be taken. In a process of gradual implementation, it was decided to start in the first class with the relational lifestyle aspects and later in classes 2, 3 and 4 with different aspects of sexuality and (choices in) partnership and lifestyle. In this way they managed to reduce the issues to be discussed by all teachers in a certain class, and there was ample opportunity to discuss more specific bottlenecks.

As the more personal subjects became more easily talked about in the classroom and the staff room of the college, new issues arose for discussion: aggressiveness, drug and tobacco use, use of weapons, etc., and the need for a school policy in all these matters was more urgently felt. One organisational solution was found in having a 'mentor' for each class to discuss the different 'lifestyle issues' with pupils. Later 'lifestyle' became a separate subject in the curriculum for all 12/13 year olds in the first form. Also, 'confidential persons' for pupils were nominated.

From the start the 'external' health promotion workers of the local Public Health Institute - later to be backed up by other network partners - supported the school in consultation and advice, offering appropriate lesson and information material, organising workshops at school, courses for tutors, procedures for complaints, etc. One such point of advice was the supply of information on the relational and sexual lifestyles of different ethnic groups. Another major point was to support the teachers in answering their questions on discussing sexuality with pupils and give them more self-confidence in this field. Characteristically, the Public Health Institute's support also developed into the promotion of more general school health issues, in which the institute started to collaborate with other prevention institutes to fulfil specific needs of schools.

### **Achievements/Outcomes**

After five years' experience the college has a curriculum for four classes regarding relational and sexual lifestyle and a work group of teachers that will continue to co-ordinate and improve the programme and the guiding activities for pupils (mentor system, rules of behaviour, procedures for complaints of pupils etc). The curriculum has been structurally embedded in the work plan of the school as an important aspect of a school health care policy.

Moreover, other 'lifestyle issues' are more readily discussed in the classroom. Each class has a 'mentor' to do this, and the mentors of each year discuss their experiences with (individual) pupils regularly.

Since 1993 a subject called 'lifestyle' has been introduced into the curriculum for all pupils in the first form and the project on relational/sexual lifestyle has proved to be a first step towards a more comprehensive school health policy. Of prime importance: pupils are interested in and motivated for these lessons and teachers are largely enthusiastic, although the need to share problems and experiences remains invariably large.

The school has a central work group with a co-ordinator for the lifestyle project who keeps things going and takes care of up-to-date information and materials. The intense support of agencies from outside the school will be continued, partly to be supplied from a 'Living Together' regional network, co-ordinate by the Public Health Institute. This network has a wide spectrum of support, namely from institutions specialised in prevention of sexual harassment and other relevant relational/sexual issues.

The Public Health Institute also offers forms of support with other 'external' organisations, for instance in alcohol/drugs abuse.

The school's work group co-ordinator participates in the external network and in this way the needs of the schools are assessed and adequately dealt with.

## **Reflection/Evaluation**

The college opted for a lifestyle project in order to respond to real interaction problems among pupils. The project contributes to the creation of a climate of openness, mutual respect and non-discrimination, which stands central in the philosophy of the school.

Once a project on relational and sexual lifestyle had been successfully introduced into the school's organisation and curriculum, the first step had been made towards other health issues to be introduced in the policy of the school.

Conditions for a successful implementation have been the commitment of the whole school population (include school management), the internal organisation structure with a work group and a central 'health co-ordinator', the mentor system in the school, and the support from external 'health promoting networks'. Also, the smooth information and communication flow between the internal school organisation and the external supportive networks has been a determining factor for success.

## CASE STUDY 5

### ENVIRONMENTAL EDUCATION ON WASTE AND RESOURCES

**"Follow health and safety instructions at work concerning production, handling or use of any substance which may cause cancer."** (Point 4, European Code Against Cancer).

The environment, both in the workplace and beyond, can affect the health of the individual. Learning how to take action on environmental issues is crucial in addressing point 4 of the Cancer Code.

#### **Background**

This is a Case Study on Environmental Education from a school in the Jaegerspris municipality in Denmark.

The school is participating in the joint Nordic project "Environmental Education in the Nordic countries" (MUVIN), which focuses on the themes of conflicts of interest, ethics and aesthetics in schools' work with environmental problems.

The school has pupils from first to tenth grade (5-16 years old). An eighth grade (age about 14) worked with waste as an example of an environmental problem during the school year 92/93.

## **Aims**

The project aimed at developing the pupils' ability to take action in the environmental sphere, so that they could take actions (now and in the future) that conserve and improve the environment. The primary long-term aim was to ensure that future generations could live a satisfactory life.

Work at uncovering conflicts of interest was considered a necessary precondition.

## **Participants**

Participants in the project were 17 pupils and two of the class teachers. One of the teachers taught the class Danish and, in addition, was class teacher, while the other teacher taught the class Biology, History and Religion. During the project, several key people from the local community also collaborated.

A consultant participated from The Research Centre of Environmental and Health Education at The Royal Danish School of Educational Studies, which is responsible for teachers' in-service training in Denmark. The consultant's job was to support the teachers and discuss the project with them.

## **Methods and Actions**

The actual project can be divided into three periods: a preparatory period, an intensive 4-week project period and a follow-up and finishing treatment period.

## **Preparation**

The teachers agreed from the start that the pupils should help to decide what the subject was to be.

In May 1992, the primary idea of the project was presented to the pupils who were immediately positive. Then the pupils in groups prepared lists of the environmental subjects that worried them most.

On the basis of the pupils' wishes and the teachers' deliberations, it was agreed to work with the subject of waste. A local environmental problem was chosen because it would be easier to involve people from the local area and to make an action plan. The problem formulated jointly by the teachers and pupils was: "Why is waste a problem in our society today, how has the problem arisen and how can we help to solve the problems associated with waste?"

In August the project was presented to the parent group who were positive, suggesting ideas and making comments. Dialogue with the parents was important because private households would be involved in the project.

## **The intensive 4 weeks**

In this period, September/October 92, all the class lessons dealt with the project.

Activities and experiences were used in this first phase to help the pupils get an insight into the problems associated with waste. Discussion of films and articles, visiting a composting plant, visiting a waste disposal plant, compost trials at the school, analysis of packaging, etc., were the means used to try to achieve this insight.

The teachers tried to focus on the conflicting interests in the subject and make them visible. This was done while reading different texts, when preparing questions for the works manager at the joint-municipal composting plant and during discussion of the films. The teachers and pupils jointly tried to develop techniques for interviews, analysing texts etc., which could reveal possible conflicts of interest in society and put them in focus.

A 'waste happening' was also planned for all the 6th, 7th, 8th and 9th grade classes in the following week to arouse attention and widen the scope of the discussions. In this phase, a pupil press-group worked with articles and approaches to the local newspapers. The local papers were invited to the 'waste happening'.

The waste happening, for which the pupils themselves were responsible, focused on how much households contributed to the amount of waste. During the first week, the pupils at home had kept an account of their families' waste production. At the waste happening, they made a waste mountain, to show the class' total weekly production of waste. They also performed a sketch about different shopping habits, displayed placards and made compost trials for the rest of the pupils in the school. Five articles appeared in the local papers before and after the happening.

In the second phase, aimed at elucidating the background for our waste problems, the pupils' grandparents were invited to talk about waste "long ago".

In the third phase, the action aspect was in focus. First, this was done by learning about organisations/authorities who have an influence on environmental and waste problems. For example, they learned about (and visited) Greenpeace, questions were prepared and a visit arranged from a representative of the municipality's technical administration and the chairman of the municipality's environment committee.

Second, the class itself prepared a catalogue of possible actions concerned with waste - a total of 31. The idea was that the class itself should start specific actions on the basis of their insight and the values that had been discussed. After joint discussion of all the proposals, the class proceeded to an "advisory" vote (where the teachers did not have a vote), and the class decided to start initiatives in 14 of the 31 areas.

The 14 actions were directed at the school (a paper re-cycling container, red and green sorting in the school, compost container for home economics, etc) and at the local community/family (write letters to the newspapers about people's shopping habits, give information about the toxic substance PVC etc.)

### **Follow-up phase**

In this period work with the project was done only in the lessons where the teachers had the class beforehand. The actions that had been adopted had now to be put into practice and the barriers that were encountered had to be discussed and, if possible, surmounted.

## **Outcomes**

Actions were initiated in the school as well as in the local community. One group built a compost container for the school, while another group worked at controlling the school's recycling arrangements for cardboard and paper. A third group worked on a slide-series about waste, a fourth at writing letters to the newspapers and fifth at finishing a folder entitled "Boycott PVC". This folder was also sent as a letter to one of the local papers. Others wrote letters to a large industrial company concerning their use of polluting packaging containing PVC.

As the slide-series was completed, other classes were very interested in borrowing it and several of the pupils in the class were "lent" to other classes to present and comment on the slides.

## **Reflection**

Subsequent interviews with pupils (and teachers) showed that the project had lived up to the aim of inspiring the wish and ability to act in the environmental sphere.

An absolutely crucial precondition for the success in maintaining and reinforcing commitment and knowledge about the serious environmental problems was that, throughout the project, the pupils had a great degree of influence (on choice of subject, choice of action, etc). Subsequently, the pupils expressed the feeling that it had been "their own" project.

Another precondition was the dialogue with the pupils' parents. The parent group was informed and involved during the project, and had therefore backed it up all the time.

A third precondition was that the starting point was a problem that really existed in the local community. So the teaching was authentic. This is why it was possible to have direct experiences with the local community and key people from it.

A fourth precondition lay in team-teaching. Both teachers were present all the time and could support and inspire each other. Both teachers said that it was fantastically valuable not to "stand alone".

A fifth precondition concerns the in-service training dimension. Critical questions as well as comments and course work proper from the "external" consultant supported the teachers during their planning.

