Conference Report: Education & Health in Partnership: a European Conference on linking education with the promotion of health in schools
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1. Introduction

Egmond aan Zee proved to be a brilliant venue for this European conference linking education with the promotion of health in schools. The lighthouse on the Dutch coast providing an illuminating and safe environment for ships on a stormy sea offered a metaphor for the real life business of health promoting schools. However, the advantages of the venue were more than metaphorical. The warmth of the welcome from our Dutch hosts and their excellent planning ensured a well organized and highly stimulating event for the four hundred and fifty delegates from all over Europe. In addition to the European participants, there were colleagues from Australia, Canada, the United States of America, Uruguay, the United Arab Emirates and South Africa to give a global dimension to the event.

The themes of the conference were as follows:
Effectiveness
Policy
Concepts
Teachers
Curriculum
Partnership
Participation

The themes of effectiveness, policy and participation, featured in keynote sessions and all of the themes were explored in workshops and paper sessions over the three days of the event.

It was thought extremely important to attract policy makers to Egmond and the strategy of offering government ministers and officials a specific session, the ministerial meeting, within the programme, proved successful.

The conference also provided a showcase for young people involved in the Young Minds Project. Twelve countries were well represented by a confident group of young people who demonstrated a wide range of skills and creativity in their project work. This innovative project attracted considerable media attention including national television. With participation being an important theme of the conference, a range of other modes of communication and participation were offered to delegates. This included an information market with a cyber café where delegates could contribute to a digital debate on conference issues as well as accessing e-mail and web facilities. In addition there were opportunities to present poster papers and country reports and several external agencies took the opportunity to display and demonstrate their services.

Delegates were kept up to date with a daily report from the conference rapporteur Ian Young and also from daily editions of ‘The Lighthouse’, the conference newspaper.
2. Opening Ceremony

The conference facilitator Clive Needle introduced the opening speakers after a stunning audio-visual welcome to the emotional strains of Ludwig van Beethoven’s Egmont overture.

The delegates were given a warm welcome by Aginus Kalis, Director of Public Health, on behalf of the State Secretary of the Dutch Ministry of Health, Welfare and Sport. He explained that, “the Action Programme for promoting health in schools in the Netherlands” had just been published and that his ministry was currently preparing a major policy paper in which the healthy school concept is one of five “spearheads”.

Dr Kalis referred to the importance of the social environment when he described research from the United States of America which demonstrated that when young people feel connected to their school, they are less likely to use tobacco, alcohol or illegal substances.

He also stated that the curriculum of the schools needed to meet the demands and needs of the young people. In relation to this he revealed that the Netherlands was planning an extension of young people’s services to create an integrated system of which health promoting schools would be a key part. He suggested that the ebb and flow of the tides at Egmond was a metaphor for the ecological interaction of school students and the environment of the school.
Gudjon Magnusson, Director a.i., Division of Technical Support, at the WHO Regional Office for Europe, welcomed the participants on behalf of the Regional Office. He explored the importance of mental health promotion in schools and made the point that bullying behaviour was not only an issue for the victim but was also a problem for the perpetrator, the school and society in general. He suggested to the delegates that their work was of great importance as through sustainable and collaborative approaches to health promotion in schools they could help to build a new generation of healthy citizens in Europe.

The International Planning Committee of the European Network of Health Promoting Schools was represented by Gottfried Thesen of the Public Health Directorate of the European Commission. He stated with conviction that the education sectors in each country had the competence, responsibility and power to move the health promoting schools movement forward. He also explained that the Commission were at present considering their future commitment to health promoting schools and that he was hopeful that there would be further resource support available in the future for the health promoting schools movement.

“Through sustainable and collaborative approaches to health promotion in schools you can help to build a new generation of healthy citizens in Europe.”

Gudjon Magnusson

David Stears – An Appreciation

Ian Young paid a special tribute to David Stears from Canterbury Christ Church University College in United Kingdom and the following is an extract from the tribute.

David died in September 2002 and he was a member of both the task force and the scientific committee for this conference. He was well known to many throughout Europe for his work in health promotion in schools. Elias Canetti, a Bulgarian born novelist said, “it is important what a person still plans at the end. It shows the injustice in his death.”

There is a feeling of disbelief and sadness in David's death but also a feeling of injustice. He believed passionately in the work in which he was involved with the International Planning Committee and the Technical Secretariat of the European Network for Health Promoting Schools. His commitment, enthusiasm and his love of working in a team are just some of the reasons why we will remember David. He had been an athlete and he was a good man to have in any team.

We will remember his friendship, his humanity and his broad smile.
Great Expectations and Great Quotations

“It is time to check the extent to which the health promoting school concept is embedded in education policy in the member states.”

Gottfried Thesen, European Commission

“One of the most liberating ways forward is to get children to identify their own issues to work on, by starting with their everyday life, for example their play or their journey to school.”

Roger Hart, USA

“Schools are not society’s problem solvers.”

Don Nutbeam, England, United Kingdom

“I want to give every child a flying start.”

Jane Davidson, Wales, United Kingdom

“The key question is not why health is so important, but what is education and how can health education contribute to it?”

Geert ten Dam, the Netherlands

“If you think in ecosystemic terms you have to take a global perspective.”

Tian Kirsten, South Africa

“We have participated in one of the most important events of our live.”

Young Minds Project, Portugal

“As the Czechs do not have any sea, touching its spirit is extremely important.”

Young Minds Project, Czech Republic

“We have moved from pilot to policy.”

Erio Ziglio, WHO Regional Office for Europe

“I have learned that I need to say everything three times.”

Clive Needle
3. Keynote Effectiveness

3.1 Jean-Claude Vuille, Professor Emeritus in Social Paediatrics, Department of Public Health, City of Berne, Switzerland

These are the extended highlights of the presentation of Jean-Claude Vuille who explored the issue of measuring the effectiveness of health promoting schools from a health perspective.

If we explore the objectives of health promotion and education in schools I suggest the shared objectives could be summarized as follows:
- Low prevalence of disease and functional complaints
- Good self-declared state of health
- Good personal health care
- No substance abuse
- Emotional wellbeing
- High sense of coherence
- Life skills
- Adaptive behaviour
- High academic performance
Data from our project “Healthy Teams at Schools of the City of Berne” suggest that health and educational objectives are dependent on each other.

It is also clear that there is a relationship between factors or behaviours that are health-related such as smoking and academic achievement.

I wish to pose the question, “does emphasis on academic performance enhance the health of pupils, or is health promotion good for academic achievement or both?”
Effectiveness can be defined as the extent to which the objectives of a certain activity have been achieved under normal conditions.

Examples of different approaches to measuring effectiveness would include the following:

1. Before/After study where baseline data is collected and after intervention outcomes are measured after specific time periods.

   Errors which can occur, are of three basic types:

   Error Type I  The results of the study suggest an effect when there is none in reality (usually caused by insufficient control of other function or variables).

   Error Type II  Results of the study suggest no effect where there is an effect in reality. (This may be because the sample was not large enough or insufficient consideration of sub groups).

   Error Type III  Results of the study find no effect where there is none in reality, though the intervention is potentially effective. (This may be because the intervention may not have been intensive enough or too short a time duration).

2. From the medical paradigm, the randomized controlled trial (RCT) is often portrayed as the “gold standard” of effectiveness measures. The question should be asked, “can schools be randomized to a health promoting and a control group?”

3. The observational controlled study is a third potential method of reviewing. This shares many of the problems of the RCT in terms of selecting control schools and no participant schools.

4. A fourth and favoured method in terms of measuring effectiveness of health promoting schools is what Keith Tones calls “judicial review”.

   In this approach the indicators and the relationship between indicators should be measured in as many schools as possible and there is an attempt to link the process of change with outcomes through intermediate variables.

   In practical terms how can we build effectiveness measurements into the life of a busy school?

   As a practical suggestion we may wish to consider one measuring and review day per year. We could have on-line data assessment from all stakeholders and the school having an input into the selection of instruments with professional research support for the analysis. Systems could be developed for automatic processing of the data and for reporting back to the school community.
I wish to finish by posing questions that may be central to some of your discussions:

• Does emphasis on academic performance enhance the health of pupils, or is health promotion good for academic achievement, or both?
• Can schools be randomized to a health promoting group and a control group?
• Is health promotion in schools important enough to warrant a continuous monitoring of its progress?

"As a practical suggestion we may wish to consider one measuring and review day per year in schools."  

Jean-Claude Vuille
3.2 Geert ten Dam, Professor of Education, University of Amsterdam, the Netherlands

These are the extended highlights of the presentation of Geert ten Dam who explored the issues from an educational perspective.

Introduction

I would like to talk about the theme of the conference, Education and Health in Partnership, from an educational perspective. This means that my talk is not centred around the question, “why is health such an important theme for pupils and how can we implement this theme in schools?” The key question I would like to raise is, “what should education have in mind for pupils and how can health education contribute to this?” I think that this question provides a good starting point for a more effective partnership between education and health.

Main Task of Education

Let me make it clear from the beginning what I think the main task of education is. In a nutshell: schools must prepare pupils for competent participation in society. From my perspective, the learning of pupils or becoming a competent participant is not just a matter of acquiring knowledge and skills. It also implies becoming a member of the community of practice. In fact, the wish to belong to that community may provide the more powerful motive for learning to participate. Belonging requires a person to see himself as a member, taking
responsibility for his own actions (including the use of knowledge and skills) from that position. The learning process thus implies a change in personal identity. Learning to participate is at the same time learning to become a specific person. Education must contribute to these learning processes of young people.

In many countries increasing attention is being given to the moral and social tasks of education. In the Netherlands, for example, all secondary schools have a statutory obligation to provide “a broad personal and community-orientated education.” This involves, for example, the acquisition of communicative skills, learning about the norms and values of your own culture and of other cultures and how to deal with them, and learning how to function as a democratic citizen in a multicultural society. Such educational aims can also be seen in other countries. In England, the subject “citizenship” has been introduced as a compulsory part of the renewed national curriculum. In the USA, concepts such as “values education”, “moral education” or “democratic education” are part of the curriculum.

What do these splendid objectives actually mean? In the Netherlands all school subjects and thus all teachers must contribute to the broad personal and social development of pupils. This must be realized in relation to domain-specific knowledge and skills. For example, in the subject Biology, pupils must learn:
• to comply with the demands of the environment, hygiene, health and ergonomics;
• what addiction means and the consequences it can have.
These are just two concrete objectives that are relevant to health education.

I mention the objectives of education because health education must become integrated into education as a whole. If not, health education will remain, as it were, the spare wheel in the car. Fortunately, current thinking favours health education. However, health education must then be developed in such a way that it contributes to the learning processes of pupils, as I’ve just outlined from a social-cultural perspective. Health education must help pupils to develop their own identity. Learning about health must help them to participate increasingly competently in the social and cultural practices which society considers to be important.

So I definitely disagree with the proposition that the main justification for health education lies in the fact that “good health is a prerequisite for pupils educational achievement.” This may be true, and such an argument is sometimes useful. But the most important reason for schools to pay attention to health education must be that this social theme has the potential to make a valuable contribution to the main task of education: identity development and learning to participate in society.
The Importance of Social Themes in Education

The emergence of social themes in education can generally be associated with the fact that society is increasingly confronted with problems like drugs, criminality, racism and environmental pollution; problems that education must respond to. Social themes include multicultural education, environmental education, peace education and health education. What the different social themes have in common is that they are all inextricably interwoven in social issues.

But the introduction of social themes in the curriculum is also based on criticism of the way in which schools contribute to the cognitive, social and moral development of pupils and to citizenship. One point which constantly recurs in the debate is the feeling that education is largely isolated from society. One of the problems is that the curriculum is mainly organized by subject or discipline, which leads to the dispersal of meaningful learning content, and little attention being paid to the development of values and the agency of pupils. In contrast, the various social themes emphatically endeavour to organize interdisciplinary learning processes around social issues. The focus on “knowledge and insight into social relations” is characteristic of the social themes. The skills and attitudes aimed at are mainly skills related to dealing with social diversity and the dynamics of society. Social themes therefore have the potential to make a valuable contribution to, what I call, the main task of education: acquiring the competencies to participate in your own, critical way in society.

An Overfull Curriculum

With the introduction of social themes the curriculum is in danger of becoming overfull. Constant demands are made on teachers’ flexibility and ability to implement the innovations. Bearing in mind the danger of an overfull curriculum, it is important to question whether schools can work effectively on developing the knowledge, skills and attitudes that the different social themes demand of pupils. By effectively, I mean in such a way that the conditions are present for pupils to apply what they learned independently and flexibly in new situations, in and outside the school.

If you take a closer look at the objectives of the different social themes, you will see that they actually overlap. The knowledge aspired to in the social themes is fairly specific, that is to say, linked to a specific social theme. Generalization is difficult. At the most, a common element is the fact that social themes focus to a greater or lesser degree on insight into social relations. This is not the case if you look at the objectives concerning skills and attitudes. These overlap substantially. Whether you look at health education, environmental education or multicultural education, you come across the same skills: being able to look at a problem from different perspectives, to deal with diversity, to deal with one’s own feelings of uncertainty, to communicate effectively, to state what you
are prepared to accept and not prepared to accept, being able to make choices and weigh up the different issues involved. The same holds true for attitudes. Almost regardless of which social theme, you come across the following:

- sensitivity to differences between people and willingness to take these differences seriously;
- willingness to deal with the uncertainty and dynamics involved in the making of society;
- a respectful attitude towards others and what they are prepared and not prepared to accept;
- caution in making judgements.

The overlap or common basis doesn’t mean that the social theme makes no difference. Of course the subject in question is important. And even more so, research on learning and instruction shows that cognition is always context linked. What is meant by this, is that the learning of knowledge and skills (and attitudes) always occurs in a specific domain. An attitude like “respect for others” or skills like “coping with peer pressure” can’t be learned in a vacuum. Pupils learn these skills in the context of specific subject matter.

The main task in every social theme, including health education, is to teach the knowledge, skills and attitudes in a specific domain in such a way that pupils are also able to apply what they have learned in other domains both in and out of school.

This means, on the one hand, that health education is not the only social theme in which pupils learn the “stock-in-trade” which is important in taking care of their own health. We have already seen that skills that are necessary to keep healthy are also important in other social themes. So health education as a theme can’t and doesn’t have to address every social problem. On the other hand, health education is important as a meaningful, relevant social theme, in which pupils learn useful things which are only important to health. This very important conclusion must be taken into account in the development of effective strategies to implement health education in schools.

