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Schools for Health in Europe

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# MATERIALS FOR TEACHERS

October 2019

Learning about health and health  
promotion in schools

Key concepts and activities

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- 3 Introduction
  - 4 PART I: Selected Key Concepts
  - 5 What is a Health Promoting School?
    - 5 The idea of settings for health promotion
    - 6 The development of the 'Health Promoting Schools' initiative
    - 6 Main components of a Health Promoting School
  - 8 Different conceptualisations of health within Health Promoting Schools
    - 8 The concept of health within different scientific disciplines
    - 9 Health in schools
      - 9 The pathogenic (medical) model
      - 10 The World Health Organization (WHO) model
      - 10 The salutogenic model
      - 12 The quality of life model
      - 12 The socio-ecological model
  - 14 PART II: Participatory processes and learning outcomes
  - 15 Participation as a key pillar of school health promotion
    - 15 What is participation and why is it important?
    - 16 How to enable participation?
  - 18 Teaching of health literacy and action competence
    - 18 Health literacy as an outcome of learning in, through and about health
    - 22 From action experiences to action competence
    - 23 Health literacy and action competence supportive schools
  - 24 PART III: Examples of teaching activities
    - 25 Activity 1. Categorising different perspectives of health
    - 26 Activity 2. Health Alias
    - 26 Activity 3. Mapping exercise: the concept of health and wellbeing
    - 27 Activity 4. Photo stories: a safe and happy school
    - 27 Activity 5. Assessment of the school environment: If I were a Minister...
    - 28 Activity 6. The whole-school environment: how does our school promote or hinder health and wellbeing?
    - 28 Activity 7. Action for health
    - 30 Activity 8. 'Voices for Health'
    - 31 Activity 9. The New Story Dialogue Evaluation
  - 32 References

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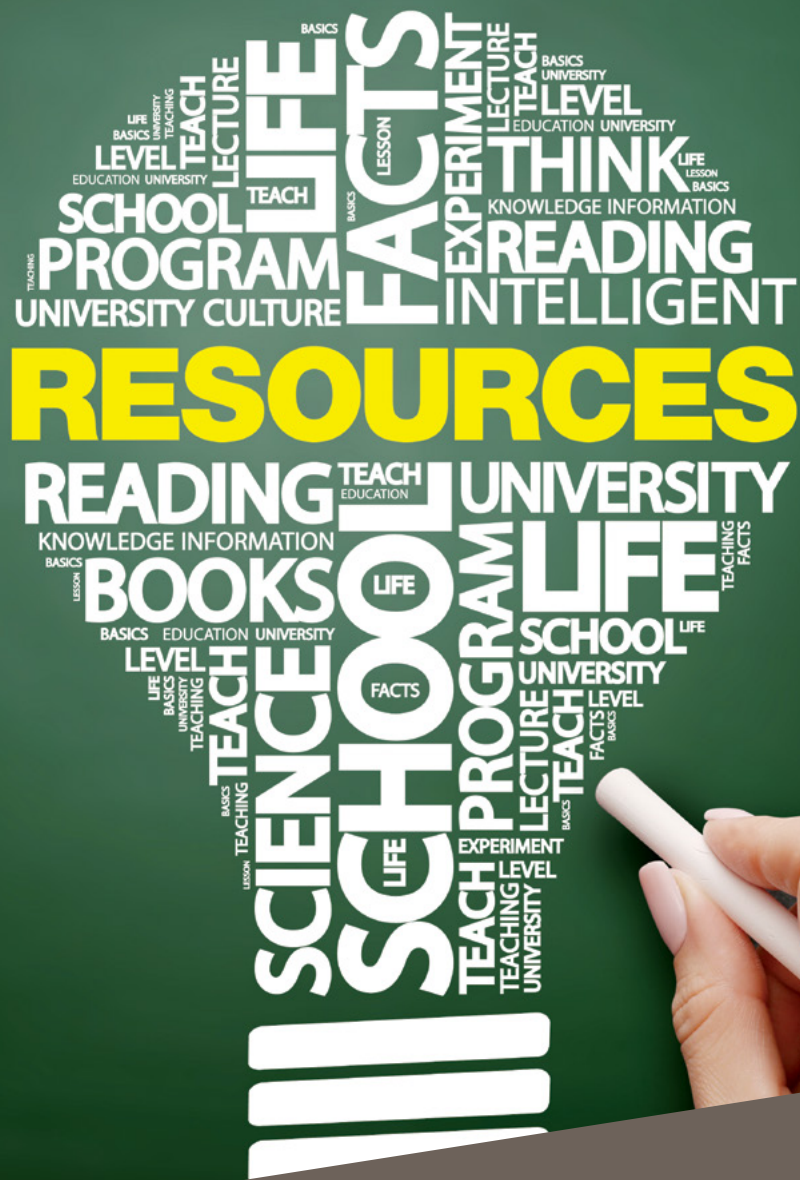
## INTRODUCTION

Schools reach most school-aged children, therefore they are important settings for the promotion of students' health and wellbeing as well as being pertinent to the delivery of health-related learning. Taking a whole school and healthy settings approach, they support students' empowerment and participation to "actively use and shape the environment and thus create or solve problems relating to health" (WHO Health Promotion Glossary 1998).