**CASE STUDY 6:**  
**THE HEALTH PROMOTING SCHOOL IN WALES**

**"Do not smoke. Smokers, stop as quickly as possible and do not smoke in the presence of others."** (Point 1, European Code Against Cancer).

**"Frequently eat fresh fruits and vegetables and cereals with high fibre intake."** (Point 5, European Code Against Cancer).

**"Avoid becoming overweight and limit your intake of fatty foods."** (Point 6, European Code Against Cancer).

**Background**

In Wales a joint programme was set up between Health Promotion Wales (HPW), the national health promotion agency, and the Curriculum Council for Wales (CCW), the body with responsibility for the implementation of the National Curriculum in Wales. This programme aimed to support teachers by developing, evaluating and documenting examples of practical approaches to health education including its co-ordination and management; and in particular, examples of health promoting schools.

All schools were invited to submit proposals for developing as a health promoting school by considering one area of health. They were asked to co-ordinate work in the curriculum with work in the school environment and/or work with the family and community.

The following case studies from individual secondary schools are the result of a year's work in these schools, and are largely reproduced from *The Health Promoting School in Wales*, CCW/HPW, 1994.

### **School A**

School A is an 11-18 school with 1150 pupils and 66 teachers. The school has a well-developed personal and social education (PSE) programme in which all pupils receive one half hour lesson each week. This school is situated near a motorway and a number of industries and is concerned that a large number of staff and pupils suffer from respiratory problems.

### **Aims & Objectives**

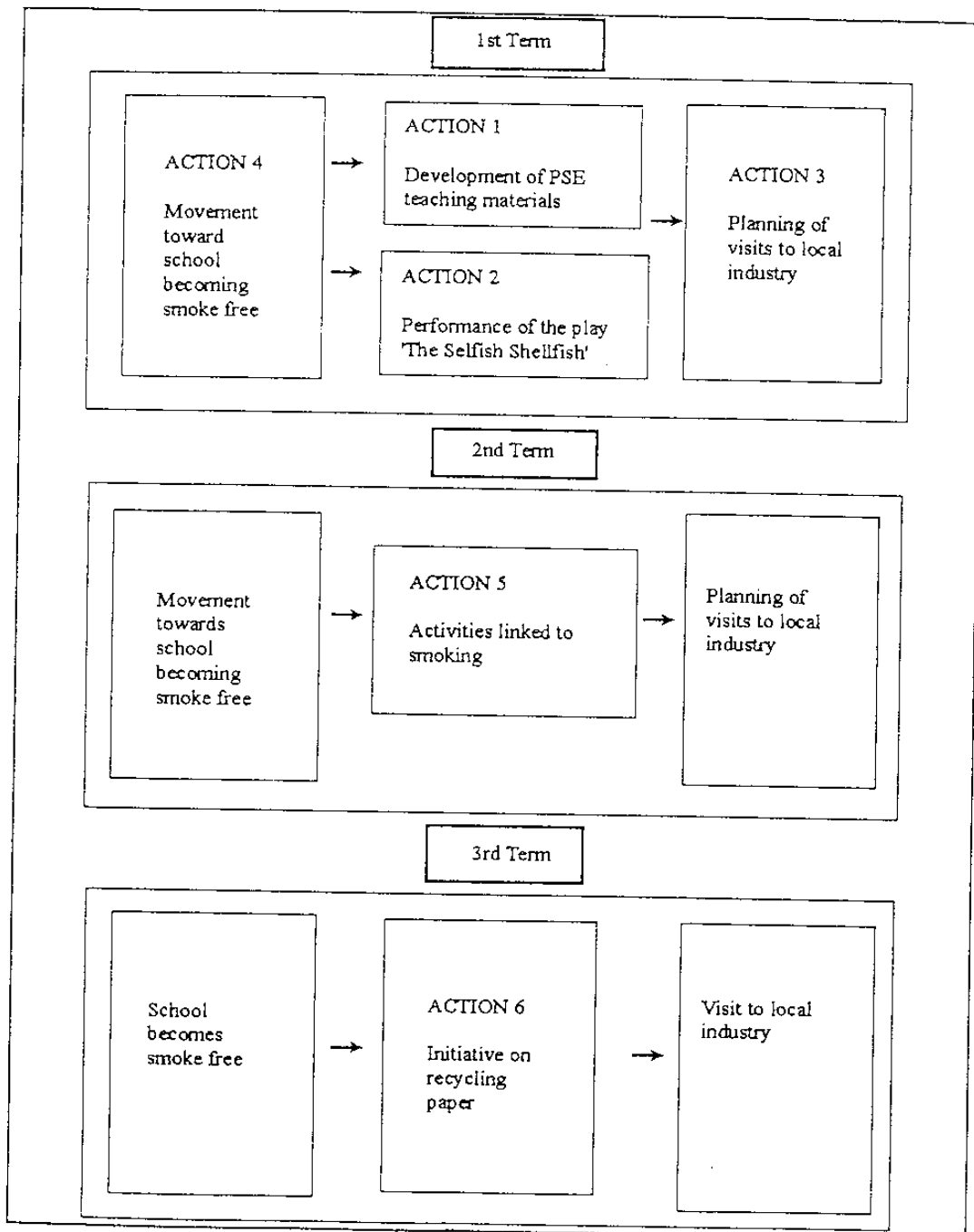
#### **Aims**

To consider the environmental aspects of health education.

To consider smoking as an environmental issue.

## Objectives

To undertake a series of activities as indicated on the flowchart below:



## **Participants**

The project was co-ordinated by the teacher in charge of personal and social education. Funding was provided by CCW to allow this teacher to be released from her teaching commitment for 7 days during the year.

Discussions took place at the start of, and during, the project with the officer from HPW/CCW and the health education advisory teacher from the local education authority.

## **Methods and Actions**

The school planned and embarked upon a number of initiatives linked to pollution and smoking. Some of these activities have become embedded in the school's curriculum and environment, e.g. the teaching and becoming smoke free. Other activities have happened which may or may not be repeated in future years. These are special events which have been used to raise awareness of the issues related to smoking.

**Action 1** Six weeks of PSE provision with Year 8 (12-13 year olds) was given to the topic of pollution. Materials were produced by staff and used in draft form before being modified for use in the next academic year. Pupils considered specific problems as they related to the school e.g. they performed a survey to identify litter problems in the school grounds. As a result many litter bins were resited and are now being well used.

**Action 2** Year 13 pupils (Age 17-18) performed the play *The Selfish Shellfish* for all Year 8 pupils and for pupils from the associated primary schools. The play dealt with the topic of marine pollution. The play was used as a starting point for the PSE work on pollution in the secondary school, and was also used to initiate work in the primary schools.

**Action 3** The school tried to arrange visits to local industries to investigate the measures taken by them to combat pollution. The programme of visits did not materialise as hoped for the academic year in question. However, some visits for the next academic year have been confirmed with local firms responsible for land fill.

**Action 4** The school started to move towards becoming smoke free by entering a transition period of one term during which staff were allowed to smoke in one designated room only. During this time staff were increasingly vigilant in the school grounds to prevent any pupils smoking on the premises. Pupils were generally responsive to the argument that if staff couldn't smoke then neither could they.

**Action 5** A number of activities were developed linked to smoking;

- . PSE lessons in Year 8 covered the topic of smoking as a natural extension to the work on pollution.
- . Pupils in Years 7, 8 and 9 (11-14 year olds) were invited to enter a competition to design a T-shirt focusing on the problems of pollution including smoking. A cash prize was awarded and the winning design was printed onto a T-shirt for the winner.
- . Discussions began with a local voluntary organisation to provide smoking cessation sessions for pupils, initially targeting girls aged 14-15.

**Action 6** A 'pilot' paper recycling activity took place. One Year 8 class publicised the activity and organised the collection of waste paper. A local firm provided a skip as a paper collection point on a short term basis.

### Achievements/Outcomes

- . The PSE programme for Year 8 now contains materials on pollution and on smoking as an environmental issue.
  
- . Links were developed with the local primary schools through the production of the play *The Selfish Shellfish*. These links were used to jointly plan work on an area of health and it is hoped to follow this up with work on other areas of health in the future.
  
- . Some visits have been arranged to local industry so that the pupils can explore the opportunities used by industry to minimise pollution.
  
- . The school has limited smoking in the school to one small room which is not in an area visited by pupils.
  
- . Smoking cessation classes have been set up for 14-15 year old girls. It is hoped that if peer leaders attend these classes, then others will follow.
  
- . The school is repeating the activity on the recycling of paper and hopes to start recycling cans also.

## **Reflection/Evaluation**

The development of a plan of action helped to sort a number of separate activities into a coherent whole.

In some cases the time needed for planning of activities was much longer than anticipated eg. the arrangements of visits to local industry and the setting up of smoking cessation groups. However, the school has shown a long term commitment to health promotion by planning these activities into the next academic year.

The school found it beneficial to start off some actions as pilot projects or transition periods and then to build on success e.g. becoming a smoke free zone, setting up a recycling facility.

The school has worked towards health promoting school principles by considering the school environment, e.g. litter, smoke, and by linking with the community to develop social awareness in terms of recycling and keeping the school smoke free.

## **School B**

### **Aims & Objectives**

#### **Aim**

School B is an 11-18 school with 900 pupils and 56 teachers. The school does not have a timetabled PSE lesson. School lunches are provided by contract caterers who also provide a morning snack service. Snacks are also available from the school tuck shop which is run by pupils. A soft drinks machine is situated on the school premises.

To improve the nutrition of pupils in the school in the 11-14 age range.