**Transfer**

Perhaps, what I have just described does provide a solution to the problem of the overfull curriculum, but a huge new problem has emerged. Namely, the problem of transfer. An important characteristic of the teaching-learning process is the extent to which pupils acquire the ability to apply what they learned in different and new situations. This is called **transfer**. This is a question of achieving learning outcomes that are not exclusively linked to a specific subject or theme but can also be applied to other new learning situations. Moreover, the learning outcomes aspired to in social themes like health education are primarily used out of school rather than in school, both now and later.
Transfer doesn’t happen automatically. A number of factors seem to be important in bringing about the transfer. Deep processing of the subject matter is essential and an important condition for this is that the subject matter is meaningful to pupils. Pupils must understand the subject matter, be able to apply the ideas and give their own examples. Moreover, the subject matter must make sense to pupils on a personal level. What has been learned must have meaning for pupils in the context of their personal objectives, so that the pupil internalises the subject content whilst learning. This can be stimulated by linking the subject matter to situations, present or future, in which pupils should be able to and want to, use the knowledge and skills they have learned. An important question is, “what are the relevant cultural practices for pupils around which a health education curriculum can be organized?” Visible connections between school learning and cultural practices can also help to prevent motivation problems.

Pupils must be given as many opportunities for participation as possible during the learning process. Health-related behaviour is learned in practical situations. Pupils acquire skills by participating in a culture in which these skills are actually demanded. It’s not just a matter of learning about something, it’s learning by participating. You can see this in health education, for example, in projects when pupils make a plan for a no-smoking school. In such projects pupils are given the opportunity to use the necessary knowledge, skills and attitudes. And above all, they learn to take responsibility for their own actions. It is also important that pupils become aware of what they have learned. They must be able to express explicitly what general principles are involved and where one might come across these principles again. In this context, educational research often suggests that alternately contextualizing and decontextualizing the subject matter as being particularly effective. Starting from a specific context, pupils learn to explore that principle together. Reflecting on the subject matter plays an important role in this. What has been learned is then less imprisoned in a specific situation.

Pupils must not only gain insight into the subject matter, but also into their own learning process. For example: the ability to recognize the influence of group norms on one’s own process of thinking and be capable of regulating it. This focus on one’s own learning process is known as metacognition. A useful teaching strategy for stimulating metacognition is group discussion. In particular, the cooperation between pupils, the problems that have arisen in working together, the strategies employed to solve these problems, etc., are used to teach pupils how to reflect on their social skills and attitudes. With regard to health education, pupils can think about their own reaction patterns in situations where there’s a risk of behaving in a manner that is detrimental to health. In this way, they can develop strategies for alternative actions. Finally, pupils who are reasonably self-confident will in general be more likely to apply what they have learned in new situations independently and flexibly.
Self-confidence is an affective condition for transfer. It is important that health education pays explicit attention to it. For example:

- the confidence of pupils in their own ability to learn;
- pupils’ confidence in what they already know;
- pupils’ confidence in being able to make a valuable contribution to the group and their classmates.

• This promotes participation in the communal learning process.

**Conclusion**

To round off, I’ll summarize what I’ve said in two points.

1) As an educationalist I find it extremely important to pay attention to health issues in schools. Not so much because of the specific goal – the health of pupils – important as that is. But first and foremost because health represents a relevant social theme that gives pupils the opportunity to acquire those competencies (knowledge skills and attitudes) which are necessary to participate in society. This is the main task of education.

2) Health education is only effective – and strictly speaking, this is also true of education as a whole – when it’s taught in such a way that it promotes transfer of learning. This is where we should be channelling our energy. Then health education in schools will become more attractive as an educational innovation. This is to the benefit of everyone. Education and health then really do form a partnership.

“Health education should be taught in such a way that it promotes the transfer of learning. This is where we should be channelling our energy.”

*Geert ten Dam*
3.3 Reflection

After the stimulating and contrasting presentations of Jean-Claude Vuille and Geert ten Dam a plenary discussion was held. There was a strong response from the delegates who felt that the conference had been launched with a flourish and there were many questions.

Some delegates took the view that ten Dam’s presentation, while extremely interesting, had focused mainly on the curriculum and not on wider issues of school curricula. Ten Dam made it clear that she had been asked to speak about effectiveness from an education point of view in relation to the education/health partnership. She had not been asked to specifically explore the health promoting school from an education perspective. When she was asked what were the factors that would promote or support the development of a good climate in schools? She responded by noting the following:

• good educational leadership;
• good teaching;
• good dialogue between pupils and teachers;
• a safe, secure environment.

A participant stated that effectiveness studies on schools should be concentrated mainly on the factors that promote/inhibit change in schools rather than only on outcomes.

Jean-Claude Vuille expressed the view that the different perspectives of education and health specialists were to an extent because of their different ways of working.

In summing up the discussion the rapporteur Ian Young suggested that while some of the differences, in the approach of education and health reflect real differences, we should not lose sight of the features which the two sectors had in common. He summarized them as follows:

• health and education objectives are clearly linked with each other;
• health education goals are inextricably linked with education goals;
• the important value of transfer of learning between related areas such as health education, environmental education, citizenship, etc. are challenges for all of us in education and health.

He stated that the language we use in health and education reflects subtle differences and we need to be aware and acknowledge them. For example, educationalists may use the term curriculum to cover the whole school experience whereas health educators may be referring only to the learning and teaching in the classroom. We all need to be sensitive to these differences in meaning. The term health promotion is not embedded in the mainstream of schools educational research literature, perhaps because it is not seen as necessary, as education has a wider use of the term curriculum. Many of the education terms such as transfer have broadly equivalent terms in the health
promotion literature, for example, action competence. When these differences are explored it becomes more evident that health and education have broadly similar or overlapping goals and our technical language maybe exaggerating apparent differences between our conceptual thinking.
4. Keynote Policy

4.1 Jane Davidson, Minister for Education and Lifelong Learning, Wales

These are the extended highlights of Jane Davidson’s presentation which is an exemplar of policy development from a ministerial perspective in Wales.

Bore da I chi I gyd – good morning from Wales.

I am glad to be here and to share experiences from Wales not the least because I have an abiding interest in bringing health and education together. In 1999, before I became a full-time politician, I co-wrote a book entitled ‘Freeing the Dragon’ looking at how, in Wales we could develop an active public health agenda, bringing the health and local government agendas closer together to tackle inequalities in health. In this document we strongly promoted the role of the healthy school.

I wish to explain the situation in Wales to give a context for my presentation. Wales is a small country of just under three million people. In 1999 the National Assembly was established with powers devolved from the United Kingdom parliament. Education and Health are two of these powers; and in the Welsh Assembly Government we have separate Education and Health Ministers.
Health and Education are the Assembly’s key priorities and we believe that effective collaboration between health and education ministries is crucial to the success of health promoting schools. In my contribution today, I will give you some background to the development of this and the policy decision involved. But first I would like to share with you our thinking on education policy in Wales in order to show how health promoting schools link into our wider agenda.

The Learning Country

Last September we published our key policy document, ‘The Learning Country’, which sets out our vision for education and training in Wales over the decade to 2010. ‘The Learning Country’ describes our goal of developing approaches to ensure that Wales has one of the best education and lifelong learning systems in the world. I want to:

• give every child a flying start;
• put the needs of the learners first;
• raise standards across the board;
• support teachers;
• provide a more rounded and flexible curriculum;
• enhance social inclusion;
• remove barriers to learning – including poor school buildings.

In order to drive forward this challenging agenda, I am implementing a series of measures. Of particular relevance to this conference are our ambitions to:

• build stronger foundations for learning in primary schools with improvements in early years;
• improve transition between primary and secondary schools;
• enable schools to act individually and in partnership as learning resources for their communities.

I believe passionately in developing policy in partnership with our communities and operating from a clear evidence base.

One of my key commitments is to support the rounded development of children through a proposed statutory foundation phase with a play-based curriculum extending from age three to seven. I have pledged to learn from what is known in the world and have seen countries which have literacy and numeracy better than ours at age 11, often with statutory education starting later than the age of five and with imaginative, challenging agendas for their youngest children.

One thing is clear, if we are to fully develop the potential of these young learners, then we must cater for their health needs. Healthy children will have healthy brains and we are keen to make sure that as part of this agenda we develop healthy environments for learning from age three onwards.
Another key area for us is to respond to the evidence that the progress which pupils make at primary school is not always sustained when they move to secondary school. We need to ensure that learning and pastoral support builds on the momentum established in the primary school.

Again this is an area where an important interaction exists between health and education. Pupils who feel safe and supported, who are content with their learning environment, and with their own self-image, are less likely to become disaffected. Clearly this is an issue which can be tackled effectively within a health promoting school. Particularly as one of our criteria for health promoting school development deals with the social transition of pupils.

The Development of the Welsh Network of Health Promoting School Schemes

In common with many of you, Wales developed a pilot project as part of the European Network of Health Promoting Schools. This pilot project ran until 1997 and involved 12 schools. The policy that first drove the move from this pilot project was within the health sector. The document, ‘Better Health, Better Wales’ (1998), set out a vision for improving health in Wales. The development of a network of health promoting schools in Wales was a commitment in that document. This commitment was achieved by the workings of a multi-agency group, with both local and national representatives, from various areas of health and education. This group prepared the ‘Framework for the Welsh Network of Healthy School Schemes’. Within this framework, local schemes were encouraged to develop with a minimum of five schools and with a three-year minimum commitment. It was specifically stated that this development should be within a local health and education partnership. There was strong guidance to local schemes to include the development of their local network within policy documents for each sector.

‘Better Health Better Wales’ did a lot to raise awareness of the range of factors which affect people’s health; and to develop the role of different organizations, including schools, in improving the health of children and young people. It’s successor document, ‘Well Being in Wales’, has just been launched for consultation by the Minister for Health and Social Services. It takes our approach a stage further to ensure that policies and programmes across all sectors add value to each other to improve health and to reduce the inequalities in health in Wales.

‘Well Being in Wales’ emphasises the importance of the role of education in improving health, and indicates the desire to extend the network as well as to actively use schemes to support a national nutrition strategy.
Links Between Health Promoting Schools and Education Policies

I have already acknowledged the role that education can play in improving physical, mental and social health; and the role of health in contributing to educational achievement. I should like to share a few examples of that interaction.

We are keen to narrow the gap in achievement within, and between, our schools particularly between our more deprived and more affluent communities. As part of this approach we have asked our school inspectorate to look at the achievement of pupils within our health promoting schools in order to identify any educational gains from this policy.

Our healthy school network has encouraged the involvement of pupils in decision-making; for instance some schools are running tobacco action groups where young people work alongside the adults in the school to develop policy linked to smoking prevention. This approach is mirrored in ‘The Learning Country’, which makes a firm commitment to young people and pupil involvement in all aspects of school life by the development of School Councils in all schools in Wales. These will link into area youth forums and National Youth Council for Wales. I must also draw your attention to ‘Canllaw Online’ – which provides support for young people including health advice. This initiative features as an example of good practice in the European White Paper on Youth published in February this year.

We have introduced a new ‘Framework for Personal and Social Education in Wales’ which guides schools to look at activity both within and beyond the curriculum. This was followed by a consultation on the desirability of making this framework statutory for which there is overwhelming support – not least because without a framework, young people’s experiences across Wales varied hugely.

The framework was accompanied by a case study publication, showing how schools could meet the requirements of the Framework. One of those case studies charts the work of a health promoting school.

There are also links to our wish to develop out-of-school hours learning, much of which is linked to the setting up of breakfast clubs, and to a range of sporting and other activities.

- The Assembly Government established a specialist Task Force to agree and promote a common vision for the future development of physical education (PE) and school sport in Wales. This decision was based on the recognition that PE and school sport are not just about providing opportunities for young people to “let off steam” or, at the other end of the scale, just about developing the champions of the future – although in some fields this would be very welcome.
There is no doubt that PE and school sport are important in that they contribute to the health, physical fitness and the general development of all young people. We have therefore set up Curriculum Development Centres (CDCs) to test innovative approaches to the delivery of the PE curriculum. The approaches used and lessons derived – over a two-year period – will be shared with other primary and secondary schools to contribute to the raising of standards across Wales and the ambition that all young people will have at least two hours a week of quality PE.

To date good progress has been made with ten CDCs due to be in place by the end of this month and Wales to be fully served by the end of 2003. Firm linkages have been established with the Welsh Network of Healthy School Schemes.

Improving the concentration of our young people is a priority, and I expect ‘The Class Moves!’ materials to have an impact here. These materials were developed from a health perspective in Wales, with officials working with the Dutch originators to produce a resource for Wales in both English and Welsh as we are a bilingual country. During trialing, teachers and pupils identified the importance of the materials in assisting concentration and behaviour, as well as contributing to the pupils’ awareness of their bodies, and of health issues.

Many of the schools involved in our Welsh Network of Healthy School Schemes have identified the need to improve the nutrition of their pupils. The value of healthy meals is acknowledged in ‘The Learning Country’ with a pledge to increase the number of fruit tuck shops in Wales. Funding from the health budget has allowed over 250 such fruit tuck shops to flourish. We have also tackled the “healthy child” agenda through a programme called ‘Safe Routes to School’ where we encourage Local Authorities to adopt and develop opportunities for children to walk and cycle safely to school.

In summary, I believe that we have been successful in Wales in developing a sustainable health promoting school network which demonstrates collaborative agendas in both health and education. We have a network of 22 local schemes, one in each local authority area, which cover all of Wales. Over 400 of our schools are actively involved, and there is a clear strategy to involve more.

Our local healthy school coordinators come from a variety of health and education backgrounds. They work closely together, and with the national coordinator, to ensure that good practice is shared. I believe that part of the success in Wales is due to the fact that we are a small country able to develop close national – local links.

However, I would hope that the sorts of policy initiatives I have described demonstrate a convergence of health and education policy which could also be effective elsewhere. Equally, part of being a Learning Country means that we are also ready to learn from other countries, and this is another reason why I am so pleased to be here today.
I should like to see best practice from around the world influencing our developments in Wales so that our schools become the centre of a healthy and learning community. This conference is an important opportunity for people to network. I hope that there will be further opportunities to share education and health policies, and to look closely at their interaction across Europe. In this way all schools benefit from the good practice of others.

There is a fundamental question that remains for me. If we are going to encourage children, particularly those from our most deprived communities to take on board the messages about health then we can not have a sterile argument about who leads the agenda. The Ministers for Health, Education, Local Government and Transport, are all involved in the initiatives I have described in Wales. The challenge for this conference is how to lift the health promoting school up the political agenda.

Thank you.

"I want to give every child a flying start."  

Jane Davidson
4.2 Constantino Sakellarides, National School of Public Health, Portugal

These are the extended highlights of the keynote presentation of Constantino Sakellarides of the National School of Public Health, Portugal.

Thank you for the opportunity to speak at this conference.

I would like to submit to you two simple propositions:

1. Community-based partnerships involving such key sectors as health and education are likely to become an important part of the kind of social fabric that democratic governance will depend upon in the future.

2. Currently the most critical requirement for developing and sustaining the social infra-structures of such governance is appropriate leadership – the sort of leadership capable of making the benefits of community-based networks tangible, concrete and inspiring to all those involved.