### The aim of this material for teachers is to:

introduce key pillars and concepts for health promoting schools describe health literacy and action competence as outcomes of school health education highlight the importance of student participation to promote core values of (Schools for Health in Europe (SHE) and) a health promoting school give examples for teaching activities that support learning of concepts and topics mentioned above, but also opportunities for students to participate in developing the school environment in a more health promoting direction.

The material is divided into three sections: (i) Key selected concepts, (ii) Participatory processes and learning outcomes, and (iii) Examples of teaching activities. The material is developed to help teachers and other educators foster learning of "knowledge and skills which enables students to build competencies and take action related to health, well-being and educational attainment" (SHE).



## PART I

# SELECTED KEY CONCEPTS

## What is a Health Promoting School?

In this section, we define the notion of 'health promoting schools' which was developed as part of the 'settings' approach to improving health and wellbeing from the 1980s onwards, and which is still endorsed in Europe and around the globe today. We briefly highlight the development of the initiative of health promoting schools in the World Health Organization (WHO) European Region, and present the main components of a school which can be characterised as 'health promoting'. The components are not static. Instead, they are interpreted, specified and modified in different countries and educational contexts. Nevertheless, the main idea remains unchanged - that the school is perceived as a dynamic system which affects the students' educational experience more broadly and thus their health and wellbeing. Consequently, the students' competences and disposition to take care of their own health and the health of others, is developed not only in the classroom but also through the everyday life of the school as a community.

### The idea of settings for health promotion

The 'settings' approach to health promotion was initiated following the Ottawa Charter issued by the World Health Organization (WHO) in 1986. This political document drew attention to the ways in which the everyday places, arenas, organisations and institutions dynamically interact with people's health and wellbeing. The charter helped to shift the focus from individual behaviour regulation to social and societal forces related to health and wellbeing.

The first international initiative within this framework was WHO's Healthy Cities network. Following this initiative, a number of networks, projects and interventions took place in different settings, such as health promoting schools, kindergartens, hospitals and workplaces.

The settings approach does not simply imply an 'evidence-based', static intervention to be implemented in different arenas with a view to promoting health and wellbeing (for example, Whitelaw et al., 2001; Simovska & McNamara, 2015). Rather, it refers to a generic approach to the promotion of health and wellbeing underpinned by the principles linked to the

socio-ecological concept of health; societal determinants, equity, empowerment and emancipation.

Thus, a 'setting for health and wellbeing' is defined by WHO as a place or social context where people engage in daily activities and in which cultural, historical, environmental, organisational and personal dynamics interact to affect health and wellbeing.

#### Applied to schools, the definition is as follows:

**||** A health promoting school is a school that has a constant focus on providing children and young people with opportunities to live, learn and play (WHO, 1991).



## The development of the 'Health Promoting Schools' initiative

The concept of 'health promoting schools' emerged in Europe in the early 1980s. It was further developed at the World Health Organization (WHO) Health Promoting Schools Symposium in Scotland in 1986 and advanced a few years later in the publication entitled 'The Healthy School' (Young & Williams, 1989). In accordance with these developments and the main democratic principles, health promotion in schools is defined as a social process of individual and community empowerment and agency.

The European Network of Health Promoting Schools (ENHPS) was officially established in 1991 by the WHO European office, the Council of Europe and the

European Commission. The initiative drew on the five principles from the Ottawa Charter. Since 2017, the network has been named "Schools for Health in Europe Network Foundation" (SHE). It is organised as an independent Non-Governmental Organisation (NGO) supported by the European Commission and working closely with the WHO European Office. The network consists of national and regional coordinators from thirty-two countries in the WHO European Region, with more countries in the process of taking up membership. The SHE core values continue to reflect the original ideas and strongly relate to equity, sustainability, inclusion, empowerment and democracy ([www.schoolsforhealth.org](http://www.schoolsforhealth.org)).