## **Objectives**

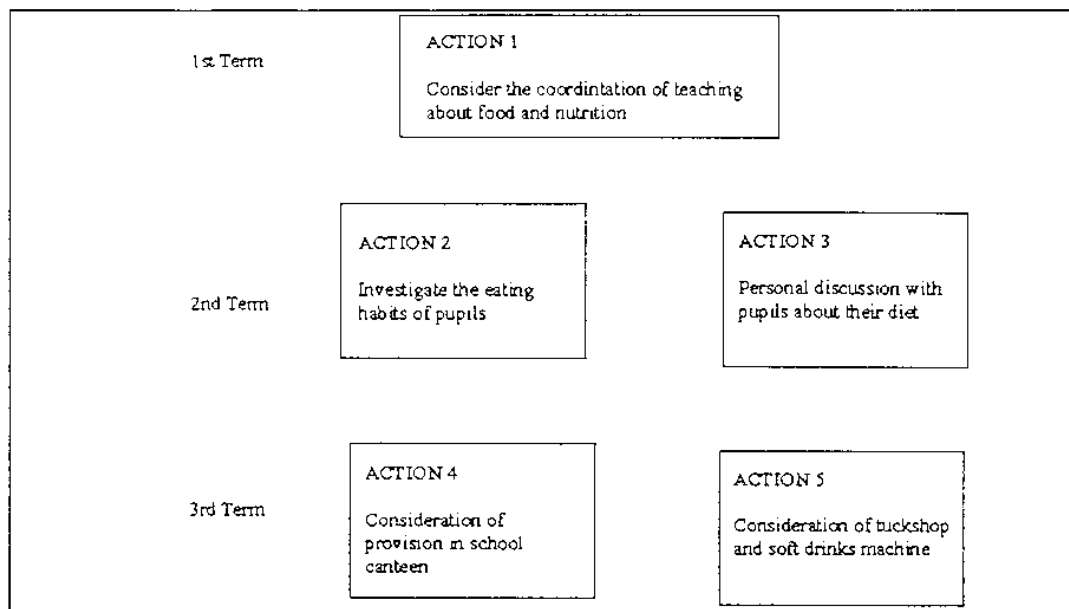
To undertake a series of activities as indicated on the flow chart below:

## **Participants**

The project was co-ordinated by the teacher with responsibility for personal and social education. Funding was provided by CCW to allow this teacher to be released from her teaching commitment for 7 days during the school year.

Initial discussions were undertaken with the officer from HPW/CCW. The school also undertook discussions with a local dietician, local nurses and a nutritional biochemist.

## Methods and Actions



**Action 1** The school performed a whole school audit of health education provision. This indicated duplication in the area of food and nutrition between two subjects - science and technology. The two departments worked together to develop a co-ordinated approach which resulted in the two departments undertaking teaching to Year 7 (11-12 year olds) in the same half term. This teaching was supported by creative writing in English lessons, calculations relating to food intake in mathematics and contributions from information technology and art.

**Action 2** Year 7 pupils kept a record of their diet for a complete week. These records were analysed by external consultants; a dietician and a nutritional biochemist. These consultants developed an analysis tool, the *Food Rainbow*, which the pupils could use to analyse their own diets. Different colours represented different groups of food and pupils were given guidance as to the ideal number of portions to be taken from each group during a day.

The *Food Rainbow* and an explanatory letter were sent home to parents.

**Action 3** Pupils completed a second diet diary and local health authority personnel spent time in detailed discussions with individual pupils concerning their diet. The information gained from these discussions, and the diet diaries, was used to inform future action.

**Action 4** Discussions were undertaken with the county school meals organiser and the chief cook. Although many healthy options were already available in the canteen the following additional actions were taken:

- . sweets and fizzy drinks are being phased out of the canteen, to be replaced by homemade biscuits, milk and cereal.
- . all crisps provided in the canteen are now the low fat, low salt varieties.
- . chips are only available on two days per week. On the other three days pupils have a choice of pasta, baked potatoes or mashed potatoes.

In addition to changes in the provision of goods in the canteen, the decision was taken that no pupils from Years 7-9 (ages 11-14) should be allowed out of the school premises during lunchtime. In this way the school can have a greater influence on their pupils' lunchtime diet.

**Action 5** The school investigated the school tuck shop and soft drinks machine with the intention of providing healthier alternatives. The tuck shop is run by a group of Year 12 students (aged 16-17) as a business venture. Discussion took place part way through a school year

regarding the provision of healthier options and it was considered unfair to change the objectives given to the group at that stage. However, the objective for the next group in the next school year was modified to be 'to run a tuck shop which promotes healthier snacks, and to make a profit doing so'.

The soft drinks machine is to stock 'diet' alternatives to the sugary fizzy drinks previously on offer. A milk can machine is also to be provided alongside the soft drinks machine.

### **Outcomes**

- . The teaching on food and nutrition for Years 7-9 is now co-ordinated to prevent duplication.
- . Pupils have been encouraged to analyse their own diets in detail and to consider possible improvements.
- . The school meal and snack provision in the canteen has been improved to limit the number of less-healthy alternatives available.
- . The school tuck shop has been improved and now provides healthier options.

### **On Reflection/Evaluation**

The school decided to survey the pupils' eating habits to provide information for use when negotiating action on the schools food and drink provision. The school has provided the pupils with specific advice and has then acted on the influences over which it has some control, i.e. the canteen and tuck shop.

Throughout the project the school has encouraged the development of the pupils by helping them to establish the values and skills needed for them to take control of their own diets. The pupils have been encouraged to view themselves as individuals capable of reasoned action.

The school appreciates that evaluation of progress is necessary. The diet diaries, and their analysis using the *Food Rainbow*, will therefore be repeated in the next academic year.

### **Summary**

A limited number of schools in Wales have been helped to develop as health promoting schools by the HPW/CCW joint programme. The information gained from these schools will be used to help individual schools move towards the goals of the health promoting school and also to inform future national projects. It should be noted from the activities listed that schools have undertaken action at two different levels. Some activities will become embedded in the school curriculum and ethos. Other activities are of a limited duration, but have been used to stimulate interest and encourage future activity.

## **CASE STUDY 7**

### **FOOD EDUCATION - EXAMPLE OF A COURSE IN ITALY**

**"Frequently eat fresh fruits and vegetables and cereals with high fibre content."** (Point 5, European Code Against Cancer).

**"Avoid becoming overweight and limit your intake of fatty foods."** (Point 6, European Code Against Cancer).

#### **Background**

The District Health Authority (U.S.L.) of Arezzo (Tuscany, Italy) covers a population of 313,000 and its area is situated between two rivers, the Arno and the Tiber.

The health education initiatives described in this case study were carried out in close co-operation with the U.S.L. and the Education Office in Arezzo. Within the U.S.L. a department specialising in health education has been operating for several years.

At the beginning of each school year the Health Education Office sends to the head teacher of each middle, grammar and primary school a set of teaching courses selected and planned on the basis of the experience accumulated over the years.

In 1993 - 1994 the following Health Education courses were offered:

- 1 - Hygiene and Prevention - Environmental Education
- 2 - Health and Food
- 3 - Emotional Education (Sex education, AIDS).
- 4 - Health and Safety

5 - Quality of Life: prevention of drug dependency (smoking, alcohol, drugs, medicines).

6 - Prevention of Tumours

7 - Prevention of Infectious Diseases

The head teachers select the various courses to be given during the year in their schools, present them to the committee and board of governors of each institute and reply to the U.S.L. stating their choice.

The U.S.L. receives the choices made by the head teachers, supplies information material and all the educational tools assembled for each Health Education course and ensures a direct presence of doctors and their own health officials in the schools. Consequently, the school is and remains in charge of the educational activity. The U.S.L., with its own resources and staff, has the role of a scientific and methodological reference point at the direct request of the school.

The educational measures taken in the schools and in the population go hand-in-hand with the opening, within the health framework of the U.S.L., of a clinical nutrition office and a consultation for young people, available to all those who wish to receive personalised advice to eliminate the risk of disease, for students and parents who come under the U.S.L.

Also, in co-operation with the Arezzo Education Office, the U.S.L. organises specific courses on training and health education for teachers and parents who request them.

The health education programmes most requested and with the highest levels of participation were:

- a) Food Education
- b) Emotional Education

### **Aims/objectives**

The educational basis underlying these two courses is the acquisition of a bodily identity and of self-satisfaction on the part of the child and the adolescent, issues which also concern parents.

The courses include teaching about the environment and the history relating to one's native soil and the people belonging to it.

The idea is developed of an "ecological niche", meaning a population forming part of a territory, a landscape, an economy, a history, an art, a religion, an environment etc.

The proposal for Food Education also has the aim of eliminating factors which encourage the appearance and development of carcinoma of the stomach.

Arezzo is an area with an annual mortality rate of 75 per 100,000 as a result of gastric causes.

## Organisation and Teaching of a Model of Food Education, Applied to Middle Schools and Grammar Schools

The educational programme is based on a personal food survey carried out by the pupil, by entering on a form the foods taken in one or more days, and classified according to their type and weight.

By using a program on a computer disk, entitled "How are you eating?", it is possible to work out the food intake of a pupil during the period of nutritional monitoring. This provides a personal nutritional profile for each student.

This profile is a qualitative and quantitative judgment of the diet of the pupil, on his "way of eating", on the analysis of the foods taken, to highlight whether they are correct, excessive or deficient with regard to age, sex, height, weight and the condition of the person concerned.

The food survey becomes an "open and indirect questionnaire", which plays a dynamic and constructive role in promoting interpersonal comparison between students.

Each nutritional profile becomes the scientific "text" of the food education programme. Once this stage has been completed, the teachers in charge of the health education courses can use the findings to introduce new scientific data aimed at improving eating patterns.

### **On Reflection**

It is important to mention the contribution to the effectiveness of the course made by the presence of several teachers or staff from outside the school in areas such as history, agriculture,

the environment, economics, hygiene, pollution and geology. They helped to make the point that food is not only a physiological need, but also related to the area in which it is cultivated and produced.