The way I chose to approach these propositions reflects what I have learned from the Portuguese experience in implementing, at an impressive pace, an extended health promoting schools network. Some of the national and local leaders of the Portuguese network are here today. This is also a tribute to their commitment to health promotion.

From the notion of the “supreme rule of law” found in the Magna Carta (13th Century), to the “social contract” formulation of J.J. Rousseau (18th Century), and the welfare state ideals of the industrial revolution (19th Century) came about the modern public vertical bureaucracies we know today. These became the “social protection machineries” of the 20th Century.
During the last 30 years of the 20th century the idea of “social policy” matured. In the health sector the ‘Primary Health Care Principles’ (1979), the ‘European Target Oriented Health for all Policy’ (1984), and the ‘Health Promotion Ottawa Charter’ (1986) became the main landmarks of health policy development. In the emergent “health contract” policy objectives – not the traditional organizational arrangements of the welfare state – became the focal issue. Appropriate health organizations are those that can deliver agreed policy targets.

By the turn of the Millennium, the basic ideas and experiences pertaining to health policy development were not yet widespread enough when new challenges became evident:

• in order for targeted policies to become something more than formal statements, new forms of governance were necessary (stewardship, steering through information and knowledge, people centred);
• beyond national governance, local and global governance also matters. An increasing number of issues do not have suitable national solutions (food safety, drugs policies, technical developments and patents, communicable disease control and rapid alert and response systems).

Thinking and acting both locally and globally, through local, national and global “health contracts”, requires interconnected networks and communities of knowledge and practice, enhanced by tangible achievements.

Policies are commitments to change something in the future. In post-modern societies we need to find new ways to link collective commitments with individual choice, local debate to global decisions.
The ever-increasing rate of change in the nature of our world must also be considered in its implications for policy development.

The “social contract” development path – from the rule of law, to social protection, health policy and multilevel governance – shown in the above chart makes the case for strong prospective thinking.

This notion is further underlined by the “development cycles” described below. From the first wave of industrialization utilizing water power, through to the digital networks, software and new media of today, the rate of change accelerates. What are the expected ingredients of the next development cycle looming ahead on a not so distant horizon?

- New forms of energy with different distributional features?
- The effects of the “new biology”?
- A “human ware” where intellectual capital, new learning paradigms, and the role of emotions are more critical?

The political, managerial and technical requirements for “horizontal governance” in health and education are considerably complex. Heavily process-orientated initiatives often become tangled in their demanding procedural difficulties. Considerable efforts and resource inputs with no timely and clear results challenge seriously the very sustainability of the initiative. A sophisticated leadership network is necessary in order to succeed. This needs to be proactive and prospectively oriented, politically sensitive, skilful managerially, and above all capable of making the benefits attributable to these education and health partnerships tangible. A few examples may make these points clearer.
Asthma in School Children

Asthma is a very common condition. It affects approximately 10% of school children and 5% of adults. Currently, it seems that this high prevalence is increasing. Acute episodes are disabling and distressing and they require urgent treatment. However, this simple, traditional and common approach – treating urgently and effectively acute asthma episodes – can be substituted by a more interesting one. School children can be taught to measure periodically their respiratory output, using very simple portable technologies, with the help of their friends, parents and teachers. In doing so everyone is introduced to a new “learning through experience” mode. It becomes apparent that respiratory dynamics are influenced by “internal factors” (apprehension, anxiety, stress or bronchial infection) and by external ones (humidity, air pollution, environmental dust and pollen air contents). It also becomes evident that these factors can be influenced by individual or collective action. This calls for experimenting, monitoring and evaluating. It is also possible to predict acute asthma episodes, since respiratory output can be shown to decrease sometimes before the acute episode takes place. Often the small adjustments in medication can actually prevent an acute attack.

Furthermore this kind of concrete, hands-on learning experience makes it possible to address, in a more meaningful and tangible way, more general issues such as “global climate” or “access and cost of medical technologies and pharmaceutical drugs”. When this happens local communities are empowered to think globally.

These are not scenarios about the future. This is starting to happen. Health promoting schools should be able to show that they can avoid school absenteeism, failure to go to work by parents, emergency room utilization and hospitalization due to acute asthma episodes. By so doing schools become community settings where the children and adults alike can find better ways to learn about the human body and to understand and influence the world they live in.

School Crisis Management – the Case of Meningitis

We are often reminded of how important it is to learn to take part in crisis management situations. Sporadic cases of meningitis are relatively common in school populations, particularly in winter and early spring. Meningitis is a serious disease. Once a case of meningitis has occurred in school there is fear that more cases may occur, transmitted by the diseased child. Appropriate crisis management could involve the following stages:

• early and effective communication;
• fear-control strategies;
• evidence based protective measures;
• close monitoring and quick response to unexpected situations;
• open collaboration between parent, school and health authorities.

These can help to avoid panic and unnecessary disruption of school life while providing an appropriate level of protection to school populations and to the community at large. This approach can be seen as an opportunity to improve the quality of the education and health partnerships, while also providing a lively learning model on crisis management to the school population and to the local community. Crisis management models of good practice could become part of every health promoting school's learning equipment.

Schools that contribute positively to healthier communities might be those that provide learning opportunities for dealing effectively with behavioural differences.

Two situations involving Asperger’s syndrome illustrate my point. Asperger’s syndrome, a milder condition within the autism spectrum disorders, is more frequent in school populations than was previously thought.

The first situation I would like to refer to here is described in a written statement by a 12 year old girl and tells us about, “how it feels to cry myself to sleep”, when a school environment cannot cope well with such behavioural differences.

“…here is my song.
I am a little girl with glasses, the one they call a geek.
A little girl who never smiles because I have braces on my teeth.
I know how it feels to cry myself to sleep.
I’m that kid on every playground who is always chosen last
A little girl trying to overcome my past…”

The second case refers to an award-winning website developed by a person with Asperger’s syndrome.

The home page starts with an “Oops…a wrong planet” (in fact not a “wrong” planet but a different one) and closes with a quote from an inspired poet:

“…could you take a chance? Could you find a way?
To see me shining through
In everything I do
And see me beautiful”.

Health and educational policies are not just big words. When translated into tangible local action and global influence by good governance and effective leadership, they can make a difference on what matters.
5 Keynote Participation

Roger Hart, The City University of New York, United States of America

These are the extended highlights of the presentation of Roger Hart who explored issues related to young people’s participation in their own learning from the perspective of his work in environmental education.

Thank you for the opportunity to be at this conference and to address you on the subject of participation. In the developmental psychology literature it is well known that doing or experiencing is central to learning yet it is unusual to have educational projects that are self-generated. That is generated from the learner’s own wish to investigate a specific issue.

It has become apparent that children do not progress in a stepwise way. This stepwise model of learning developed from a naïve interpretation of Piaget’s stages of learning. Vigotsky takes the view that learning precedes development.

Resilience in children is in part affected by opportunities to participate both formally and informally. Participation enables children to develop autonomy and responsibility, not creating dependence but helping young people to understand interdependence. This in turn will help young people to become responsible citizens.
In my view we need to integrate health education with environmental education, citizenship and other related social issues. In reality I hope your movement dies as it needs to become part of a wider integrated approach. The original reasons for setting up schools have a strong link to the factories of the industrial revolution. That is, they were largely utilitarian and geared to a product at the end of the assembly line. In reality we now need citizens, particularly in the northern hemisphere, that have a broader view and will see health as a global issue. To achieve this we need young people to initiate more of their own learning by drawing on their own experience. For example, if you are a school in a racist community and you do not talk about racism – you are a racist school. Ignoring the problem doesn’t absolve the school of the problem.

One of the most liberating ways forward is to get children to identify their own issues to work on, by starting with their everyday life, for example their play or their journey to school. Most schools are tightly controlled by age groups but when they work in mixed groups across ages they learn from each other and this gives added value to the approach.

Children are particularly interested in environmental issues and will often select these when they have the opportunity to initiate their own learning. Sustainable development is defined as the ability to use the resources in the present without threatening access to, and availability of, resources in the future. It isn’t just about the natural environment it is also about the right to make a living and our relationship with the physical world including the built environment.

When the slogan “Act locally, think globally” was developed an opportunity was missed, in my opinion. It should have been “Act and think locally and think globally!” In my view the original implied that the local population was being told what to do rather than being empowered by starting with their own learning.

I wish to suggest an action model for children’s participation in their own learning, I would suggest we consider the following.

**Action Research Model for Children’s Participation**
The further planning referred to in the model may involve young people in discovering the barriers to change. Even though young people do not always succeed in bringing about change, this is an experience they can utilize as citizens and is an important learning experience.

“One of the most liberating ways forward is to get children to identify their own issues to work on, by starting with their everyday life, for example their play or their journey to school.”

Roger Hart
6. Ministerial Meeting on the Theme of Policy

The organizations supporting the ENHPS, the Council of Europe, the European Commission and the WHO Regional Office for Europe agreed to set up a series of ministerial meetings on the issue of health promoting schools and the first one was held as an event within the main conference agenda. The audience for the meeting were officials from the Ministries of Health and Education in the EC and EU accession countries. At the meeting participants discussed the status and progress of the ENHPS. It is planned to hold further events in other parts of Europe especially Central and Eastern Europe, the Caucasus and Central Asian Republics, in the future.

The ministerial meeting representatives of the International Planning Committee made brief introductory remarks.

Karl-Friedrich Bopp of the Council of Europe gave examples of the importance of the health economics argument when he stated that there was evidence that one dental cavity prevented through fluoride rinsing cost an average of 4 dollars against 64 dollars spent on treating a cavity. He suggested that the Egmond Agenda should be used to pass on a powerful argument on the economics of prevention and health promotion.

Gottfried Thesen of the European Commission took a historical perspective and suggested that it was time to check the extent to which the health promoting school concept is embedded in educational policy in member states.

Erio Ziglio of WHO Regional Office for Europe stated that the main feature of the health promoting schools movement, from this perspective was the development of a sustainable international partnership between the European Commission, the Council of Europe and the World Health Organization. He commented that we had moved the network “from pilot to policy”.

6.1 Presentation: Finding common ground in Health and Education: the Healthy Schools Programme

These are the extended highlights of Don Nutbeam’s presentation, head of Public Health, Department of Health, England, at the ministerial meeting within the Egmond Conference.

Thank you for the opportunity to present at this meeting. I wish to reflect on past events in the health promoting schools movement, to then focus on the present and suggest ideas for future developments.
To an extent we can view three phases of evolution in the health and education partnership as it relates to schools. These three phases of evolution are:

- phase 1: schools as a convenient venue;
- phase 2: schools as institutions;
- phase 3: schools as educational institutions.

In phase 1, schools were seen as an important point of access to young people for educational programmes. There was a growth in the number, scope and sophistication of classroom-based educational programmes directed towards achieving behavioural goals—especially related to tobacco, drug misuse and sexual health. Many of the classroom-based initiatives increasingly took account of improved understanding of the psycho-social determinants of behaviour and were largely directed at developing the personal and social skills of the students.

In phase 2, viewing the school as an institution, the underlying assumption was that early promising results from classroom-based interventions were not sustainable without other forms of institutional support. There was a growing awareness of the influence of the hidden curriculum of schools and that wider aspects in the life of schools, such as their organization and climate, had an impact upon the effectiveness of classroom-based work. Research increasingly provided insights that these wider aspects of organization and whole school policies could have an impact on the health and wellbeing of students and staff.

In phase 3, recognizing schools as educational institutions, there was progressive recognition that schools are not merely convenient institutions for health promotion. It was also increasingly apparent that:

- curriculum time available is limited for health education;
- there is limited time and resources available to support specialist teacher education and training;
- policy and environmental change in schools is difficult to implement and sustain.

Research\(^1\) indicates that pupils most engaged in school are more likely to succeed academically and to display positive health behaviours. The corollary of this is that pupils who are most alienated are more likely to engage in high-risk behaviours.

The evidence also suggests that schools can overcome or reduce alienation of students by:

- providing opportunities for a meaningful contribution to school/community life;

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achieving more participatory approaches to teaching and learning;
reinforcing personal and social responsibility through school organization;
raising awareness of economic exploitation;
providing an anchor for students in difficulties.

In addition, I would suggest that schools can create a supportive environment for health by:
• providing a comprehensive and integrated health education programme for students;
• adopting organizational practices which complement the teaching programme;
• offering a supportive social environment for students;
• fostering links with resources in the community and making optimum use of school health services;
• creating a safe and secure physical environment.

In England, the government launched the Healthy Schools Programme in 1998 and it is jointly funded and managed by the government’s Health and Education Departments. The team is based at the Health Development Agency in London to support the implementation of the programme across England.

The National Healthy Schools standard provides an accreditation process for health and education partnerships at a local education authority level. At school level the standard will be concerned with:
• leadership, effective management of change;
• policy development;
• curriculum planning;
• teaching and learning;
• school culture and environment;
• giving pupils a voice;
• providing pupil support services;
• staff development;
• partnership development;
• assessing, recording and reporting school achievements.

Tangible progress has already been made. This is clear from the fact that formal education and health partnerships exist in all parts of the country and funding is now provided to all local education authorities with priority being given to schools in areas of deprivation.

In addition more than half of the schools in England are involved in the programme and a series of support resources or tools have been developed to assist schools. Further details of the programme and these resources are available on the website www.wiredforhealth.gov.uk

It is planned to develop a set of health and education improvement indicators for use in schools in the future but there is some evidence of progress already in schools involved in the programme compared to schools nationally. These areas of progress relate to:
• the behaviour of pupils;
• the standards of work in the classroom;
• the quality of the PSHE programme;
• the management and support of pupils;

In the future we intend to establish a national accreditation programme for schools and we aim to have 100% of schools serving deprived communities involved in the programme by the year 2006. The website referred to earlier will be further developed as a good practice database and interactive forum for school practitioners.

In conclusion, I believe we must recognize that schools cannot solve all of society’s health and social problems and that we must acknowledge that the primary business of schools is the education and social development of young people. We should take encouragement from the fact that there is a considerable coincidence of the determinants, and therefore, strategies to achieve the best academic, social and health outcomes for students.
7. Young Minds Project

This project, which was central to the Egmond Conference, inspires young people, teachers and schools to engage in educational dialogue aimed at both promoting meaningful discussion and making a difference with regard to health.

Participants in Young Minds included students, teachers and facilitators from the following countries: Czech Republic, Denmark, the Netherlands, Iceland, Finland, The Former Yugoslav Republic of Macedonia, Portugal, Scotland, Slovenia, Spain, Sweden and Switzerland (Appendix III – List of Participating Schools).

The students work in teams and collaborate to explore the following health topics:
- alcohol, youth, culture;
- nutrition, food, culture;
- wellbeing and school environment.
Their website is www.young-minds.net.