A further food survey is needed at the end of the course to verify any variations in behaviour and habits compared with information gleaned at the beginning of the survey. This will monitor the effectiveness of the programme for each student.

On the basis of the nutritional profiles at the beginning and the end, it will be possible to have a general framework for the behaviour and feeding habits of a population of young people with a scientific validity. This can then be compared to other research and other programmes presented in medical and educational literature in Italy and abroad.

## **CHAPTER 8**

### **CASE STUDIES,**

### **EUROPEAN NETWORK OF HEALTH PROMOTING SCHOOLS**

## **CASE STUDY 1**

### **THE EXTENDED CONCEPT OF HEALTH** **A PROJECT AT THE KATRINEDALS SCHOOL**

#### **The School**

Katrinédals is a Folkeskole and has 450 pupils and 36 teachers. It is situated in a pleasant residential area. This could be described as a comparatively advantaged environment of families with a good level of living and motivated parents.

The school was built 60 years ago and was the first of an architectural model, later quite widely repeated. There is a large oval assembly hall, round which most of the classrooms are situated, with second and third floor classrooms being reached by open corridors (like long balconies) which circle the great hall.

Children have "their own classroom", which they decorate to their own taste and the teachers go to the classroom, rather than the pupils moving. The exception is for classes which need special equipment i.e. laboratories.

The outside environment is also very pleasant and there is a "leisure centre" attached, which children can reach through the school grounds without crossing any roads.

The library and rooms for the school doctor, nurse and dentist were all very attractive and friendly.

In the PC laboratory, they have a number of programmes with world data on health (1993). They also have the HFA database.

#### **Aims**

At the Katrinédals School we have realised that health has more to it than carrots and coarse bread. Factors like the physical work environment, confidence and pleasure in work are extremely important; frustrations can hardly be avoided, However.

On the basis of WHO's broad definition of the concept of health we in the school want a well-functioning group of pupils, staff and parents who are aware of the importance of this extended concept of health in everyday life, in schools as well as at home. We want a group of people who are able to act - jointly or individually - for the promotion of the health of themselves and others.

#### **Organization and Method**

The project was constructed like a three step rocket:

1. the future workshop for the three groups: pupils, staff and parents

2. the planning of the course of changes of selected subjects
3. the carrying out of the plans and evaluating the results

The future workshop is a course with a working method that takes the participants through three stages:

1. the stage of criticism in which you get the chance to express your dissatisfaction with everyday issues
2. the stage of visions and ideas in which you express all your dreams on how things could be
3. the stage of implementation in which you attempt to bring the visions down to a level that fits into the actual everyday life

### **Course of events**

Centre for education innovation within the school system of Copenhagen was ready to assist us with advice and ideas. They recommended us to apply to various funds for contributions and undertook to assist and support through the whole course of events.

After various unsuccessful applications a little over a year later the health funds finally promised to subsidise the first part of the project: the future workshop.

During a weekend in the Spring of 1991 the course was arranged for the staff and in September we were able to run it for the pupils. Here it should be noted that even when working with the pupils the whole staff participated, teachers as well as the health staff, caretakers, etc.

On Friday and Saturday of the same week, the future workshop was arranged for the parents by the persons who had run it with the staff. seventy parents attended the course. On Saturday the works of all groups were displayed on the walls of the main hall. A great variety of ideas, drawn or written were represented by means of role playing by the participants.

Then the ideas of the stage of implementation were collected in a book. it was written by an unemployed person and edited by a teacher. This book was sent to all homes before Christmas with an invitation to a working Saturday after Christmas, on which we intended to choose the "most wanted things" and establish work groups concerning these subjects.

Three main groups were established dealing with:

1. Premises (for instance the school yard and the class rooms)
2. Cooperation between school and home (especially concerning the feeling of security at school)
3. Unity and structure in teaching (among other things cross-disciplinary teamwork)

These groups consisting of pupils, parents and staff worked for a period of 1 1/2 years with the chosen proposals. First they tried to create an overview of:

which kind of changes would be necessary for the day to day life in school,

- \* the amount of money needed
- \* the actual effort needed
- \* in order to carry out the suggested activities

Then they started successively to carry out the ideas. As a starting point they addressed the more simple things which did not demand a large amount of resources neither economically nor in effort and then later after a long period of planning and necessary fund raising they started working on the more demanding projects.

## **Results:**

### 1. Physical settings

The largest project has been to improve the facilities in the school yard used by the oldest pupils. The group has prepared a biannual schedule. The schedule has undergone modifications due to the setting up a working weekend where parents pupils and staff installed a series of play equipment. Also the group has initiated permanent permission for pupils to stay indoors during breaks, play equipment has been installed in the assembly hall, the canteen has been extended, a specific area for playing ball in the playground has been arranged, a large clock has been installed in the playground etc.

### 2. Cooperation between parents and school

It was a major wish especially from the parents that the facilities of the school could be used for different activities outside schoolhours. This has resulted in the project "Open Thursday" where pupils and parents have access to the school facilities every Thursday afternoon and evening. It is possible for the parents together with

their children to initiate different activities such as drama, different sports, cooking, painting, music and so on. The planning and management of each activity is conducted by the parents themselves. In addition the group has developed a "Welcome leaflet" for new pupils/parents and a discussion framework to be used at parents evenings and at other consultations for parents.

### 3. Entirety and Structure

The group has prepared several introductions to debate a reorganisation of everyday life of the school and the structure of the education. The outcome of these discussions between teachers and parents has been that the school every year will organise two topic weeks with participation of all classes. The yearly allocation of subjects should have the aim of attaining teachers mainly to specific age groups of pupils e.g. early primary, late primary, early secondary, who will, as such, teach the main part of the lessons

within this age group. This will strengthen the cooperation connected to each class and make the preparation of each lesson more flexible.

This cooperation between staff, parents and partly pupils has shown great value in the everyday life of the school and hopefully the results have contributed to create a better school for everyone. But hopefully, the project as a whole will not turn out to be a one-off affair. We would like to see it as the first attempt made in clarifying the expectancies of the school. Times change and so do expectations, and we shall have to face the fact that if we want a vital and relevant school we shall at all times have our fingers on the pulse of movements among groups related to the school. We must at all times set new targets for our intentions for the school.

When evaluating a project, one is often inclined to say that it was a great success - it would be terrible to have to admit that the whole thing was a big flop.

As with all health promoting and preventive work - it is very difficult, not to say impossible, to conclude that the aims of our project were achieved. have our pupils, teachers and parents learned to take action to improve their own health and have they obtained a broader concept of health. Fortunately, we did achieve a certain number of concrete results following the project and these have now been integrated into the daily life of the school.

But of course, it has not been without problems and I will describe some of the barriers which we met:

### **Problems**

We realised very soon that not all teachers were equally interested. Although we tried to get everybody involved in the project, we have to admit that this is not possible with such a large and varied group of people.

Here, it is very important that all persons involved are fully informed of what is going on. Both with colleagues and parents, it was very important to inform them not only

of the practical things but also on the wider aspects of our project, what our aims were, what we intended to do etc. We have to admit that we were not very good at this and we had many long and difficult discussions - both with colleagues and parents. Much of this could have been avoided with better information.

Of course, we must admit that we were very ambitious, expecting the whole school and also the parents to be involved. This is a huge number of people to motivate - probably too big. Perhaps we should have split into smaller entities, for example, down to the individual classes and later have pooled our experiences. I think that this would have been easier and the interest of the individual would have been greater.

The interest and involvement of the pupils created a special problem. The procedure which we had chosen i.e. in working groups, exchanging results with each other, etc.

was not very inspiring for the pupils. The process took too long and the aim of the whole thing sometimes drowned in discussions, practical hindrances, etc. Many pupils who were included in the working groups dropped out along the way and this was a pity.

However, despite this, the cooperation between pupils, parents and teachers has meant a great deal for the daily life of the school. We HAVE made a better school for all of us - and therefore have a better life at the school. We have not finished yet, but have started a process whereby we constantly set new aims for our school and these are reviewed according to the times we live in and the demands which users have.

### **The Health Promoting School**

While the working groups were still in operation, we had an invitation from "The Royal Danish School of Educational Studies" to participate in the project "The Health Promoting School", a joint European project involving EU, Council of Europe and WHO. At this stage we had used a lot of time and energy on our first project - we wondered whether there would be any more time and energy left to invest in something new at this stage. Nevertheless it was inspiring to have an invitation to participate especially since only eleven Danish comprehensive schools and schools with higher secondary education were able to join in from the very beginning.

### **Study Group Work**

A part of "The Health Promoting School" project is a study group with the participation of all teachers, management and school nurse. Since a major part of the project is to develop acting competence towards your own and others state of health, we spent the 50 hours that were set aside for each participant last year to discuss: What is action competence in relation to your own and others state of health and how can we develop action competence amongst the pupils? We had educators brought in and had a good back up from the Royal Danish School of Educational Studies. This year we have all been granted 40 hours for the study groups. At this stage the teachers have formed working groups and these are formulating their proposals for projects to be developed in the period of October to December 1994.

The background for deciding to establish a study group involving the whole teaching staff, as well as others, should be seen in the light of two things:

1. Firstly, we hoped that, by doing it this way, we could avoid some problems. If we had formed a smaller study group of really interested persons, then this group would later on have to inform and convince the rest of the staff of their ideas and thoughts and implement their projects with them;
2. Secondly, the subject of health in the school is not one which can be placed under one or two subjects. Health-related topics and problems should be dealt with across all subjects in school. We therefore found it very important that all teachers received the same theoretical background so that they could include this issue in their teaching.

As mentioned before, study group work began in the Autumn of 1993. During the first half year, most of the time was spent in finding a joint standpoint. In the project team, we thought it important to spend a lot of time discussing in depth the concepts:

- \* what is the broad concept of health;
- \* what is understood by "action competence"
- \* what potential and barriers exist when working with this issue at school etc.