Key Features of the Project

- **Student participation:** students are genuinely involved in dialogue and decision-making about specific aspects of the topic on which they are working.
- **Action and change orientation:** the student project-work is directed towards action and change; students’ ideas and visions have a crucial role in deciding about actions to be taken with regard to promoting health in their schools and communities.
- **The use of Information and Communication Technology (ICT):** students use the web and other new technologies to investigate the topics, exchange and discuss ideas, present their findings and initiate a broader debate.
- **Cross cultural collaboration:** students cooperate in order to explore cultural differences and similarities with regard to the health topics, and place emphasis on global interconnectedness and social responsibility.

The coordinating centre for the project is the Research Programme for Environmental and Health Education at the Danish University of Education.

**Young Minds at Egmond**

The students interviewed delegates at the conference including an hour-long session with Jane Davidson, the Minister for Education and Lifelong Learning, Wales. The following transcript is part of the students’ interview with Jane Davidson.
Young Minds – Gunnar, Iceland and Lina, Sweden, “How do you think that students themselves can improve their wellbeing in schools?”

Jane Davidson, “Well one of the things we are setting up in Wales, is a school council in every school, because I am such a strong fan of participation and I think youth ought to be able to directly comment on services. And where schools have school councils now, quite a few of our secondary schools in particular have them. It is really encouraging to have the school to give pupils a budget, it does not have to be a big budget, just a budget so that they will actually feel in control of that money.”

Venka Simovska, the coordinator of Young Minds was delighted with the impact of Young Minds. She stated,

The participation of Young Minds demonstrated that when involved genuinely, young people could influence the conference process in a meaningful way. Young people’s confidence and competence to play an active role in the conference in Egmond is a clear indicator of their ownership and empowerment.

I believe that the preconditions for this include that:
• young people should be involved in their own project at a conference, related to the main conference focus;
• their project should involve cross-cultural collaboration and joint actions at the conference;
• this cross-cultural collaboration has to involve a development phase before the conference;
• young people should be involved in early phases of planning and decision –
  deciding about both the content and process of the project;
• young people taking action should be an integral part of the school projects
  before the conference.

The importance of the experience to the young people is reflected in the
following views.

“We have participated in one of the most important events of our lives.
We have learned more in these few days than in our entire student life!”

*Portuguese Young Minds*

“We are full of impressions, new experiences in cross-cultural and social
collaboration that have helped us open many new chapters in our own and
school lives”.

*Slovenian Young Minds*

The importance of the environment, not only for a conference but for life was
reflected in this poignant statement.

“As the Czechs do not have any sea, touching its spirit is extremely
important… the never-ending longing of the Czech nation.”

*Czech Young Minds*

The importance of the international experience was expressed as follows.

“Here we are back in Denmark after five fantastic days in the Netherlands.
We loved working together in a different way, helping each other in defiance
of boundaries.”

*Danish Young Minds*

The project was featured on National BBC Television on the Scots Gaelic
language programme, Eorpa (Europe), on 3 October 2002 and this was
conducted in the Gaelic language with interviews with the head teacher of
Plockton High School, Scotland, Young Minds students, Venka Simovska and
conference organizer Goof Buijs.
8. Introduction to the Workshops and Paper Sessions

The conference programme linked the workshops, paper sessions and active posters, through the conference themes of Effectiveness, Policy, Concepts, Teachers, Curriculum, Partnerships and Participation.

The following section of this report reflects on the content which was discussed in almost 150 specific contributions and interactive debates.

For readers who wish further information from the original sources a number/letter reference code relates items to specific sessions. The full numbered list of sessions is given in Appendix IV.

Each of the seven themes is considered in turn and although it hasn’t been possible to refer to every paper, the key issues are described in a way which attempts to reflect the rich variety of the contributions and debate which were a central part of the conference.

8.1 Effectiveness

The theme of effectiveness was explored on day one of the conference in two keynote sessions from a health and education perspective.

In the interactive sessions this theme generated considerable debate which posed fundamental questions which were explored but not fully resolved. These questions could be summarized as follows:

• Do we have a shared understanding of what we are trying to achieve in health promoting schools?
• What constitutes evidence of effectiveness?
• Do we know that health promoting schools are effective? If we do know this have we shared this knowledge with key stakeholders and policy makers?
• Have we utilized fully the research on whole-school effectiveness in relation to health promoting schools?

Some of the differences in the positions taken on these issues reflect the stages of development of health promotion in different countries, but also reflect different traditions and cultural factors.

Even within a country, some of the above questions may be unresolved. For example in Denmark (3A) it was suggested that a lack of clarity in curriculum guidelines as to what was important, limited the design or effectiveness measures within the health education curriculum.
In Slovenia (2A) smoking prevention initiatives demonstrated positive outcomes in terms of pupils' behavioural intent not to smoke. However, the limits of this type of measure were also acknowledged, especially when dealing with behaviours that could be addictive.

A Welsh study (38) concluded that given the complexity of smoking uptake it was unlikely that a single intervention would be successful with all pupils and that this had implications for both the approach used and the effectiveness measures associated with the intervention.

In Ireland (4A) qualitative action research was helping to define best practice in both curriculum development and at a professional development level.

A qualitative analysis approach in Belgium (4A) was helping to unravel the factors which facilitated the successful implementation of health promotion in schools. These were described as the:
- familiarity of school staff with the principles, concepts and methods of health promotion;
- position of the head teacher;
- collaboration between the school, parents and local community;
- collaboration with school counselling services;
- coordination between education and health policy.

In Australia (3A) quantitative scales for gathering evidence on health promoting school effectiveness have been developed. These included sub-scales monitoring students, staff/teachers, parents, school principals (head teachers) and health workers.

In Norway (2A) the strong relationship between student satisfaction with school and academic achievement was explored. The Health Behaviour in School-Aged Children Survey shows that the increased autonomy of students which health promoting schools promote is also linked to students' satisfaction with schools. These studies do not show a clear cause and effect relationship but they demonstrate associations which are important in relation to health promoting schools.

A study from Switzerland (3A) favoured the judicial review approach. It also referred to the importance of acknowledging that some of the outcomes from health promoting schools were long term and suggested the need to repeat evaluations as a means of measuring long-term trends.

A review paper from USA (2A) described strategies that had proved effective in school health. The conclusions were that:
- school-based health intervention can improve academic performance;
- students' health and nutrition status affects their enrolment;
- coordinated strategies produce a greater effect than individual strategies;
- strategies must be targeted;
health education is most effective when it uses interactive methods; health promotion for teachers benefits their health, morale and quality of instruction.

In conclusion and in answer to the fundamental questions posed at the beginning of this section, the following is emerging.

We do not have complete consensus on what we are trying to achieve, and therefore measure, across all countries or even within all countries. However, we are now debating all the issues openly compared to a decade ago and there is much that is now agreed on what is practical, credible and ethical.

There is also a growing realization that the health sector has to work in partnership with the education sector. This implies that the health sector must accept the reality of schools as educational institutions. Related to this issue is the need to take account of other research relating to effective schools, which can enlighten work in health promoting schools.

8.2 Policy

There was a broad consensus at the conference that effective policy development is a cornerstone on which health promotion in schools can be built.

The sessions reflected the importance of policy development at a number of different levels. That is at the international, national, regional, school and classroom levels.

There appears to be a growing understanding of the factors which can promote or inhibit good policy development and of the process of policy development relating to health promotion in schools.

The issue of the sustainability of policy development is also now on the agenda because in some countries lessons are being learned from earlier policy development which has not proved sustainable.

At the international level, the collaboration of the European Commission, the Council of Europe and the WHO Regional Office for Europe, in supporting and facilitating member states, to share their policy development experiences, is viewed as a significant factor in the progress that has been made to date.

In the Flemish-speaking part of Belgium (1B), like many other parts of Europe, there have been significant changes in the education system in the last few years. The view was expressed that the health promoting school concept had not evolved in tune with rapid changes in the education system because it was not fully integrated into the education system. The issue of sustainable funding of health promoting schools was also a problem that had created difficulties because it was still dependent to an extent on external support.
In Belgium they are now in the process of facilitating the dialogue with policy
makers and stakeholders in the education system to enable health promoting
school policy to be more integrated into the mainstream of the education
system.

In a workshop session (3B) delegates shared views from their own experience
on the challenges, barriers and successes in policy development. This group
explored issues such as:
• understanding the ingredients of empowerment;
• power relations and the role of advocacy;
• the definition of different roles;
• establishing common goals;
• leading a process of empowerment.

The group agreed that national coordinators for health promoting schools were
an essential prerequisite for policy development. Professionals needed to feel
valued in the process and key players needed skills in advocacy.
Empowerment was seen as the philosophical basis for health promotion in
policy development and in all other aspects of development.

In Hungary (2C) the concept of an alliance of education and health is viewed
as central to their approach to policy development. A new health education
curriculum for primary schools has been developed and associated teacher
education and training has been built into this process. Outcome evaluation of
the new teaching materials report more happy, self-confident students.

In Slovenia (1B) an intersectoral approach has also been taken and the
following factors were seen as central to enabling the continuity of health
promotion in schools:
• a strong national support centre;
• a well structured programme;
• a close relationship between school project teams and potential allies within
  the health sector;
• mass media support.

In Scotland (country report poster) policy development has culminated in
government policy papers in both health and education giving unequivocal
support for the further development of health promoting schools.

The Government recognizes the concept of the health promoting school as
important in ensuring not only that health education is integral to the
curriculum but also that school ethos, policies, services and extra-curricular
activities foster mental, physical and social wellbeing and healthy development.

As stated in the workshop on policy (3B) the advocacy role has been essential
in embedding health promoting schools in government policy in several
countries. For example, the statement from the Thessaloniki conference that
every child should have the opportunity to be educated in a health promotingschool has been important to national coordinators and others in their
advocacy role.

In the Russian Federation (2B) the promotion of health in school is recognized
by the government as a promising approach to achieving the nation’s health
and education goals. In addition, at a classroom level in Russia (1C) there is a
policy of using relaxation, self-massage and movement to reduce student
tension and fatigue in a parallel development to the approach of ‘The Class
Moves!’ in the Netherlands.

A reform of school medical centres in the French-speaking part of Belgium
(1B) reflects the influence of health promoting school policy on the supporting
infrastructure. From September 2002 a new law came into effect which will
reduce the medical screening component of school medical centres’ work and
allow more time for health promotion work with students. A large training and
dissemination process is being developed to support this new approach.

In the Netherlands (1B) regional health promotion agencies are collaborating
through new health promoting school teams assisted by one of the workers in
the regional health promotion agencies. These school-based teams include
parental and student representatives and they will draw on school health data
in planning their approach in each school. This approach reflects a desire to
have greater coordination of health promotion in schools in the Netherlands
and a desire to more closely meet the needs of students and specific school
communities.

In conclusion, it appears that in the last five years the health promoting school
movement has started to become embedded in national, regional and school
policies across Europe, “moving from pilot to policy” to quote Erio Ziglio. In
some countries this process is at an early stage of development because
health promotion challenges the vertical bureaucracies as described by
Constantino Sakellarides in his keynote presentation. Even in countries which
have health promoting school policy statements embedded in the mainstream
of government policy in the education and health sectors, there is still much to
be achieved in translating words into action or in “walking the talk”. As we
develop a more sophisticated understanding of the policy process, this will
allow all countries to learn from others’ experiences in policy development.

8.3 Concepts

The conference theme of concepts generated a large number of papers, which
showed that there is still debate about fundamental aspects of health and
health promoting schools, as well as interest in newer concepts which are
emerging.
The issues discussed could be classified into four clusters of concepts. The first cluster is fundamental issues such as revisiting our concepts of health. Do we all share the same starting point? The second cluster of concepts focus on participation, democracy and related concepts which have gradually become more and more central to the health promoting schools movement. The third cluster relates to concepts tied to the overall aims of health promoting schools such as empowerment, action competence, health literacy and lifeskills. A fourth cluster relates to ideas and concepts which are part of other initiatives but which health promoting schools are adopting because they support the achievement of related aims in schools. For example, school effectiveness, ecological concepts, learning transfer, multiple intelligences, complexity science.

The workshop on the theme of policy (2D) returned to fundamentals and suggested that there was a need for the movement to adopt a uniform definition of health that was broad enough to be inclusive. This was viewed as a way to get greater involvement and commitment to health promotion in schools. In addition, the workshop group felt that there was a great need for more research on the concept and practical realities of participation within health promoting schools. Roger Hart’s presentation helped to clarify levels of participation but there was a great need to explore related issues, such as the effectiveness of greater student participation.

Colleagues from South Africa (1D) explored the concept of health literacy which they suggested is attained when a person can:

- evaluate information pertaining to his/her health and wellness;
- integrate this information;
- make a structural change or an adaptation to his/her lifestyle and conditions.

Health literacy is viewed as a key part of the movement to sustain local and global initiatives on health.

In addition a case was made (3C) for the use of the terms wellbeing and wellness because of the physical domination of some people’s views of health and the risk that health is seen only as the health sector’s business.

Exploring the concept of school climate through qualitative research in Sweden (3C) revealed that the existence of a well-defined idea of what a school stands for appears to be important in influencing the staff and students’ views of themselves and their school.

In Ireland (2E) there is a collaboration with Australia which is developing a mental health promotion resource for secondary schools. It aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful. Positive effects have been revealed by the research in Ireland and there are discussions ongoing with Germany and Switzerland (2E) to produce materials and guidelines for adaptation within Europe.
The associated concept of the social climate of schools was explored in the Czech Republic (4C). The social climate of health promoting schools was compared with a group of control schools and using a specific rating scale and questionnaires it was apparent that in all characteristics of social climate the health promoting schools scored more highly. In addition, there appeared to be more openness in health promoting schools to admit problems such as bullying behaviours.

In the Netherlands (1D) within the context of a special subject “Art of Living” human ethical education links with health education and values education. In this method the class and school community actively develop and help to create the climate of the school. The authors link the concept to the development of social capital in schools.

In Greece (1E) a project is looking at the promotion of equality, citizens’ rights and tolerance of cultural differences within school. This has identified that school pupils, teachers, parents and community members need further education in cultural tolerance in the emerging multi-cultural societies. The point is made that equality and citizens’ rights are ethical ideals that the school of the 21st century has to promote for a functional democratic society.

The important role of skills development was explored in a paper from the Education Development Centre in the USA (1D). Critical success factors for effective lifeskills approaches were identified and these included:

• moving from education programmes delivered in isolation to a comprehensive approach;
• moving towards efficient placement within the curriculum;
• moving from generic lifeskills towards linking content and behavioural outcomes.

In conclusion, this final point from the USA paper is an interesting link with keynote speaker Geert ten Dam’s exploration of the concept of the transfer of learning. Given the pressure on school curricula and the overlap of many social education movements such as health education, citizenship, environmental education and development education, it is self-evident that we have to maximise learning opportunities and help young people transfer learning from one context to others.

Other priority areas for further conceptual research and development relate to the active participation of students in their own learning and the implications of this for schools. The other trend which is apparent from the conceptual sessions is the breadth of the issues explored which is to a large extent a product of the broader concepts of health which are now part of the currency in the health promoting schools.
8.4 Teachers

The issues relating to the theme of teachers at the conference sessions could be broadly allocated to two categories. Firstly, issues related to teachers’ health and wellbeing within the context of health promoting schools. In this section some of the initiatives were at the organizational level and in some cases draw upon wider initiatives on promoting health in workplaces generally. In other cases the approach to teachers’ health was at a more individualistic level, enabling teachers to develop skills to cope with stress or to avoid “burn-out”.

A second group of projects relate more to teacher competencies and training as part of professional skills development and it is encouraging to see the wide range of initiatives that are underway in this area. These two categories are not distinct as teachers’ satisfaction with their work is clearly influenced by their own skills development and performance which can in turn influence aspects of their health and wellbeing.

A workshop (1J) on teachers’ health hosted by representatives from England and Wales, but attracting a diverse group, reached a consensus that staff health and wellbeing was increasingly moving up the agenda in many countries. The specific issues varied in different countries, including changes in demography of the teaching profession with more older teachers in post, higher expectations of teachers resulting in more stress, and an increasing rate of change in curricula and assessment demands.
There was agreement that many of the issues pertaining to teachers were related, and there was recognition of the importance of sharing experiences as the teachers’ role in health promoting schools was underdeveloped and important to future development.

In Australia (2F) an important study currently being conducted in primary schools is attempting to identify pathways of influence between organizational (school) factors and personal health issues of teachers. A comparison is built into the design to see if schools that give health promotion a higher priority differ from other schools in those pathways of influence.

A Norwegian study (2F) indicates that there are a number of conditions at the organizational level which enable teachers to facilitate health promotion in schools in general. These conditions are common goals, good leadership, sufficient and available resources, and cooperation inside the school and with the local community.

In the Netherlands (2F) higher staff absentee rates in schools has started to focus more attention on prevention issues. Initiatives are being set up to integrate a workplace health promotion approach with quality management tools.

A South African study (poster 26) investigated the potential of “Clinically Standardized Meditation” techniques to assist teachers to control stress and promote wellness. The study produced statistically significant changes in the experimental group suggesting that these strategies may have a role to play in promoting wellbeing in teachers.

In the second category relating to teachers’ professional development, a Czech study (2G) investigated the key competencies in which teachers needed additional support. It revealed the following as vital competencies:
- to manage and evaluate the learning process;
- to reflect on one’s own work, including written reflection;
- to use strategies of teaching and learning that provide the desirable characteristics of the educational processes;
- to model the required skills in everyday life.

In Slovenia (3D) evaluation of lifelong professional training courses has indicated that teachers need and value new knowledge and skills relating to health education and health promotion. In Norway (3D) while motivation to participate in school health promotion is good, the implementation of the project in individual schools can affect individual teacher motivation towards the project.

In Denmark (3D) the health promoting schools project includes intensive courses for teachers, consisting of 30 to 60 lessons per year and there is also support throughout the year from consultants. Research associated with this
suggests that the development of health education in Danish schools depends on:
• the teachers’ participation in training;
• the teachers’ understanding of health;
• the teachers’ willingness to change their practice;
• the head teachers’ support of the teachers.

Also in Denmark (3D) a research project concluded that it was possible to detect and follow a parallel development of the action competence of pupils and the pedagogical competence of their teacher. The need for further research on teacher competencies relating to facilitating the active involvement of pupils, was identified.

In Scotland, (4E) a three-year randomized controlled trial on sex education was undertaken in 25 schools and teacher education and training was a key part of this project. A deficit was identified in the trainers available to support the expansion of this project and a core group of 24 trainers have received intensive training to facilitate the dissemination process. In addition to the training manual a curriculum resource with associated video materials has been produced. Schools will only receive the curriculum materials if a commitment to training is given. Also in Scotland (4E), a training manual, entitled ‘Confidence to Teach’, is being developed from the ENHPS project in Scotland. This arose from teachers requesting support to deal with complex issues such as body image, self-esteem, dieting behaviours, puberty and physical activity.

In conclusion the wide range of active research and development projects in this area shows that teachers’ health and teachers’ professional development are high in the priorities of many countries. The relationship of these two areas becomes evident in some of the above projects. Many teachers across Europe recognize that they need support in being more effective in health education and health promotion. If they get high quality support there is evidence that there is a pay-off in terms of their own competencies, their health and the education and health of their students. Also there is a growing focus on organizational development of schools through the issue of health.

8.5 Curriculum

The curriculum within health promoting schools has been a central issue from the outset of the health promoting schools movement. The term is often used in different ways between the education and health sectors and the importance of clarifying this has been referred to in the reflection which followed the opening keynote presentations.

There are differences between countries as to whether the curriculum is centrally (nationally) prescribed or whether there are broad guidelines with
flexibility at a school level. These differences will also impact on strategies to influence curriculum change in specific countries.
The links between health education and other curriculum areas such as environmental education and safety education was an issue raised both in Geert ten Dam’s keynote paper and in several of the workshop and paper sessions. There is a growing realization that ready-made classroom resources without associated training are limited in their effectiveness. In addition, the papers reflect an increasing trend away from topic-specific approaches to more generic and holistic approaches in many countries.

Another issue that is being discussed is the tension between a rigidly prescribed curriculum on the one hand and the need for teachers to draw on young people’s pre-existing knowledge, and the benefits of a highly participative approach, on the other hand.

A workshop (1F) looked at various factors including the role of ready made, externally-produced classroom materials to support the health education curriculum. There was an overall consensus that utilizing ready-made learning resources can be an obstacle to the further development of the health promoting school. The workshop also considered young people’s needs and utilizing parents as a resource within health promoting schools.

In Croatia (4F) there has been a significant development of training manuals to respond to the needs of schools to deliver the curriculum. Between 1995 and 2002 five manuals have been produced involving students, teachers, school counsellors and doctors. The participative approach to developing the manuals has resulted in a broad ownership and widespread use within the health promoting schools network.

In Lithuania (2H) the links between health education and sustainable development has been made within the context of the strategy for ‘Education for Sustainable Development Agenda – Baltic 21’.

The relationship of health education to safety education in schools was explored in a paper from Switzerland (2I). The case for safety education being a part of health education in schools was linked to factors such as:
• accidents are the most frequent cause of death of young people in most industrialized countries;
• safety and health education both explore risk competence;
• safety and health share many whole-school issues.

In Austria (3E) an evaluation of health promoting schools showed specific positive health-related changes in 13-year old girls. It also demonstrated that schools are building sustainability into their project structures but need support with project management. The biggest obstacles related to integrating health promotion into the overall school programmes and in involving pupils and parents in decision-making.
In Finland (3E) a substantial evaluation project of the Finnish network is being currently undertaken. The curriculum appears to be well developed and the schools are clear about their mission. In some schools there is a concern that progress is dependent on a single teacher. While networking is more established there is much more to be done in networking with other professionals in the community associated with the school.

An initiative in Portugal (1G) is investigating the life quality and wellbeing of higher education students in relation to a range of factors including the academic context of the student’s life.

In England (1G) a study was conducted into smoking risk in relation to engagement with a school-based smoking intervention. It concluded that disengagement from school generally, an established risk factor for smoking, generalizes to disengagement from didactic school-based health promotion programmes.

A qualitative study in Scotland (1G) investigated why school staff may not enforce pupil smoking bans. The study found that staff decisions were largely context-dependent or motivated by personal or professional values. The case was made that sometimes teachers make a judgement that intervening on smoking may interfere with relationships that teachers have built up with pupils who may have significant problems in their lives.

In the Netherlands (2H) new curriculum materials on smoking were developed which promote a foundation of knowledge, skills, attitudes, intentions and social skills for primary-age pupils. First experiences have shown that schools are willing to adopt such programmes as long as the material is practical and contributes to the schools’ educational aims.

In conclusion, it is becoming clear that in many European countries the health promoting school concept has strongly influenced curriculum design. In addition, there is an increasing recognition that resource production to support curricula has to actively involve stakeholders and be integrated with training initiatives.

Lastly, it is becoming evident that it is necessary to demonstrate the relationship between health education and overlapping areas of the crowded curriculum.

**8.6 Partnership**

One of the most remarkable features of the health promoting schools movement has been the extent of the international partnerships which have been generated to address practical issues in health promoting schools. Examples of countries working together under the banner of health promoting
schools on specific projects or on more generic development work include: Canada and the Ukraine; England and Hungary; Wales, Scotland, Germany and The Netherlands; Uruguay and Spain; Denmark and The Former Yugoslav Republic of Macedonia; South Africa and Sweden; Australia and Ireland.

There is clearly a willingness at an international level to share experiences and skills and the European Network of Health Promoting Schools has been a catalyst for these international partnerships. As referred to earlier, the collaboration of the international agencies on the planning committee of the network has established partnership working as the norm.

One of the most significant developments in partnership working has been the increasing involvement of young people as “active-dialogue partners” in the approach to health promotion in schools in several countries.

Partnership working has been extremely important to the process of actively involving and supporting vulnerable young people such as those displaced from their communities by conflict or economic forces.

In some countries there has been a trend to establish new alliances including support from the private commercial sector to further the development of health promotion in schools. There has also been a trend towards extending the range of organizations and sectors which are regarded as important partners for health promoting schools as the concept has developed across Europe, such as social services, community schools and environmental agencies.

A workshop (3G) on the theme of partnership between the school health services and education personnel in the context of the health promoting school generated considerable debate. A desire to conduct a review of the present position in Europe, was a specific outcome from this group. It was acknowledged that in some European countries the general role of the school health sector was changing to give a greater emphasis to health promotion rather than screening and prevention. However, it was suggested that in many countries the traditional role of the school health services was still the dominant paradigm. There was a consensus that the potential role of school health professionals in the development of health promoting schools is not always fully recognized. The view was expressed that there is still a need to improve communication and cooperation between school staff and health professionals. The chair of this session indicated that participants were interested in the possibility of extending their collaboration at the workshop into further research and development work.

In Lithuania (poster 19) the need for school health professionals to have more training for work in schools, to facilitate better partnerships, supported the conclusion of workshop (3G).
A presentation from USA (1H) explored how a partnership council links schools, colleges, state agencies, healthcare providers and non-governmental organizations around common goals.

In Germany (1H) an alliance of organizations supporting initiatives in health promoting schools is being developed. This involves building a cooperative structure with the private sector to support school health promotion. The concept involves the development of a shared understanding of the evidence base and aims to use resources more effectively within a partnership model.

An international partnership, The Youth for Health Project, is a collaboration between the Ukraine and Canada (1H). An innovative curriculum has been developed for grades 1 to 11 in 18 pilot schools and this involves students, parents, teachers and school managers. It includes interactive methods, peer education and a significant training component which have been developed over a four-year period.

In Greece (2J) the concept of the health promoting school has embraced issues relating to youth employment prospects as a key part of young people’s health and welfare. The research phase of the project showed a lack of awareness among pupils about the reality of employment prospects. It highlighted the need for young people to develop skills relating to autonomy, creativity, empowerment and self-esteem in the context of citizenship.

The programme Health Teams at School in Switzerland (2J) has encouraged a partnership approach in schools with teachers, parents, pupils, education authorities and health professionals. These teams have resulted in measurable increases in sustainable projects but the least improvement related to engaging the support of head teachers.

A government-funded demonstration project in Scotland (4G) entitled “Healthy Respect” focuses on young people’s sexual health and involves health, education, young people’s services and other partner agencies. The approach of the project has enabled it to reach young people who may be marginalized and who may have the greatest social needs.

In The Former Yugoslav Republic of Macedonia (4G) a specific project has focused on the special needs of refugee children whose lives have been disrupted by conflict and war. The project assists the children and their families to become part of a new community which creates a supportive network for their educational health.

The concept of a partnership with students is central to a Danish project (poster 16) involving the education and health sectors. The students are viewed as active-dialogue partners with a high degree of influence in the direction and nature of the approach.
In conclusion, it is evident that a partnership approach is increasingly becoming viewed as the norm in many countries. This works at the level of students, professionals, agencies, sectors and countries. Some of this work cuts across traditional approaches, professional identities and bureaucracies. It is therefore extremely challenging.

Yet the health education literature shows the limitations of a traditional approach based only on classroom work. Research is increasingly showing that change comes about when educational initiatives with young people involve a coordinated approach that links in with young people’s services and a supportive social environment.

8.7 Participation

The theme of participation was mostly explored in terms of greater pupil or student participation in health education and health promotion at the conference. However, there are also examples of other applications of the concept of participation under the previous theme of partnership and also in this section evidence of greater participation of stakeholders such as parents.

With reference to the participation of young people in their own learning there was a revisiting of fundamental concepts of health with young children. There was evidence of use of Roger Hart’s model of levels of participation being used as a model within a specific project. A trend towards involving young people more on their needs, on their view of educational approaches and on their views on wider policy issues, was also evident.

All of this reflects changing approaches within specific countries, as well as the greater emphasis on democracy in the health promoting school movement.

Starting with fundamental concepts, a study was conducted in Denmark (1J), which used an open-ended questioning technique, with children aged five to seven years. This investigated the children’s concepts of health. It found that children of this age do not appear to associate wellbeing or a good life with being healthy. Good health in this study was linked more to specific examples such as tooth-brushing or eating vegetables by the children.

This study, and that of another Danish project (1I) on inequalities, reminds us that we have to involve fully the young people in the learning process if we are to take account of their pre-existing beliefs as part of the learning process.

In the Netherlands (1I) an informal project asked young people to talk about the issues which were most important to them. These could be classified as the future, friendship, sexuality and relationships, and alcohol and tobacco. This has led to a website being produced which is currently being tested.
A participative approach to promoting positive mental health was developed with professionals and young people working together in Ireland (2K). This involves the production of a school journal and an associated video diary that illustrates the principles behind the process of partnerships with young people.

A paper (2K) outlined participation in the Macedonian Health Promoting Schools and explored examples of additional support for schools in communities coping with the stress of prolonged conflict and crisis. This involved university students adding their support to facilitate pupils’ greater participation in health promoting school projects. A central part of the project was attempting to change adults’ perceptions of young people’s abilities to take an active role in community changes. This utilized Bjarne Bruun Jensen’s model of S-IVAC consisting of the stages: selection, investigation, vision, action and change. The project increased adults’ interest in children's activities and promoted the children’s critical thinking skills.

In Finland (poster 33) health education is now being established as a subject in the new national curriculum. Pupils were involved in giving their views on what for them made for good quality health education in the classroom. Preliminary findings indicated the importance of the personality and style of the teacher and a preference for a non-judgemental and participative approach. They also valued real-life examples and indicated that they understood that they themselves had an active role in creating successful lessons.