At the beginning of the study group work, it very soon became clear that again such a large group of people consisting of the whole staff, covers a very wide range and has very different viewpoints. It is therefore very difficult to steer, and it became apparent also that some of the teachers at that time were ready to continue on their own and wanted the large study group to be split into smaller units. On the other hand, there was a large group of teachers who still required a theoretical background and wanted to discuss amongst each other and were not yet ready to split into smaller groups. This, of course, created some friction, but the steering group found it important that we all had a joint background upon which to continue and we managed to formulate a joint set of problems.

Around Christmas we were ready to split into smaller groups. Upon the wishes of all those involved, the following study groups were formed:

#### Pupil consultations:

How can we develop pupil consultations so that this gives the individual pupil a better understanding of himself, insight, knowledge and potential;

#### Boy/girl problems

Are there any sex discriminating roles in the children's daily lives which prevent them from having a good life? How can this be tackled?

#### Project-oriented teaching

How can we organise across-the-board teaching themes on health and health-related subjects;

#### The four lives

If our lives are split into four parts:

- \* family
- \* leisure
- \* work
- \* community

How can the school better influence links between these lives?

In the Spring, the whole school had a project week where the theme was "In search of health". The aim of this week was to present the pupils with a better concept of health

and try to make them think more in terms of health. We are now in the second year of study group work. This year is split into two phases:

- \* development of ideas and planning of a teaching sequence
- \* carrying out of the sequence
- \* evaluating the process
- \* exchange of experiences

At the moment, we are well into phase 2.

Some exciting projects have been devised which, at present, are being carried out in the individual classes or groups of pupils.

### Boy/girl problem

Class range: Kindergarten class, 1st and 2nd classes

Aim:

The overall aim for the project is to motivate girls and boys to seek new areas of experience and try new activities

It prepares girls and boys for a well-balanced life i.e. a life which is physically, psychologically and socially in harmony.

It enhances action competence in all spheres, private, social and public as well as in leisure.

### Pupil consultations

Class range: 1st class, 3rd, 4th and 5th classes

Aim:

Each pupil should gradually, throughout school life, move towards taking more responsibility for his/her own progress and development, both intellectually as well as socially.

Secondary aim:

- \* to teach the pupils to express their feelings in words
- \* to increase the pupil's self-awareness
- \* to start learning to distinguish what is best for themselves and for the class as a whole

Pupil consultations should motivate and increase the responsibility of the pupil, as well as give the individual and the whole group the potential to find out how they can influence what they want from their social life. Dialogue with teachers will promote the pupil's insight into and influence on:

- \* own intellectual capacity
- \* own social development

In this health-promoting school, pupil consultation is one element in the work to enhance the individual child's and the group's development, so that pupils may attain improved action competencies.

Adolescence, self-esteem, boys/girls:

Class range. 6th and 7th grade

Aim:

The aim is to actively promote and support pupil's self-esteem during adolescence. In the health-promoting school enhanced self-esteem will lead to increased action competence.

Project work:

Class range: 8th and 9th grade

Aim:

The aim of the topic and working method is that the pupil can learn to illustrate a contemporary issue in a problem-oriented way, that is, by defining the reality and describing it, accounting for it and coming to terms with it. In this way, they can and choose in the future.

**Conclusion**

By the end of this school year, that is Summer 1995, we will have completed the second part of our project, that is, the study group work, in the European Network of Health Promoting Schools. We do not know at the moment how we will organise the next steps. Neither have we discussed the future with other schools taking part in the Danish part of this Network.

At Katrinedals school, we have tried through this project to set our own aims for health education at the school. The next step will be to discover how to carry on. How can we ensure that health-promoting activities are still included in the daily life of the school.

As mentioned, we have not yet taken any decision about this at the school. We are of course looking forward to receiving the experiences from other on-going projects so that we can learn from these experiences. There are however two factors which will have a large influence on health work at the school in the future.

The first is that all staff and health personnel have been involved in two years study group work and with differing degrees of interest - have been informed and have discussed the whole topic of health education in the school. Furthermore, they have tried to carry out education sequences as part of the health-promoting school. This has given each teacher a good basis to be able to, on one's own and with other colleagues to include health on the agenda in each class.

The second thing which we have established is a Health Committee. I think that this body is very important when schools in future will have to formulate their own plans for health education. It is here that health promotion work can be coordinated and laid out at the school thus ensuring continuity within teaching.

That pupils have the possibility of taking action - both together and individually - in order to improve their own and other's health and thereby promote harmony and well-being for all at the school is the basis for both the social and also the pedagogical work at school.

## **CASE STUDY 2**

### **INTERNATIONAL COOPERATION, CZECH REPUBLIC**

#### **Background**

The Czech Republic and Denmark were among the first seven countries admitted to the European Network of Health Promoting Schools. The Health Promoting Schools Project is based on the WHO definition of health as a state of physical, mental and social wellbeing. Our goal is to bring up citizens with active approach to their own health and their living conditions. The education to health is based on the holistic concept of health and its aim is to enhance the ability of positive action. In this type of education, a close cooperation between the school and the local community working in both directions, represents an inevitable condition. Our project corresponds well with the philosophy of health education in the context of learning more about other nations and countries, building friendly relations among the European countries and, in a wider sense, enhancing the social health.

#### **Objectives**

The project itself was focused on developing children's active positive intervention in the local community, as well as their ability to identify and investigate a problem, and find ways how to solve it. The goal of the project was education focused on action competence, and introducing the pupils to the main principles of actions which should result in positive changes in the future.

Both the promoting factors, and barriers have been examined. The project was based on theoretical work by Mr Bjarne Bruun Jensen from the Royal Danish School of Educational Studies.

#### **Participants**

The coordinating institutions of the Health Promoting Schools Project of both countries - the Royal Danish School of Education Studies in Denmark, and the National Centre for Health Promoting in the Czech Republic, participated in the project. The project was carried out by schools in Måløv, Denmark, and in Dubec and Dobré, Czech Republic. The Dubec school is a small school in a Prague suburb, with about 300 pupils aged 6 to 15 years. The school in Dobré is situated in a small village in East Bohemia (125 pupils aged 6 to 15). The school in Måløv is located in a suburban part of Copenhagen and is attended by 500 pupils (age 5 to 16 years).

The project was carried out with financial support of the Danish Foundation of Democracy.

## **Methods and actions**

The project attracted both teachers and students - it was focused on issues related to their health and environment, and it offered methods and possible ways to influence them.

The content of the project was a healthy environment. In Måløv, the project dealt with meaningful sorting and processing of waste, and in wider sense, with ecological aspects of packing. In Dubec, the project concentrated on the content of nitrates in vegetables, pollen allergens, and pollution of surface and underground water. In Dobré, the project topic was "Healthy Forest" as a biotope. Each of the schools chose a topic of its own, reflecting the current issues in their region.

A number of modern teaching methods were demonstrated during the work on the project. The children could choose the topic they wanted to work on (Måløv), mixed age groups were formed, children worked in groups, and more teachers were present in the classroom at a time. The entire local community served as a "classroom". The format was that of an experiment and its evaluation, during which the teacher took the role of a consultant. The conclusions children made served as a starting point for practical action (e.g. letter to the mayor, discussion at the City Hall).

The project was planned in February 1994, the one-week project in Måløv took place in June 1994, and the two-day projects in schools in Dubec and Dobré took place in September 1994.

The final part of each of the projects, evaluation, was always carried out with active participation of teachers and representatives of the coordinating centre of the partner country.

## **Outcomes**

The project received a wide response, both in the respective schools, and in the whole community. In an interview which took place one month after the project finished, the children already made plans and suggestions concerning the future project and its topic. All of them liked the project, and the way it was performed. The children learned in practice that an active approach is possible, and that their teacher can become their adviser or older friend. They took their first steps in building an active approach to life and health, and acquired their first experiences in becoming active in influencing their environment, and participating in the changes within the community. It strengthened their motivation to get involved in wider international relations. They acquired direct knowledge of issues concerning the local community, and got personally involved in them. Through their children, also parents were involved in the project and its contents. Children of different age groups were able to cooperate and communicate in a productive way. Also, the described teaching methods proved to be more effective than the "classic" classroom methods.

The teachers were able to verify that the new perspective in teaching methods, and in a narrow sense, in health education, education promoting democratic principles and values, should be an integral part of the entire educational process.

During the project, the whole community served as classroom to the children. The project gives hope for an increased collaboration between school and society. A collaboration from which both partners will benefit.

### **On reflection**

I would like to thank our Danish partners for their cooperation which has by no means finished yet. In November 1994, the schools in Måløv, Dobré and Dubec started to communicate by electronic mail. They are currently planning an exchange of children.

We would like to thank the WHO and the Danish Foundation of Democracy for their assistance and support during the work on the project.

The project was presented at the "European Health Policy Conference" and the workshop on "Health Education and Democracy" which were held in Copenhagen in December 1994.

### **CASE STUDY 3**

#### **PROVIDING A SOUND BODY FOR A SOUND SPIRIT, CROATIA**

Varazdin IInd School

#### **Background**

With its 1308 pupils and 76 school staff the IInd Primary School is the biggest primary school in Varazdin. It is attended by pupils aged 7-15 years divided into grade 1-8 distributed into 44 classes, with an average of 30 pupils per class. Twenty-three teachers teach on main subjects (for grades 1-4) and 37 on other subjects (in gradees 5-8). The school's staff service employs a psychologist and a school pedagogue.

The school is accommodated in a 68-year-old building in the very town centre. A spacious school yard and a school playground, both of which are in the town's park, form its environs.

Both a residential area and some family houses are within the school's catchment area. Pupil families vary in their socio-economic patterns, ranging from markedly poor to very good social conditions. However, pupils of the average economic standing, the so-called middle class, prevail.