In Bulgaria (poster 35) students are being consulted about their own perceptions of health care and their needs in terms of a general practitioner service, as the school health service provision has changed at a time of economic transition in the country.

A study with young people in Hungary (poster 36) indicated that a better school atmosphere, better relationships with classmates and the involvement of parents were associated with better health outcomes for the young people. It suggested that family atmosphere, school atmosphere and relationships with their peers had a direct effect on their health through their sense of “self”.

In Finland (poster 31) research into the role of parents supporting their children aged 13 to 16 was undertaken. It suggested that parents had clear values about the children’s upbringing. However their knowledge of symptoms of depression and drug use, as well as changes in adolescents’ health behaviour, was much less. Further research is suggested to explore in more detail specific aspects of parent-adolescent communication.

The workshop on participation (4H) merged with session (4J), which had the overlapping theme of student participation in a cross-cultural perspective. This group took the view that real participation of students was still under-developed within the health promoting school movement, although one can
observe from the previous examples that more research is now being undertaken to open up this issue for real debate. The workshop came to the conclusion that there was a need to define what constitutes evidence of participation of students, as the aims of this work are complex. There was also considerable debate around the use of new technology to facilitate the participation of young people in issues of interest in relation to their own health. It was believed by some that this was limited because of the risk of a lack of access to the medium for some students, who may have the greatest needs. Others took the view that the World Wide Web and other technologies had considerable potential for the future for all young people.

In conclusion, there was a feeling at the conference that the issue of student participation, its definition and its potential value as part of health promoting schools, requires considerably more research and development. This work is required not only to help define our conceptual base but also to measure the effectiveness of participative approaches in the future.
9. Closing Plenary: The Panel Session

Clive Needle introduced the panel which consisted of the following volunteers from the delegates:

Concha Colomer, Spain
Gunnar Orn Ingolfsson, Young Minds, Iceland
Gottfried Thesen, European Commission
Elizabeth Müller-Heck, Germany
Heidi Peltonen, Finland

Concha Colomer remarked that she felt very positive about the conference and she believed that we had made significant progress since the event in Thessaloniki.

Gunnar Orn Ingolfsson said he had enjoyed the experience of participating in the event and in being involved in Young Minds. He stated that delegates at the conference had been very interested in the project and remarked that the Welsh Minister of Education and Lifelong Learning, Jane Davidson, had spent over an hour asking questions and learning more about the project.

Gottfried Thesen added that five years ago at Thessaloniki there were still some people asking “what is a health promoting school?” People no longer asked this question, he stated.
Concha Colomer added a note of caution that a more traditional model of medical and nursing practitioners delivering health education still dominated in some countries. Charles Viljoen from South Africa complimented those involved in building the network in Europe, but offered a timely reminder of our interdependence in global terms.

You need to be careful in Europe that you don’t become complacent because you have a successful network. There is a whole other world out there. There is a risk of the north looking down on the south…

Anna Lea Björnsdottir from Iceland requested that the Young Minds project be further developed and Ian Young suggested that the European Commission might wish to consider funding an extension to involve more countries and conduct associated research.

Derek Colquhoun from England raised two separate issues. “Where are the architects? Where are the planners? Where are the social workers? Where are the parents?” He took the view that a broader range of partners and stakeholders should have been present at the event. He also asked if we had a genuine partnership between education and health and that sometimes it seemed to be more health versus education.

Steve Thorpe from England pointed out that schools are workplaces as well as learning centres and also made a plea for more participation of, and links with, parents.

When asked by Clive Needle what delegates would do to translate the ideas and enthusiasm of the conference into action Anna Lea from Iceland stated that she would set up a meeting with the Minister of Education in Iceland. Gunnar had plans to invite the Minister of Education to his home for dinner and a persuasive chat about the Egmond Agenda!

While delegates were reflecting on the fact that the future of health promotion in schools is in capable hands, Concha Colomer suggested that an effort should be made to make the most of this event by placing the Egmond Agenda on the European Parliament’s agenda.

Clive Needle thanked participants for their views which had raised several issues that would be significant for both the conference report and the future development of health promoting schools.
10. The Egmond agenda

A new tool to help establish and develop health promotion in schools and related sectors across Europe.

“The Health Promoting School improves young people’s abilities to take action and generate change. It provides a setting, within which they can gain a sense of achievement, working together with teachers and others. Young people’s empowerment, linked to their visions and ideas, enables them to influence their lives and living conditions.” (WHO, 1997)

Principles into practice

The first European Conference on Health Promoting Schools was held in Greece in 1997. It proclaimed that health promoting schools (HPS) are an investment in health, education and in democracy.

The outcome of that Conference was a set of principles. They defined the values and purposes of HPS, and set out methods that could be used to establish those principles in practice.

The core principles

• Partnership
• Equity and access
• Empowerment and action competence
• Health knowledge and understanding
• Safe and supportive environments
• Health promoting teaching and learning methodologies
• Curriculum based health promotion
• Democratic practices and participation
• Involvement of stakeholders, communities and parents
• Evaluation for building on success

Evidence

Many partners in European countries have worked to introduce, strengthen and sustain distinctive HPS approaches. Evidence is now available to show:

• how successful and sustainable HPS approaches are built
• how they might be supported by policies that establish the process within health and education sectors

The Egmond agenda

A Conference was held in 2002 to consider progress made and to take the HPS process forward. It took place at Egmond-an-Zee in the Netherlands. It included participants from 43 European countries – and representatives from many of their national ministries. As one result, this tool embodies the best evidence and practical steps understood as essential in building successful HPS programmes.
It is clear that the most successful outcomes arise from programmes developed through collaboration between health and education sectors.

There are three main components to this Agenda:

- CONDITIONS
- PROGRAMMING
- EVALUATION

Each component is essential to develop and sustain health promoting schools. There is no priority order for their implementation, but some may be seen as important early steps.

### 10.1 Conditions

**One: Situation analysis**

It is important to carry out a national analysis of the situation concerning the status of HPS development. This analysis should look at needs and available resources, current practices and methods for data collection. Such information can be collected through assessments of:

- knowledge, attitudes, skills, competencies, behaviour and health status of young people
- the contributions of health and education sectors to health promotion
- involvement of other agencies and related sectors
- financial resources needed
- available experience of other countries
- the “functional health” status of schools as organizations

**Two: Partnership**

For an HPS initiative to achieve lasting success, partnership must operate in a fair and transparent way at several levels.

The experience in Europe has shown that HPS initiatives are most effective when true partnership is practiced within and between all players in the process. This should include ministries, their institutions, pupils, teachers, NGOs, stakeholders and interested parties in relevant communities.

At national level the two most influential partners are generally the Ministries of Health and Education. For example, effective partnership has been demonstrated when partners agree which agency should lead a programme depending on national circumstances. Alternatively, a consensus based collaborative model may prove more appropriate.

It is important to achieve clarity about mutual objectives and ensure that resources are dispersed fairly. Partners need to agree on the advantages that they bring to a programme, and recognize where additional expertise is needed, so some flexibility is helpful in setting agendas. This will help to instil an authentic sense of ownership, which will add to sustainability.
Three: Advocacy
Introducing and adopting the HPS approach is best understood as a process. The framework of a Health Promoting School enables effective, comprehensive programmes of health promotion and education to be established. Moreover, there is evidence that programmes on specific health topics offered by other agencies can be more effectively introduced in an HPS framework.

But that evidence alone may not be enough. Policy-makers need a range of good reasons to support HPS approaches. Decision-makers need to be convinced that investing in HPS programmes is worthwhile – and contributes to policy objectives in related sectors. Furthermore, the process should be sustainable so as to withstand political, economic and social change. Broad based advocacy is necessary to achieve this.

Stakeholders from health, education and other sectors involved or in supporting or delivering HPS programmes need to be involved in the advocacy process, being instrumental in advocating for investment in HPS programmes.

Four: Theoretical base
A sound theoretical base is essential for implementation of a national HPS approach. Effective programmes are based upon a theory of building comprehensive health promotion approaches. Such approaches address factors that provide protection from risk as well as those that cause risks to health.

The approach is implemented through health and education programmes that
• Create safe and supportive environments
• Establish a health education curriculum
• Foster relationships with families and communities
• Prepare young people to cope with demands of everyday life

This implies an understanding that change and development are integral tools of the process. There are political implications related to the process such as conflicting policy areas and priorities, resource allocation, theoretical and philosophical direction.

10.2 Programming
Five: Programme content and objectives
Policy development should result in long-term national objective setting and action programming for school health. Key elements of a national action programme for school health are:
• information exchange on activities and initiatives;
• linking with current national policy development in education and health (life skills, based education, competence development, effective schools,
safe schools, child friendly schools, health targets and priority setting, participation, action-oriented teaching and learning)

• advocacy
• networking
• initiatives to improve the quality of HPS programmes, to foster health and support quality education, and to create positive school cultures and environments.

Six: Long term planning
Evidence shows that the development period of a national HPS programme can be from three to eight years. This, therefore, requires long term planning and sustainable political commitment.
It is recommended to develop a national action programme within a planning cycle of three to five years, when objectives and outcomes can be assessed and, if necessary, redefined.

A national structure combined with a regional / local structure for health promoting schools has been found to be most effective. This provides support to schools, creates synergies, enables management and coordination, and helps innovation and implementation of programmes.

Effective collaboration between Ministries of Health and Education is critical to success. This process enables integrated use of resources, shared financial and political support, and the engagement of agencies and institutes from both sectors in joint initiatives.

Seven: Teacher education and professional development
An HPS programme introduces concepts and methodologies that may be unfamiliar to officials in health and education ministries and other actors such as teachers. Successful HPS initiatives have developed extensive education programmes for teachers, trainers and health workers.

Building the capacity of personnel and providing opportunities for professional development has been shown to be an effective strategy in HPS policy. It has shown tangible benefits for learning, skills development and social capital.

This should apply to all involved, but particularly to teacher training before and during service, and should include accredited courses that include the broader public health themes underpinning health promoting schools.

This vital component requires investment and strengthened links between relevant institutes to ensure effective course design, evaluation and development of the evidence base.
10.3 Evaluation

Eight: Evaluate
Monitoring and evaluation are essential parts of a national action programme for health promoting schools. Evaluation that accompanies theoretically based programmes and provides evidence of effectiveness has been seen to influence success in developing sustainable school health policy. Good evaluation, which includes both process and outcome evaluation, has been seen to aid the progress of action plans in becoming nationally implemented programmes.

Embedding the values of ethical, evidence-based research is consistent with overall HPS approaches and offers learning and related benefits within school communities.

A school is, of course, fundamentally a place of learning. But it is also a unique social and cultural meeting place for people from many backgrounds. A Health Promoting School embodies practical and conceptual links between education, health and participatory values. It relies on input, experiences and decisions at local levels, yet learns from and contributes to wider goals, objectives and developments.

There will always be new challenges to be faced. An HPS programme can never be complete, or stop learning from others. The policy cycle: – “design – implement – monitor – evaluate” is crucial to sustainable success.

Therefore it is planned that the Action Points related to the Egmond Agenda will be developed, offering a practical tool, guide, encouragement – and perhaps even inspiration – for existing or potential participants and policy makers, wherever they feature in that cycle.

The European Network for Health Promoting Schools is a partnership between participants with European countries and with international institutional support from:
The European Commission, The Council of Europe and the World Health Organization Regional Office for Europe

Technical support for the ENHPS is provided by the Technical Secretariat to which all enquiries concerning the programme may be directed.

ENHPS Technical Secretariat
WHO Regional Office for Europe
Scherfigsvej 8, 2100 Copenhagen, Denmark
Tel: +45 39171235, Fax: +45 39 171818, E mail: bdm@who.dk
Web site: http://www.euro.who.int/enhps
Appendix I

The EVA Project

Vivian Barnekow Rasmussen, WHO Regional Office for Europe, referred briefly at the conference to the EVA Project conducted by Danielle Piette. This project had identified emergent stages in the sustainable development of health promoting schools across Europe countries. These were outlined as follows:

• identity – creating a common identity;
• information – spreading the message;
• credibility – key people believing in the approach;
• relevance – key people perceiving the approach as relevant;
• feasible – key people perceiving that it can work;
• policy – building health promoting schools policy into national policy statements.

EVA II had identified success as including:

• examples of improved relationships between schools;
• impact on national curriculum;
• teacher empowerment;
• improved relationships/partnerships between health and education sectors/ministries;
• improved school climate.

The problems and constraints most commonly identified were in relation to

• a lack of resources;
• teacher education and training;
• a lack of collaboration with other networks.
Appendix II

Organizing Committees

The Task Force
• Vivian Barnekow Rasmussen, ENHPS Technical Secretariat, WHO Regional Office for Europe, Denmark
• Bjarne Bruun Jensen, Research Centre for Environmental and Health Education, Danish University of Education, Denmark
• Goof Buijs, Netherlands Institute for Health Promotion and Disease Prevention (NIGZ), the Netherlands
• Miluse Havlinová, Counselling Centre for Health Promotion in Schools, National Institute of Public Health, Czech Republic
• Beat Hess, Federal Office of Public Health, Switzerland
• Isabel Loureiro, Comissao de Coordenacao da Promacao para a Saude (CCPES), National School of Public Health, Portugal
• Carl Parsons, Centre for Educational Research, Canterbury Christ Church University College, United Kingdom
• David Rivett, ENHPS Technical Secretariat, WHO Regional Office for Europe, Denmark
• David Stears, Centre for Health Education and Research, Canterbury Christ Church University College, United Kingdom
• Ian Young, Health Education Board for Scotland, United Kingdom

The Scientific Committee
• Bjarne Bruun Jensen, Research Programme for Environmental and Health Education, Danish University of Education, Denmark (Chairman)
• Concha Colomer, Health Promotion Unit, Escuela Valenciana de Estudios para la Salud (IVESP), Spain
• Peter Paulus, Institute of Psychology, Lüneburg University, Germany
• Theo Paulussen, Netherlands Organisation for Applied Scientific Research – Prevention and Health, the Netherlands
• Danielle Piette, Faculty of Public Health, Free University of Brussels, Belgium
• David Stears, Centre for Health Education and Research, Canterbury Christ Church University College, United Kingdom
• Jörgen Svedbom, School of Education and Communications, Jönköping University, Sweden
• Keith Tones, Health Education Research Journal, United Kingdom
• Katherine Weare, Southampton University, Health Education Unit, United Kingdom
• Barbara Woynarowska, Department of Biomedical Aspects of Development and Education, Faculty of Pedagogy, Warsaw University, Poland
The local Organizing Committee
Netherlands Institute for Health Promotion and Disease Prevention (NIGZ)
• Goof Buijs
• Sandra Bon
• Pien van Leeuwen