#### **Objectives**

The proposal to include this school into ENHPS is based on its health promoting activities so far, on an assessment of its future potential and on its capacity to expand the current and new activities in this area.

In considering the school's project we started from the fact that the living habits and lifestyle substantially influence the development, respectively prevention, of a variety of diseases. The kind of diet, physical activity, smoking and drinking, and the method of coping with stressful situations play a special role in this. Studies have shown that changing these habits has a positive preventive impact on many carcinomas (bronchus, female genitals, large intestines) Undoubtedly, in view of the ingrained habits being bad, it is in these areas that a number of measures should be taken in Croatia. Figures showing some diseases to have a greater prevalence in Croatia than in other countries corroborate this view, e.g. we have very high cardiac and circulatory system disease mortality in males.

The problem lies in adults transferring these unhealthy habits to the children. Therefore, our emphasis should be on developing a positive concept of health among children. In it, the role of schools is the most important, because parents often give children a bad example.

When drafting the school project we defined:

- our current areas of activity
- the ways for their promotion
- a list of areas in which we can and should be active (provided that additional conditions have been fulfilled)

We were pleased to find that, more or less, we already carry out a number of the activities envisaged for our inclusion into the ENHPS project. This unfolds either within the regular curriculum or through extramural activities.

Our regular curriculum includes such health components as:

- healthy diet
- addictions and their deleteriousness
- sexuality and sexually transmitted diseases (with an emphasis on AIDS)
- physical and mental maturation
- environment and health
- first aid and self-help
- health as a social category
- communication between pupils, teachers, family and the community at large
- developing a self-image and taking up personal responsibilities
- developing new learning techniques
- importance of physical activity for health etc.

Unfortunately, it is the realization of pupils' physical activities that poses most problems. Our regular physical health culture syllabus is conducted in a totally unsuitable space, a cramped low-ceiling cellar room.

Therefore, we have decided to set as our project's prime objective the erection of a new gymnasium for sports activities.

Our second objective is to create in pupils new habits and attitudes not only by introducing new and enriching the existing contents, but also by using the described new knowledge and the methods of teaching, and by developing pupil self-activity.

## **Participants**

The realization of our objectives requires the cooperation and support of all:

- teachers
- pupils
- parents
- some outside professionals
- wider community
- local authorities
- Ministry of Education and Sport
- as well as the Ministry of Health's professional assistance

The school has taken a number of initial steps towards achieving its first objective. Nevertheless, the funding should come from the Town Council and the Ministry of Education and Sport.

Precisely because the inclusion into the ENHPS project was an important argument, we have managed to obtain all requisite approvals, along with the decision to include the building of the gymnasium into investment priorities for the current year.

Although the achievement of the other objectives also depends on the cooperation of the broader community, we will perform most of the envisaged tasks inside the school.

### **Methods and activities**

The methods that we apply in running the project depend on the segments to which they are directed.

All teachers and pupils, then the parents through TPA meetings and a special bulletin board were the first to learn of the project.

The teachers have elected a project execution team consisting of biology, physical culture, art, and main class subject teachers, as well as of school director and school's pedagogical service. School physician and the County Deputy Commissioner take part as project's external members.

A number of meetings were devoted to the building of the gymnasium, for it was necessary to first inform the local authority executives about the ENHPS project and its objectives, and to make them aware of the part played by physical activity as a health component. Also, we have induced them to undertake the necessary activities. What we strove to achieve in particular and succeeded in doing, was to elicit the collaboration of our pupil's parents holding certain positions.

It was the school staff who fulfilled most of the remaining project objectives. The main emphasis was placed on the importance of supplying health educational topics through all the years of schooling.

Mainly traditional modes of teaching could be used there, because of the two main reasons:

- large number of pupils in our classes
- the teachers traditional training

But, these topics also figure in pupils' extramural activities, numbering 23 in our school. They involve the work with smaller groups of pupils who have freely elected to engage in them and are thus adequately motivated. Group activity not being as strictly programmed or methodologically defined as the regular curriculum, it allows for teacher and pupil creativity. This programme is realized by maximum pupil involvement through discussions and joint planning. Occasionally outside professionals are called in who are able to contribute to the elaboration of individual themes.

Perceiving that this working method provides a far greater satisfaction and better results, we have concluded that the regular curriculum should also be carried out in a different way to the largest extent possible. The contents in which pupils take an active part, and which range from its selection to the realization, provide them with much greater interest and motivation, and are remembered longer. Most importantly, they are far more effective where attitudes and habits are to be changed.

### **On reflection**

The entry into the ENHPS project has aroused a mix of emotions:

the pleasure of being chosen,  
the challenge of the new,  
a fear,  
and a little doubt about the feasibility of realizing the set objectives.

We drew considerable courage and motivation from the realization that we have already been doing quite a bit in the area of health promotion, so that all that is needed is just to enlarge and advance what already exists.

When defining the project, we have quickly realized that, in fact, we are not working only for a project to last a certain while, but that we also aim at fulfilling a much longer-term objective:

education a generation of children that will be aware of every aspect influencing their health, and of their responsibility to opt for a healthy lifestyle.

In so doing, we too have formed a clearer idea about what our responsibility involves with regard both to own health and to the model that we are setting our pupils.

Analyzing what teaching methods could best assure the realization of the desired goals, we began to speculate about a possible method for improving the regular curriculum. This has necessarily widened our objectives.

A strong encouragement and further motivation sprang from the results of the campaign to build the gymnasium in which we met with the understanding and support of the broader community, ending in specific actions by the local authorities.

Clearly, in project execution we have run into problems too.

The first arose in our school staff with some sceptic or indifferent individuals. Nor did we expect everybody to join with equal enthusiasm. They are not on our project's select team.

We have also met with the incomprehension and even envy of some colleagues from other schools, but this is understandable. The biggest obstacle is now overcome, after we have obtained financial approval from the Town Council and from the Ministry of Education and Sport.

Initially, this took much talk and persuasion, as well as patience and repeated "knocking on their doors". However, the results were all that more meaningful, giving us an impetus for more activities.

## CASE STUDY 4

### ÅGOTNES SCHOOL HAS BECOME A HEALTH PROMOTING SCHOOL, NORWAY

#### **Background**

Ågotnes School is a comprehensive school with primary and lower secondary education. There are 270 pupils attending first to ninth grades. The school is situated in the municipality of Fjell on Sotra which is about 30 minutes drive from Bergen, which is the main city in the area.

The school is in an area with scattered housing and a relatively high percentage of newcomers with little contact to the local village population. The unemployment rate in the area is low.

Ågotnes School joined the Norwegian network of Health Promoting Schools in 1994 and the project plans for the future three year period have been designed, and some of the practical activities have started.

#### **Objectives and participants**

The municipality has prioritized initiatives for children and adolescents regarding a well functioning and safe environment in which to grow up, and in the area of alcohol and drug prevention.

An important part of this work is carried out locally in each school. You will also find a cross department collaboration where the departments for culture, health- and social affairs and education cooperate with local teams and organizations. Parents also play an important role in this collaboration. The project team at the school consists of the headmaster, two teachers, a parents representative and a representative of the local community (Grendalaget, which is an organization dealing with environmental issues).

The voluntary youth organization in this area initiates well structured work with children and adolescents. Options are presented in areas of physical exercise, song and music. In addition there is a youth club situated in the "old school". However, in spite of the options provided by voluntary organizations some children and youngsters do not "adopt" to or are not interested in the activities offered. This is the group we shall focus on in the project. This focus will of course not rule out those who are already involved in existing activities. On the contrary, we shall build upon the positive "spirits" already existing.

#### **Methods and actions**

Our school was enlarged in 1994. The school was given a 110m basement room at its disposal. During 1994 this room has been fit out with a canteen/cafe and a workshop. There is a possibility of using the room as school canteen during school hours with the possibility of buying buns, milk etc. and in the afternoon and evening the setting is that of an informal drop-in cafe. The workshop offers opportunities for the pupils who do not feel comfortable

with theoretical subjects and it is at the same time kept open during the evening as a drop-in workshop for mending mopeds, bicycles, etc. The daily operation is a joint cooperation between school-parents, Grendalaget and the department for leisure time activities in the municipality, ensuring four opening evenings per week.

In addition to the practical approach, the school is also working on arranging and coordinating the daily work linked to health promotion activities within its framework.

The school is currently developing a curriculum for alcohol, drugs and tobacco education in cooperation with the school nurse and school doctor.

## CASE STUDY 5

### THE HEALTH PROMOTING SCHOOL

#### **Beeslack High School,**

Beeslack High School opened in August 1984 and is a six-year comprehensive school serving part of Penicuik, the adjacent communities and the surrounding rural areas, some eight miles south of Edinburgh. The school has four associated primary schools while a substantial number of pupils join S1 from a range of other primaries. The current roll is 960.

The school building is a modern purpose-built unit with excellent facilities and in the 10 years since opening, care of the building (as, for example, working collectively to minimise the depressing impact of litter and graffiti has been an important aspect of health promotion. We stress to youngsters how care of our immediate environment affects directly the quality of our lives.

In addition to school use, we believe that the facilities are a focus for an extensive daytime and evening community programme. The concept of community is an essential feature of health promotion - both the community that is the set of relationships within the school; and the two-way exchange between the school and its wider community.

The school building has specialist provision for disabled people, with ramps, handrails, disabled toilets and lifts; and disabled youngsters and adults are integrated both into school and community programmes.

Absolutely critical to all we try to achieve in health promotion are the sets of relationships which inform our daily dealings with each other (staff/staff; pupil/pupil; pupils/staff; staff/pupils). We see these relationships as the emotional base of the school. This atmosphere is shaped by daily interactions; and essentially by the signals we give about learning through the teaching methodologies we choose to adopt. It is this dual concentration on **learning** and **relationships** which underpins the aims of the school.