WHO, ENHPS Technical Secretariat, WHO Regional Office for Europe
• Vivian Barnekow Rasmussen
• David Rivett
• Tina Kiaer
• Bente Drachmann
• Jane Persson
• Gabriela Fuentes
# Appendix III

## List of Participating Schools Young Minds

<table>
<thead>
<tr>
<th>Country</th>
<th>School</th>
<th>Teacher(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>Marienlystskolen</td>
<td>Conny Laursen</td>
</tr>
<tr>
<td></td>
<td>Odinsvej 4</td>
<td><a href="mailto:Conny.laursen@skolekom.dk">Conny.laursen@skolekom.dk</a></td>
</tr>
<tr>
<td></td>
<td>3600 Frederikssund</td>
<td>Consultant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kathe Bruun Jensen</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Kathe.Bruun.Jensen@skolekom.dk">Kathe.Bruun.Jensen@skolekom.dk</a></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Zakladni Skola Masarykova</td>
<td>Ilona Shejbalova</td>
</tr>
<tr>
<td></td>
<td>V Lipkach</td>
<td><a href="mailto:shejbalova@zstgm.pvtnet.cz">shejbalova@zstgm.pvtnet.cz</a></td>
</tr>
<tr>
<td></td>
<td>500 02 Hradec Kralove</td>
<td></td>
</tr>
<tr>
<td>Iceland</td>
<td>Menntaskólinn í Kópavogi</td>
<td>Helen W. Gray</td>
</tr>
<tr>
<td></td>
<td>Kopavogur Grammar School</td>
<td><a href="mailto:helenw@ismennt.is">helenw@ismennt.is</a></td>
</tr>
<tr>
<td></td>
<td>Digranesvegur</td>
<td></td>
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<tr>
<td></td>
<td>200 Kopavogur</td>
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<tr>
<td></td>
<td>Iceland</td>
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<tr>
<td>Finland</td>
<td>Kummun School</td>
<td>Tuija Sarkikoski</td>
</tr>
<tr>
<td></td>
<td>Kummun katu 15,</td>
<td><a href="mailto:tsarkikoski@luukku.com">tsarkikoski@luukku.com</a></td>
</tr>
<tr>
<td></td>
<td>83500 Outokumpu</td>
<td>Tuula Puruskainen</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:tuulapuruska@cc.joensuu.fi">tuulapuruska@cc.joensuu.fi</a></td>
</tr>
<tr>
<td>Macedonia</td>
<td>State secondary School</td>
<td>Ana Poprizova</td>
</tr>
<tr>
<td></td>
<td>Orce Nikolov Bul.</td>
<td><a href="mailto:boro@mol.com.mk">boro@mol.com.mk</a></td>
</tr>
<tr>
<td></td>
<td>Ilinden bb Skopje</td>
<td></td>
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<tr>
<td>Netherlands</td>
<td>Pieter Jelles Montessori</td>
<td>Mirjam van de Vliet</td>
</tr>
<tr>
<td></td>
<td>Douwe Kalmaleane 2</td>
<td><a href="mailto:mirjamvandevliet@hotmail.com">mirjamvandevliet@hotmail.com</a></td>
</tr>
<tr>
<td></td>
<td>8915 HA Ljouwert</td>
<td></td>
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<tr>
<td>Portugal</td>
<td>Escola Secundária D. Dinis</td>
<td>Dr. Fátima Barroso</td>
</tr>
<tr>
<td></td>
<td>Rua adriano Lucas</td>
<td><a href="mailto:info@esec-d-dinis-cmb.rcts.pt">info@esec-d-dinis-cmb.rcts.pt</a></td>
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<tr>
<td></td>
<td>3020-264 COIMBRA</td>
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<tr>
<td>Scotland</td>
<td>Plockton High School</td>
<td>Donald Ferguson (deputy rector)</td>
</tr>
<tr>
<td></td>
<td>Wester Ross</td>
<td><a href="mailto:Donald.Ferguson@highland.gov.uk">Donald.Ferguson@highland.gov.uk</a></td>
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<tr>
<td></td>
<td>Scotland IV52 STU</td>
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<tr>
<td>Country</td>
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<td>Contact Person 1</td>
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<td>Slovenia</td>
<td>Srednja Vrtnarska sola</td>
<td>Karmen Volavsek</td>
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<tr>
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<td>Ljubljanska 97</td>
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<td></td>
<td>3000 Celje</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>IES Antonio Machado</td>
<td>Maria José Sanchez Carraso</td>
</tr>
<tr>
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<td>Alcalà de Henares</td>
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<tr>
<td>Sweden</td>
<td>Haganässchool</td>
<td>Pernilla Evaldsson</td>
</tr>
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<td></td>
<td>Box 501, 4323 Älmhult</td>
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</tr>
<tr>
<td>Switzerland</td>
<td>Schule Für Gesundheit</td>
<td>Horst Hilger</td>
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<tr>
<td></td>
<td>+ Krankenpflege</td>
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</table>
## Appendix IV

**List of Workshops and Sessions**

**Wednesday 25 September 2002**

<table>
<thead>
<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and presenter</th>
</tr>
</thead>
</table>
|    | 1 A Workshop             | Research on the effectiveness of school-based health promotion  
|    | Facilitator: Stephan Van den Broucke, Belgium  
|    | The workshop will explore the possibilities to reconcile the needs for  
|    | the planning and evaluation of health promotion with empowering the  
|    | school as a community. This will be done both from a theoretical and  
|    | a pragmatic perspective. |
|    | 1 B Paper session        | Challenges and possible solutions  
|    |                          | 1. Schoolbeat: the new challenge introducing coordinated school  
|    |                          | health promotion in the Netherlands; Mariken Leurs,  
|    |                          | The Netherlands  
|    |                          | 2. In search of updating the health promoting school: challenges for  
|    |                          | a wide implementation of the concept in Flemish education;  
|    |                          | Olaf Moens, Belgium  
|    |                          | 3. Reform of school medicine in French-speaking Belgium: from  
|    |                          | medical school centres to school health promoting centres;  
|    |                          | Geneviève Houioux, Belgium  
|    |                          | 4. When the political conditions are unstable – what works for the  
|    |                          | Network of Health Promoting Schools to survive?; Eva Stergar,  
|    |                          | Slovenia |
|    | 1 C Paper session        | Linking the comprehensive approach to specific health topics  
|    |                          | 1. Legal base of activity of health promoting schools in the Russian  
|    |                          | Federation; Vladislav Kuchma, Russian Federation  
|    |                          | 2. Organisation of the Polish Network of Health Promoting Schools.  
|    |                          | An example in building sustainable partnerships between health  
|    |                          | and education; Aldona Sito, Poland  
|    |                          | 3. Towards a national plan for children’s and young people’s health  
<p>|    |                          | and well-being – Young@Heart; Alison Giles, England UK |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and Presenter</th>
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</thead>
</table>
| 1 D | Paper session            | New concepts in health promotion  
|     |                          | 1. The health promoting school and health literacy: if you can read and understand this, thank a teacher; *Louise Postma, South Africa*  
|     |                          | 2. Life skills: a component of skills-based health education; *Cheryl Vince Whitman, USA*  
|     |                          | 3. Development of social capital in relationship with health and education; *Dhyan Vermeulen, the Netherlands*  
|     |                          | 4. Complexity science and the health promoting school; *Derek Colquhoun, England UK*  
| 1 E | Paper session            | New methods in school health promotion  
|     |                          | 1. Promoting equality and citizens rights in the emerging multicultural school; *Katerina Sokou, Greece*  
|     |                          | 2. Improving nutrition in health promoting schools in a very deprived area; *Caroline Glaser, England UK*  
|     |                          | 3. Circonova – using drama and circus for health messages in school; *Mats Lodén, Sweden*  
|     |                          | 4. Evaluation of a school-based health promotion sex programme delivered by doctors; *Christiane Thomas, Germany*  
| 1 F | Workshop                 | Developing the health promoting school  
|     |                          | *Facilitator: Jörgen Svedbom, Sweden*  
|     |                          | Workshop about the roles and possibilities for short-term projects, teaching materials/manuals and external consultants in developing the health promoting school.  
| 1 G | Paper session            | School climate in the health promoting school  
|     |                          | 1. Smoking risk in relation to engagement with a school-based smoking intervention; *Paul Aveyard, England UK*  
|     |                          | 2. Investment in health promotion in higher education; *Maria Christina Faria, Portugal*  
|     |                          | 3. Reasons why school staff do not want to enforce pupil smoking bans; *Jacki Gordon, Scotland UK*  

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1 H  Paper session  
Intersectoral working at national and regional level on school health promotion
1. An alliance for school health promotion: a new nation-wide project in Germany funded by the Bertelsmann-Group; Peter Paulus, Germany
2. Selecting and implementing research-based programmes to promote health and safety in schools: what capacities do schools need?; Cheryl Vince Whitman, USA
3. Health care education; Industry Partnership Project – Linking education, health care providers, education and non-governmental organisations; Kristin Kay Juliar, USA
4. Integrated health education curriculum for Ukrainian schools; Svitlana Oleksienko, Ukraine

1 I  Paper session  
Let young people talk about their views
1. The Healthy Schools assessments tool for pupils – a way to access pupils’ views; Wendy Ostler, Wales UK
2. Young people’s views on health and inequality in health; Bente Jensen, Denmark
3. Live 2000 – Participation in health promotion by young people in Eindhoven, the Netherlands; Toine Gribling, the Netherlands
4. Young children’s understanding of health and illness (5-7 years); Nils Holdgaard Sørensen, Denmark

1 J  Workshop  
Promoting staff health and well-being – insights from the UK
Facilitators: Claire Jones, England UK; Marilyn Toft, England UK; Sue Bowker, Wales UK
A workshop on the issue of staff health and well being. The workshop will combine the use of a short formal presentation, individual and group work and group discussion.

2 A  Paper session  
Conditions for effectiveness
1. Effective strategies, frameworks and trends in school health during the 1990s; Cheryl Vince Whitman, USA
2. Let’s promote non-smoking: a prevention programme in primary education; Mojca Bevc Stankovi, Slovenia
3. Evidence-based effects in Lithuanian health promoting schools; Jociute Aldona, Lithuania
4. How does a health promoting school contribute to the aims of schooling?; Oddrun Samdal, Norway
<table>
<thead>
<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and Presenter</th>
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<tbody>
<tr>
<td>2 B</td>
<td>Paper session</td>
<td><strong>Description and comparisons of successes</strong>&lt;br&gt;1. The Welsh network of healthy school schemes - national/local partnership in practice; Sue Bowker, Wales UK&lt;br&gt;2. Health through education; T. Schipkova, Russian Federation&lt;br&gt;3. Ukrainian Network of Health Promotion Schools: State principles of forming and development; T. Boychenko, Ukraine</td>
</tr>
<tr>
<td>2 C</td>
<td>Paper session</td>
<td><strong>Evaluation and good practices</strong>&lt;br&gt;1. Progress of health promoting schools in the Czech Republic; Alena Steflova, Czech Republic&lt;br&gt;2. Good practice of national strategy; Kädi Lepp, Estonia&lt;br&gt;3. Hungarian network as service provider; Katalin Felvinczi, Hungary</td>
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<tr>
<td>2 D</td>
<td>Workshop</td>
<td><strong>Exploring new learning approaches in health promotion</strong>&lt;br&gt;Facilitators: Bjarne Bruun Jensen, Denmark; Derek Colquhoun, England UK&lt;br&gt;A number of concepts have been developed and integrated into schools work with health education and health promotion. The aim of the workshop is to present, compare and discuss a number of these concepts in order to explore new and innovative learning approaches in health promoting schools.</td>
</tr>
<tr>
<td>2 E</td>
<td>Paper session</td>
<td><strong>Mental health in health promoting schools – new methods and approaches</strong>&lt;br&gt;1. A whole school approach to mental health promotion: adapting the Australian “Mind Matters” programme to the European context – the Irish experience; Mary Byrne, Ireland&lt;br&gt;2. MindMatters – A German adaptation of an Australian programme for mental health promotion in secondary schools; Peter Paulus, Germany&lt;br&gt;3. The timeless hour – a workbook. Harmonizing of the 2 hemispheres of a child's brain in ‘Learning by doing’, benefiting both children and tutor; Michiel Dhont, the Netherlands&lt;br&gt;4. Omsorg (dealing with bereavement) – The need for action plans towards children in loss and grief at all Danish schools; Per Bøge, Denmark</td>
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<td>No.</td>
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<td>Title and Presenter</td>
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<tr>
<td>2 F</td>
<td>Paper session</td>
<td>Workplace health promotion for teachers</td>
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<tr>
<td></td>
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<td>1. Pathways of influence: does the health promoting schools approach enhance teachers’ health, job stress and job commitment?; Kate Lemerle, Australia</td>
</tr>
<tr>
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<td>2. Initiating organizational change: enabling teachers for school-based health promotion – experiences from the Norwegian Network of Health Promoting Schools; Nina Grieg Viig, Norway</td>
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<td>3. Workplace health promotion in schools; Paul Baart, the Netherlands</td>
</tr>
<tr>
<td>2 G</td>
<td>Workshop</td>
<td>Healthy teaching requires new teacher competencies and skills</td>
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<td>Facilitator: Hana Kostalova, Czech Republic</td>
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<td>A workshop on the competencies and skills of teachers required for teaching health promotion in schools. Interactive and cooperative methods will be used, based on participants’ own experiences.</td>
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<td>2 H</td>
<td>Paper session</td>
<td>Curriculum development for the health promoting school</td>
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<tr>
<td></td>
<td></td>
<td>1. Combining key concepts in education and smoking prevention in the Netherlands; Renate Spruijt, the Netherlands</td>
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<td>2. Two government departments: one developing partnership; John Lahiff, Ireland</td>
</tr>
<tr>
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<td>3. Curriculum development: health education in the Macedonian secondary schools; Lina Kostarova-Unkovska, the Former Yugoslav Republic of Macedonia</td>
</tr>
<tr>
<td></td>
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<td>4. Health education in Lithuania: its future prospects; Ona Monkeviciene, Lithuania</td>
</tr>
<tr>
<td>2 I</td>
<td>Paper session</td>
<td>Obstacles and facilitating factors for developing health promoting schools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Health promotion in the context of school development; Emilie Achermann Fawcett, Switzerland</td>
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<tr>
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<td>2. Promotion of safety – an aspect of health promotion in schools; Beat Hess, Switzerland</td>
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<td>3. Health promotion in secondary schools: working with schools principals on building awareness, a participative approach; Emmanuelle Caspers, Belgium</td>
</tr>
<tr>
<td>No.</td>
<td>Workshop / Paper session</td>
<td>Title and Presenter</td>
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</tbody>
</table>
| 2 J | Paper session            | **Intersectoral collaboration at school level**  
1. Health teams at school: a 10 year experience in the city of Bern;  
*Maria Ine Carvajal, Switzerland*  
2. An indicator system uniting teachers and school nurses;  
*Rolf Lander, Sweden*  
3. Implementing the health promoting school concept: lessons learnt; from the ENHPS in Scotland UK; *Jo Inchley, Scotland UK*  
4. School health promotion and the labour market: pupils' empowerment; *Katerina Sokou, Greece* |
| 2 K | Paper session            | **Young people in action**  
1. Youth partnership in action; *Anne Sheridan, Ireland*  
2. Genuine student participation: perspective form the health promoting school paradigm; *Anne Sheridan, Ireland*  
3. Can health be promoted in conditions of prolonged community crisis?; *Kristina Egumenovska, the Former Yugoslav Republic of Macedonia* |

**Thursday 26 September 2002**

<table>
<thead>
<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and Presenter</th>
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</table>
| 3 A | Paper session            | **Indicators of success and evaluation methods**  
1. Case study of criteria in evaluation of health education;  
*Monica Carlsson, Denmark*  
2. Monitoring and evaluation system for health promotion projects in schools: the case of the programme “schools and health” of the Swiss Federal Office of Public Health; *Milena Chimenti, Switzerland*  
3. Gathering evidence for the effectiveness of health promotion in schools: a quantitative measure of health promoting schools;  
*Kate Lemerle, Australia*  
4. Observed differences between schools as a tool for evaluation;  
*Jean-Claude Vuille, Switzerland* |
<table>
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<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and Presenter</th>
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</thead>
</table>
| 3 B | Workshop                | **Challenges, barriers and successes – How to learn from cross-cultural comparisons**  
Facilitator: Isabel Loureiro, Portugal  
A clear policy for the development and sustainability of the Health Promoting Schools Network is crucial. Some guiding principles for health promotion in schools will be discussed:  
1. How to exercise power in an effective way – empowering for decision-taking  
2. Sharing power and responsibilities: cost-gains  
3. The art of advocacy in building an appropriate model for each country culture |
| 3 C | Paper session           | **Developing the health promoting school**  
1. Developing indicators for HPS: revisiting the meaning of the concept “health” in health promoting schools; **Tiaan Kirsten, South Africa**  
2. Governance of interdisciplinary work and school climate;  
**Agneta Nilsson, Sweden**  
3. Is a democratic health promoting school a utopian dream?;  
**Bjarne Bruun Jensen, Denmark** |
| 3 D | Paper session           | **Training teachers in health promotion**  
1. Teachers’ attitudes towards school based health promotion;  
**Hege Tjomsland, Norway**  
2. Motivation for in-service training of teachers within the Slovenian Network of Health Promoting Schools;  
**Vesna Pucelj, Slovenia**  
3. Teacher training in the health promotion schools project;  
**Vibeke Lenskjold, Denmark**  
4. Relationship between health-related action competence of the students and pedagogical competence of the teacher?;  
**Steffen Elmose, Denmark** |
| 3 E | Paper session           | **Evaluation – a crucial factor in developing health promoting schools**  
1. The evaluation of the Viennese Regional Network of Health Promoting Schools 1997-2002: methods and findings;  
**Christina Dietscher, Austria**  
2. A nutrition education programme for 12-14 year-old students to promote healthy dietary habits;  
**Marloes Martens, the Netherlands**  
3. Collaboration in the Finnish ENHPS schools as a learning;  
**Kerrtu Tossavainen, Finland** |
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<tr>
<th>No.</th>
<th>Workshop / Paper session</th>
<th>Title and Presenter</th>
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</table>
| 3 F | Paper session            | External consultants as agents for developing health promoting schools  
1. Implementation and effects of a sex education curriculum (Long Live Love) in Dutch Secondary Schools; Karin Wiefferink, the Netherlands  
2. A comprehensive approach to support of professionals in relation to the health promoting schools; Karsten Sørensen, Denmark |
| 3 G | Workshop                 | The role of school health service in developing health promoting schools – experiences, concepts  
Facilitator: Barbara Woynarowska, Poland  
Discussion on present goals, organization of school health service and its role in implementation of health promoting schools in different countries. Identification of barriers in collaboration between teachers and health professionals. Initiation of further discussion. |
| 3 H | Workshop                 | Health promoting schools in three neighbouring countries: lessons learned and looking forward  
Facilitators: Goof Buijs, the Netherlands; Olaf Moens, Belgium; Peter Paulus, Germany  
A workshop on the development of health promoting schools in Belgium, Germany and the Netherlands, facilitated by their national co-ordinators. Issues are: common factors of success and failures, needs and requirements and minimal conditions for future development of health promoting schools. |
| 3 I | Paper session            | Parents and partners  
1. Eating for health and learning – supporting schools in developing healthy eating policies; Anne McAteer, Ireland  
2. Predictors of healthy adolescent development in inner-city schools: parental support and participation; Annette Aalborg, USA  
3. Living values: Preventing violence through a programme designed to build the values and emotions essence of the child; Miriam Pais, Israel |
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<td>1. The subject ‘Life skills’ in the Dutch school system; <strong>Dimph Rubbens, the Netherlands</strong></td>
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<td>2. Programme of equalization opportunities in the education of children from rural areas; <strong>Maria Sokolowska, Poland</strong></td>
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<td>3. Development of a system of teacher training in health education and promotion as an effect of the health promoting school movement in Poland; <strong>Barbara Woynarowska, Poland</strong></td>
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<td>4. Active break kits, a motivation for children to be more physically active during break times at primary schools; <strong>Karen van Reenen, the Netherlands</strong></td>
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<td>5. Functional complaints and medicine consumption in 15-year-olds with special reference to the influence of school climate; <strong>Maria Ine Carvajal, Switzerland</strong></td>
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<td>6. The subscriber programme ‘Klassens Kalender’: a unique way of communication; <strong>Per Bøge, Denmark</strong></td>
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<td>7. Policy for all: health and education partnership as a part of legislation: Guidelines for schools; <strong>Irit Livne, Israel</strong></td>
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<td>8. Evaluation of an intervention to prevent smoking among adolescents with a lower level of education; <strong>Mathilde Crone, the Netherlands</strong></td>
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<td>9. Collaboration between education and health by means of the Dutch smokefree class competition ‘Actie Tegengif’; <strong>Renate Spruijt, the Netherlands</strong></td>
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<td>10. Promoting non-smoking in the Finnish ENHPS Schools; <strong>Kerttu Tossavainen, Finland</strong></td>
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<td>11. Assessment as a component of the programme aims at producing an impact on the student;</td>
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<td>12. Problems of the implementation of health education in schools of Ukraine; <strong>G. Danylenko, Ukraine</strong></td>
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<td>13. Health education monitoring of the mental development of the personality is the necessary condition for preservation and correction of mental health; <strong>M. Korenev, Ukraine</strong></td>
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<td>14. The Class Moves® A remarkable method to promote movement in primary schools; <strong>V. Loyko, Ukraine</strong></td>
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<td>15. The Class Moves® Posture, movement and relaxation in the classroom; <strong>Marita Stawinoga, Germany</strong></td>
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<td>16. Partnership between health and education at the regional level; <strong>Bjarne Bruun Jensen, Denmark</strong></td>
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<td>17. From good models of practice to a proactive of good models – The Swiss joint-venture school and health programme; <strong>Maelle Perez, Switzerland</strong></td>
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<td>18. Increasing the partnership between the health promoting staff, teachers and pupils in Danish primary schools; <strong>Birthe Nielsen, Denmark</strong></td>
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<td>19. Findings of the pilot study in ability of school health service to act in educational sector; <strong>Jociute Aldona, Lithuania</strong></td>
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<td>20. The concepts of human sexuality and sexual health promotion among Portuguese teachers and public health doctors; <strong>Maria Teresa Vilaça, Portugal</strong></td>
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<td>21. Formation of health culture of children in modern out-of-school institution; <strong>Albina Gerasymova, Ukraine</strong></td>
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<td>22. Decreasing of HIV/Aids morbidity and drug dependence among adolescents in Ukraine using modern prophylactic technologies; <strong>Antonia Nahorna, Ukraine</strong></td>
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<td>23. The relationship between education and health in Spain; <strong>Alejandro Garcia Cuadra, Spain</strong></td>
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<td>24. Intersectoral work in traffic injuries; <strong>Rosana Peiró-Pérez, Spain</strong></td>
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<td>25. School health nurses as sources of information – individual and social aspects in promoting young people’s health in Finnish schools; <strong>Raili Välimaa, Finland</strong></td>
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26. Towards the effectiveness of the HPS: The effects of Clinically Standardized Meditation (CSM) as a strategy for the promotion of psychological well being in teachers; Tiaan Kirsten, South Africa
27. An online Health Promoting School Toolkit; Wendy Halliday, Scotland UK
28. Evaluation of Wroclaw’s Health Promotion School Network; Leslaw Kulmatycki, Poland
29. The impact of group teaching on the acquisition of key skills to teach personal, social and health education; Malcolm Thomas, Wales UK
30. Mid level health manpower production: challenges and prospects; Sujan Marahatta, Nepal
31. Upbringing as a form of support in adolescent health learning; Heli Tyrväinen, Finland
32. A partnership project in stress management for school-aged children: the youths’ lived experience; N. Kolotii, Ukraine
33. Characteristics pupils identify for successful health lessons; Anastasya Marcheva, Bulgaria
34. Researching the psychological health of school children as the means of evaluating the effectiveness of health promoting school functioning; Gyongyi Kokonyei, Hungary
35. Research on students’ health and health care needs at D. Tsenov Academy of Economics, Svishtov, Bulgaria; Hannele Turunen, Finland
36. Impact of school as a psychosocial environment on pupils’ health and health related behaviours; Renée Guimonde-Plourde, Canada
37. Swedish and Danish teenagers’ thoughts about health – a comparative web based study of pupils in eighth grade; Carol Maher, Wales UK
38. A co-ordinated programme of initiatives on tobacco issues for young people in Wales UK; Katerina Sokou, Greece
39. Evaluation and effectiveness of the Greek Network of Health Promoting Schools; Pepa Pont Martinez, Spain
40. Report of itinerant shop of tobacco; Lars-Olof Nyrell, Sweden
41. Smoke free schools rewarded with a plaque in the Netherlands; Renate Spruijt, the Netherlands
42. Standard and methodical supply for preservation of children’s health in educational institutions; Nadia Polka, Ukraine
43. Promoting school cafeteria policy: Partnership for nutrition, education and catering in secondary schools in the Netherlands; Jeltje Snel, the Netherlands
44. Impact of health promotion intervention in educational and health policies; Isabel Loureiro, Portugal
Friday 27 September 2002

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| 4 A | Paper session            | Conditions for successful implementation  
1. Developing a partnership approach to health promotion in post-primary schools: an action research study exploring issues for parents, teachers and students; **Bernard McDonald, Ireland**  
2. Assessing the effectiveness on the Health Promoting Schools Network in Portugal; **Isabel Loureiro, Portugal**  
3. Barriers and contributing factors for the implementation of health promotion in primary and secondary schools in Flanders, Belgium; **Stephan Van den Broucke, Belgium** |
| 4 B | Paper session            | Health and health promoting schools on a global scale- future challenges!  
1. A new theory of health promoting schools based on human functioning, school organization and pedagogic practice; **Wolfgang Markham, England UK**  
2. Challenges of health in a borderless world: the development of indicators for health promoting schools; **Charles Viljoen, South Africa**  
3. The process of development of an international research network supporting health promoting schools development between South Africa and Sweden; **Bo Haglund, Sweden** |
| 4 C | Paper session            | Collaboration and supporting social structures in health promoting schools  
1. Working with parents – a model of partnership; **Janet Gaynor, Ireland**  
2. Developing the drug preventive models for schools; teachers, students and school health together; **Tiina Tervaskanto-Mäentausta, Finland**  
3. Is the social climate more secure in the health promoting schools?; **Miluse Havlinova, Czech Republic** |
| 4 D | Workshop                 | Teachers health: situation, tools, strategies  
Facilitator: Peter Paulus, Germany  
The health of teachers is one of the most important, if not the most important aspect in school health promotion: Without healthy teachers there will be no health promoting school in the long run. |
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| 4 E | Paper session            | Teaching health subjects  
1. ‘Confidence to teach’: equipping teachers to address psychosocial issues around healthy eating; Rachael Roberts, Scotland UK  
2. Sexual health and relationships education and teacher training programme in Scotland UK; Monica Merson, Scotland UK  
3. Identifying and meeting the needs of dispersed group of trainers to deliver training to teachers on sex education in Scotland UK; Monica Merson, Scotland UK  
4. The translation, modification, trailing, publication, training and dissemination of the Class Moves! ®; Gill Waring, Wales UK |
| 4 F | Paper session            | New teaching materials/manuals as agents for developing the health promoting schools  
1. An integrated approach to developing self-esteem, communication and safety among children and teachers in primary education; Elise Sijthoff, the Netherlands  
2. Process of developing manuals for Croatian ENHPS and the points learned; Marina Kuzman, Croatia  
3. The Heart Dance Award 2002 – A health dance contest getting whole schoolclasses on the move; Karen van Reenen, the Netherlands |
| 4 G | Paper session            | Intersectoral collaboration in developing specific projects  
1. Creating healthy respect; Dona Milne, Scotland UK  
2. Provision of relationship and sexuality education in schools in Northern Ireland – ongoing good practice through health/education partnership; Eileen Donnely, Northern Ireland UK  
3. The healthy school and drugs – delights and dilemmas of partnership in drug prevention; Ingrid Schulten, the Netherlands  
4. When textbooks and open doors are not enough: creating social capital as a health-promoting tool for high-risk children’s attendance to school; Lina Kostarova-Unkovska, The Former Yugoslav Republic of Macedonia |
| 4 H | Workshop                 | Young people’s participation: lessons learned and ways forward  
Facilitator: Concha Colomer, Spain  
Pupils' participation is a key issue in school health promotion but more knowledge and experience for further development and evaluation is needed. This workshop will identify the main barriers and opportunities and discuss the best strategies for the implementation of pupils' active participation. |
4 I  Paper session  Pupils’ participation in promoting healthy behaviours
1. A co-ordinated multi-agency approach to food and health in schools including strong pupil involvement; *Lynne Perry, Wales UK*
2. A study of school children’s diet and its association with health and social factors; *Anna Bjorg Aradottir, Iceland*
3. Pupils’ views of the extent to which staff can, and do, curtail pupil smoking rates; *Katrina Turner, Scotland UK*

4 J  Workshop  Student participation and action in a cross-cultural perspective
*Facilitator: Venka Simovska, Denmark*

The aim of this workshop is to discuss the concepts of genuine student participation, action and the use of ICT in cross-cultural collaboration within democratic health education and health promotion. The workshop draws on experience from the Young Minds-project. As a preparation for the workshop, participants are asked to visit the “Young Minds” stand at the conference venue.