#### **School Aims**

- \* to promote an education of the highest quality in a community of warmth, of purpose and of opportunity.
- \* to promote the understanding that we are a fully comprehensive school, S1-S6; that we have much to offer all pupils; and that we are interested in equality of opportunity for all pupils, irrespective of class, disability, gender, race or religion.
- \* to provide a full range and choice of courses with different kinds of learning experiences; and a variety of teaching methodologies - enabling all to develop their abilities.
- \* to make clear expectations of pupils, encouraging achieving at all levels and in as many situations as possible.
- \* to encourage active participation in the life of the school; and participation in responsibility.

- \* to promote active partnership between ourselves and our parents and the wider community.to promote education as a life-long process and provide access to users from the wider community - again within the spirit of warmth and of purpose.
- \* to promote, within available resources, the ideal of a health promoting school - as it affects all staff (teaching and non-teaching) and all users.
- \* to prepare youngsters for the next stage on leaving school with a range of coping skills and competences, personal, social and economic.

## **Key Economic Interventions in Health Promotion**

### **Introduction**

A fundamental argument of this case study is that the aims of education and the aims of health promotion are actually one and the same thing; and that the management issues raised by the debate on effective schooling are identical with the management issues of health promotion. In this study we concentrate on the critical management question, the "how" question. How did we go about trying to create and sustain the atmosphere essential for health promotion. Certainly the creation of ethos, mood, atmosphere, climate (call it what we will) does not happen in school by chance. it is essentially the product of management at every level.

### **The Key Management Interventions have been:**

- \* taking actions which establish a positive atmosphere;
- \* giving health education an assured place in the curriculum;
- \* using teaching methodology as a vehicle for health promotion;
- \* establishing and monitoring supportive management structures;
- \* providing appropriate staff development;
- \* developing the school as a community and its relation to the wider community; and
- \* ensuring that the key personnel have clearly defined roles.

This case study will concentrate on the management structures.

### **Ensuring Supportive Management Structures**

We believe that our style of management is consultative at all levels in the school, with the familiar range of communications and persuasions. Effective consultative management allows individuals to take more control of their lives which is central to the promotion of good health.

We employ the usual network of committees through which a wide range of staff is involved, and the main policy forum is the Senior Staff Committee (heads of department and guidance staff) which meets once a month.

More generally, we take opportunities to bring staff with a common interest and shared expertise as for example staff involved in the primary liaison programme (5-14); staff concerned with the application of technology in innovative learning; and staff involved in open learning; and in health education.

An important aspect of supportive management in relation to staff health is that problems which may cause frustration or anxiety can be lessened by effective management and timeous communication. The knowledge that problems will at least be listened to and, where possible, addressed is an important feature of stress management. This is not to minimise the issues of personnel management with a workforce of more than 80 people. But an essential role for senior management is creating for staff the physical and psychological conditions that enable people to function well.

Throughout this case study we argue that health promotion is in large part a process, an understanding which permeates our daily practices. Support for this process has to be supported in a planned, coordinated way.

#### **Four Main Kinds of Support**

- \* Actions/policies which emphasise whole-school cohesion.
- \* Staff development.
- \* The use of key personnel.
- \* The management and coordination of health education.

The first of these kinds of support is considered below, the others are considered in succeeding chapters.

#### **Whole-School Cohesion**

People who visit the school do comment on the sense of cohesion across the staff, a staff who work closely together and with clear understanding of whole-school policies.

We are conscious that such a statement will seem smug and complacent; and we remain always concerned that the achievement of such understanding is elusive, is liable to evaporate, and therefore requires regularly to be redressed. We shall see later that the whole-school sessions of our staff development programme have an important role to play in underpinning a sense of common purpose and consistent practice.

All the key areas in the life of the school are managed on a whole-school basis, for example,

**The Guidance System** which has a major role to play in the emotional health of the school. This is partly because in an obvious sense a school is managed through the way it structures guidance; and partly because many of the signals we give about the effective growth of youngsters happen through guidance.

Guidance operates a collective approach to delivery within agreed whole-school policies. This is equally the case in minor areas of policy (for example creation of a variant of a referral form) as in major ones (for example agreed procedures in dealing with reported child abuse).

This agreement to collective strategies is a key principle of our guidance system as it promotes consistency for those who use the service; and indeed may act as a buffer to individual guidance teachers who, in dealing with particular cases, are often in a vulnerable situation.

Monthly meetings of combined year teams are chaired by the head teacher. This allows for regular opportunities to review/evaluate procedures and inform others of developments within a particular year team.

**Learning Support.** We adopt a whole-school approach to learning support, reinforced by a written statement of school policy which is known, understood and operated by all staff. It is made clear that all teachers deliver learning support for all students. This approach demands integrated and consistent methods, involving consultation and cooperative teaching, largely in mainstream classes, but supported by workshops to deal with particular problems. A good indicator of the success of the programme is the willingness of students to refer themselves for learning support.

The cross-curricular approach cannot be sustained by learning support specialists alone. They require the immediate support of an extended team of staff, namely:

- \* Guidance staff working in classrooms (other than their own subject), with particular pupils in their year.
- \* Subject teachers working directly with the learning support specialist. Each session, staff wishing to work directly in learning support are given time in addition to their subject commitment in order to achieve this.
- \* Senior teachers have a cross-curricular/methodology remit and work to agreed programmes in consultation with an assistant head and the learning support specialist.

These different kinds of strategies require:

- \* a staffing policy which recognises this extended team approach, rather than a (separate) learning support "department"; and

- \* coordination by the learning support specialist and a member of the senior management team.

These are but two examples of systems which operate within a collective approach. We also, of course, take any opportunity which presents itself to underscore across-school collaboration, as for example:

**Health Weeks** coordinated by the senior teacher (health) when we hope to reinforce an awareness of health issues. During the week we engage a range of staff, as appropriate, and across several subjects. The theme of Assembly talks during the week will be health matters; the issues from the diaries will be supported by work within social education and home economics; and class tutors will work with pupils on their diaries. All of this awareness raising will coincide with the provision of foods which are "new" or "different" in the schooling dining hall (see Appendix).

## **Appendix**

### **Beeslack High School: Healthy Eating**

As we opened, the school kitchen, in line with current trends, was set up as a self-service cafeteria system. It provided a range of foods, from the traditional three course meal to snacks, salads, home-baking, sweets and drinks, catering for all tastes.

At an early stage, however, the range of main courses available did decrease in response to falling demand. It became apparent that despite the range of good food available, pupils were restricting their choice to such an extent that the typical lunch for a section of our pupils was unbalanced nutritionally, particularly in excess consumption of sugars and fats and a relative lack of dietary fibre. We were concerned that the eating habits of these pupils in the dining-hall were in contradiction to what was being taught in school, in home economics, science, social education and physical education.

A response to this concern was to set up a series of consultations/discussions both within and outside the school. Early contact was made with the Educational Catering Department of Lothian Region to discuss matters of general policy. A member of the guidance staff and the head of the home economics department discussed with the head teacher possible strategies, and advice was sought from, amongst others, Lothian Health Board and the Scottish Health Education Group (now the Health Education Board for Scotland - HEBS).

A first stage was to attempt to quantify the nature of the problem, hence the food survey. This was a completely random survey of the eating patterns of 60 pupils (2 boys and 2 girls from each register class) who ate in the school dining-hall. We limited the survey to school lunches only, as the statistical problems of setting up a control-group to monitor food consumption outside school were too great. We also clearly did not want to imply that the diets of these pupils who had lunches out with

school were inadequate. It was also recognised that although the lunch of a pupil may be unbalanced, his or her eating pattern over the course of a full day may well be more nutritionally satisfactory.

The survey was carried out over four days in one week. After eating lunch, pupils were asked to fill in a simple chart, stating what they had eaten.

This information was then transferred to a master chart giving numbers of portions of each food consumed during the week of the survey, and a bar chart was produced. This showed such a consumption of fats and sugars that it was thought unnecessary to refine further our results. The survey confirmed our own observations about the broad trend of eating habits.

A newsletter was sent to all parents giving the results of the survey, outlining the changes in eating patterns promoted by the NACNE report and emphasising, as we continually do, that we are not in the job of promoting diet fads; rather we wish to encourage sensible eating patterns. We hoped to enlist the support of the parents in this matter.

The approach then involved a reduction of those foods, the consumption of which tends to make for a nutritionally unbalanced meal while at the same time increasing the range and variety of foods which, both separately, and in combination, lend themselves to the NACNE guidelines which encourage less fat, less sugar and more fibre.

It was, and remains, a particularly important principle that we as teachers of health education and as school give consistent messages about health. It is therefore, important to ensure that food available in the school dining hall reflects, as far as possible, the healthy eating message.

This is a continuing project and, to maintain the approach, regular meetings are held between the kitchen supervisor, senior teacher (health), and AHT and, on occasion, representatives of Lothian Catering Service. The food served in the dining hall continues to be regularly reviewed in terms of overall balance, methods of preparation, presentation and the contribution it makes to a healthy diet.

The impetus is further maintained by the S1 healthy eating week, during which all first year pupils are introduced to healthy eating principles through assemblies, talks and discussions in registration time and in home economics classes. This activity is continued in S2. To give a whole-school focus, special theme days/weeks are organised at various points in the year to introduce new and different foods. In addition, a further survey has been carried out to give more detailed information on eating habits.

A word of caution to those who are interested in trying similar schemes. The support of the head teacher is important from the first - in being sympathetic to the need for

such an approach, then in regularly supporting and coordinating the efforts of those

involved. The various groups and agencies, too, must be mutually supportive as it is easy to be discouraged at apparent lack of progress.

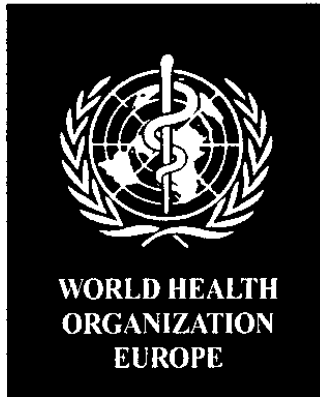
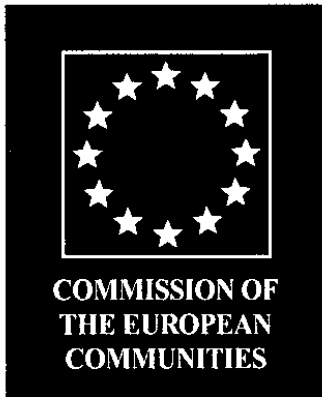
We have always regarded the project as long-term with modifications taking place gradually and, in consultation with the other parties involved, have planned the campaign in several stages. We would not pretend that the task is an easy one and we will continue to expect resistance from certain of our (older) pupils, whose eating habit in school is long established. But the rewards, too, are very real as youngsters come to recognise the reasons for healthy eating and are more willing to sample a variety of foods.

We are confident that, at the least, pupils are more conscious of diet and its importance, which was a main aim from the outset and that a consistent school approach means that our practice matches our teaching.

**APPENDIX 1**

**CERTIFICATE AND CRITERIA FOR HEALTH PROMOTING SCHOOLS**

# European Network of Health Promoting Schools



This is to confirm that

.....

is hereby designated as a  
Project School of the  
Health Promoting Schools  
Project in

.....

thus becoming a member of  
the European Network of  
Health Promoting Schools

Signed on behalf of the National  
Health Promoting Schools  
Project of \_\_\_\_\_

Signed on behalf of the  
International Planning Committee  
(Commission of the European Communities,  
Council of Europe and the World Health  
Organization's Regional Office for Europe)

**As a designated Project School within the European Network of Health Promoting Schools we agree to work towards meeting the following 12 criteria:**

- 1.** Active promotion of the self-esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school;
- 2.** the development of good relations between staff and pupils and between pupils in the daily life of the school;
- 3.** the clarification for staff and pupils of the social aims of the school;
- 4.** the provision of stimulating challenges for all pupils through a wide range of activities;
- 5.** using every opportunity to improve the physical environment of the school;
- 6.** the development of good links between the school, the home and the community;
- 7.** the development of good links between associated primary and secondary schools to plan a coherent health education curriculum;
- 8.** the active promotion of the health and well-being of school staff;
- 9.** the consideration of the role of staff exemplars in health-related issues;
- 10.** the consideration of the complementary role of school meals (if provided) to the health education curriculum;
- 11.** the realization of the potential of specialist services in the community for advice and support in health education;
- 12.** the development of the education potential of the school health services beyond routine screening towards active support for the curriculum.

## APPENDIX 2

### EUROPEAN AGAINST CANCER PROGRAMME

1. Cancer, which is responsible for one quarter of all deaths in the European Community, has always been a central concern of national health authorities. Along with accidents, it ranks as the main cause of early death (prior to the age of 75). In recent decades there has been a significant increase in mortality due to cancer as the average age of the population has increased. The most recent data (1990) show an annual rate of 1 300 000 new cases of cancer and 840 000 deaths due to it in the European Community. The incidence of cancer is increasing rapidly among those over 50; the median age at which cancer is diagnosed is approximately 65 in the Community. It is anticipated that mortality due to cancer which include effective measures for prevention and treatment.
2. The age-related increase in the incidence of cancer is the reason why worthwhile historical or geographical comparisons can only be made on age-standardized populations. With such populations, two facts emerge:
  - the frequency of cancer at a given age has not varied noticeably over recent decades;
  - it is higher in the northern Member States, and the Community average is approximately 15% lower than in the countries of Central and Eastern Europe.
3. Taking four age groups into consideration, the findings are as follows:
  - cancer is the second cause of death after accidents among children under 15, even though mortality has declined sharply as a result of progress in treatment;
  - it is also the second cause of death after violent death (accidents or suicides) for those aged 15 to 30;
  - it is a significant cause of mortality for those between 30 and 65;
  - for those over 65 it is the second cause of mortality, significantly below cardiovascular diseases, the incidence of which increases more quickly with age than that of cancer in this age group.
4. Recent data confirm that a significant proportion of cancers and of deaths through cancer may be linked to what may be termed "lifestyles". It has been established that 30% of cancers can be attributed to tobacco and that a smaller, though not insignificant, proportion of deaths by cancer may be ascribed to excessive alcohol consumption. The importance of dietary factors has still to be properly established, although the fact that it is an influence has been shown (some experts consider that 30% of deaths are linked to it). It is generally accepted that a balanced diet, including an adequate intake of fruit and vegetables is an important protection against some of the more frequent cancers. Atmospheric pollution, dietary contaminants and ionising radiation are directly responsible for less than 2% of cancer-related deaths. It is generally accepted that 70% of

cancer-related deaths have their origin in individual choices affecting our lifestyles and environment.

The European Council took note (on May and December 1985) of the concern shown by the competent national authorities and by Community citizens in the face of this disease and decided to establish a "Europe against Cancer" programme. It was then relayed via the European Commission, the Council of Ministers and the European Parliament. An initial action plan was successfully implemented in 1987-1989. In the light of the encouraging results obtained, the Council and the European Parliament approved the implementation of a second action plan for 1990-1994. These action plans have been the subject of annual reports by the Commission, forwarded regularly to the Council. In addition, in accordance with the Council decision of 17 May 1990, an evaluation report on the first six years of operation of the programme was approved by the Commission on 15 March 1993 and forwarded to the Council and the European Parliament for examination. In its resolution of 13 December 1993, the Council recognised the importance of continuing the "Europe against Cancer" programme and asked for a third action plan to be drawn up in due course.

In its resolution of 27 May 1993, the Council called for the content of this third action plan, while ensuring continuity with the preceding plans, to take account of other activities undertaken by the Community in the field of public health, particularly those to be implemented in the context of the new Article 129 of the Treaty establishing the European Community. On 24 November 1993 the Commission adopted a communication on the framework for action in the field of public health which, among other things, takes account of the wishes of the European Parliament and of the Council in this matter and places the fight against cancer among the priorities identified by the Commission and describes its relationship to them.

Another aim of the action plan is to ensure complementarity with various Community initiatives, including the protection of workers and consumers. Its main aim is to increase knowledge of the causes of cancer and possible methods of prevention. Ensuring wider dissemination of knowledge of the causes and prevention of cancer and encouraging improved comparability of information on the subject, it will contribute to the achievement of Community objectives and stimulate measures at national level in the Member States. To this end, there are recommendations for the implementation of 20 measures in the most important fields: collection of data, information, health education, cancer training for health care workers, early detection and screening, studies and measures relating to the quality of care and, finally research. In accordance with the principle of subsidiarity as set out in the Commission communication COM (93) 559 of 24 November 1993, community action is designed in such a way as to assist Member States in the fulfillment of their objectives in combating cancer, and it will be implemented in such a way as to maximise the Community added value.

### **European Code Against Cancer**

Against this background of Cancer as an important Public Health problem which is one of the commonest causes of premature and avoidable death in the European Union, the **European Code Against Cancer** was introduced to be a series of recommendations which, if followed,

could lead in many instances to a reduction in cancer incidence and also to reductions in cancer mortality. The European Code Against Cancer was used throughout Europe for six years before being revised in November 1994 by a group of cancer experts from throughout Europe. This revised version also took into account the advice, observations and recommendations of a large number of individuals and groups who had experience with using the European Code Against Cancer. In considering making recommendations to help reduce cancer risk in Europe it has been kept in mind at all times that any recommendation made to reduce cancer occurrence should not be one which could lead to an increased risk of other diseases. The ten recommendations which comprise the revised European Code Against Cancer should, if followed, also lead to improvements in other aspects of general health.

## APPENDIX 3

### Ottawa Charter for Health Promotion

*The first International Conference on health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.*

*This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs industrialised countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.*

#### **HEALTH PROMOTION**

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

#### **PREREQUISITES FOR HEALTH**

The fundamental conditions and resources for health are peace, shelter education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

#### **ADVOCATE**

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through **advocacy** for health.

#### **ENABLE**

Health promotion focuses on achieving equity in health. health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to **enable** all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

#### **MEDIATE**

The prerequisites and prospects for health cannot be ensured by the health sector alone. more importantly, health promotion demands coordinated action by all concerned: by governments,

by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to **mediate** between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

### ***HEALTH PROMOTION ACTION MEANS:***

#### **BUILD HEALTHY PUBLIC POLICY**

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

#### **CREATE SUPPORTIVE ENVIRONMENTS**

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

#### **STRENGTHEN COMMUNITY ACTION**

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

### **DEVELOP PERSONAL SKILLS**

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies and within the institutions themselves.

### **REORIENT HEALTH SERVICES**

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

### ***MOVING INTO THE FUTURE***

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

### **COMMITMENT TO HEALTH PROMOTION**

The participants in this conference pledge:

- to move into the arena of healthy public policy and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures toward harmful products, resource depletion, unhealthy living conditions and environments and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;

- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The conference urges all concerned to join them in their commitment to a strong public health alliance.

### **CALL FOR INTERNATIONAL ACTION**

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health for All by the year 2000 will become a reality.

## APPENDIX 4

### BIOGRAPHICAL DETAILS

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Alain Monnot	Principal of College Montaigne, Tours, France.
Madalena Pereira	Ministry of Education, Lisbon, Portugal.
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Trefor Williams	Consultant, WHO/EURO, Copenhagen, Denmark.
Ian Young	Programme Manager: Schools, Health Education Board for Scotland, Edinburgh, Scotland, U.K.

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