## Main components of Health Promoting School

The whole school environment is viewed as an essential arena for action if a school is to be health promoting. This implies that the emphasis is not exclusively on learning and teaching but also on the whole school ethos and culture, that is, the interpersonal relationships, school management, curriculum, policies, practices and the school's physical environment. It is considered vital that a health promoting school is a 'learning' and 'growing' community, where students develop their capabilities and attributes and improve their knowledge, skills and competences both in the classroom and in everyday school life. Also, school is an important setting for staff development and their health and wellbeing. Figure 1 portrays the main components of a health promoting school that dynamically interact and are symbiotic. These include, but are not necessarily limited to the following:

### School physical environment:

this component refers not only to the size of the classrooms and outdoor spaces, but also the indoor climate including lighting, noise, hygiene, architecture, interior design, furniture and facilities.

### School social environment:

this component points to the quality of student peer-to-peer relationships as well as the relationships between students and teachers, other staff and school leadership. This component also includes school policies related to, for example, health and wellbeing,

anti-bullying, safety, inclusion, equalities and diversity. Further, the component incorporates social media and virtual settings, as both digital and analogue communication can affect health and wellbeing and are integral to the school culture.

### Community links:

this component refers to collaboration with parents, families and partners including local authorities, non-governmental organisations (NGOs), sports and leisure clubs, third sector organisations and private enterprises that can help extend the opportunities for playing, learning and development in and beyond school.

### Healthy school policies:

this component refers to the leadership style, governing strategies and regulations, and the professional collaboration between the teachers, school nurses and other stakeholders to ensure clarity of purpose which is shared across the school community to promote and enact health and wellbeing in school.

**Individual health skills and action competencies:**

this component refers to competencies that are often developed through the curriculum including the health-related content, aims and teaching methods used in the classroom as well as interdisciplinary learning and extra-curricular activities at whole school level.

**Health services:**

this component refers to securing the access to school health services or school-linked services which focus particularly on health care and health promotion.



## Different conceptualizations of health operating in Health Promoting Schools

In this section, we outline a few conceptualisations (models) of health with an aim to support teachers and school staff to reflect upon and navigate through the complexity of the landscape, and make decisions when planning and enacting their practice within the framework of a health promoting school. It is important to emphasise that this is a selection, rather than an exhaustive list of different conceptualisations of health. The boundaries between the models are not clear-cut, they overlap and intersect in a variety of ways. In schools, teachers and non-teaching school staff work with different models at different times, sometimes combining them together. This overview can be helpful in planning and clarifying the teaching aims, content and methods.

### The concept of health within different scientific disciplines

At first glance the question “what is health?” seems simple and straightforward with many people having considered it, engaged with it, and then come up with an answer. However, as soon as we start discussing what are the best ways to promote health, it becomes evident that the conceptualisation of health is characterised by a high level of complexity and ambiguity. Health, as well as illness are experienced individually but also through a number of dynamics that shape them, such as socioeconomic background, ethnicity, culture, age, gender and disability. Further, the conceptualisation of health is embedded in the domain of practice, in the scientific discipline in which the conceptualisation is developed, and in wider socio-cultural, historical and political circumstances. A few examples of discipline-based conceptualisations are listed below:

**Medical and health sciences** focus on the diagnosing and treatment of diseases. Within these sciences, health is defined primarily as the absence of disease. Efforts to promote health concentrate on preventing diseases.

**Economy** is interested in establishing links between health and welfare in society. This originates from health being perceived and analysed through its costs to society; whether preventative measures reduce these costs, and whether inputs on health contributes to the economy.

**Psychology** engages with health through the consideration of individual agency and the subjective quality of life.

**Anthropology** looks at cultural inter-pretations of health and their relationship with people’s everyday life.

**Educational science** explores the links between health and learning, in particular, the evidence that exists between positive health and effective learning, and what capabilities and attributes students need to understand and take care of their own health, and the health of the others.

Thus, it could be argued that the concept of health is a ‘contested’ concept (Green et al., 2015). Contested means that the concept is socially constructed, it changes over time, space and the domain of utilization; its underpinning principles are value-led and open to diverse, often conflicting interpretations.



## Health in schools

Historically, health has been a subject of school practices in one way or another, and health and education have perpetually been viewed as dialectically intertwined. For example, better health may contribute to better learning and school achievement, which in turn, may be conducive to better health. The origins of health education can be tracked back to the health concerns of the 18th and 19th centuries, if not even earlier.

The diverse contesting discourses related to the definition of health mentioned above have had considerable influence on the development and the interpretations of school-based health education and health promotion. The challenge of school-based health ed-

ucation and promotion is that the above-mentioned disciplinary conceptualisations of health are interwoven with school policies in shaping and enacting practice. In other words, the work with health education and promotion in schools is both cross and interdisciplinary and draws on different understandings of health, which are sometimes explicit, distinct and complementary, and sometimes implicit, vague and contradictory to one another. While positive, because it acknowledges the complexity of health as a concept and as a phenomenon, the cross and interdisciplinary nature makes working with health education and health promotion a challenge for school leaders, teachers and school staff.

## The pathogenic (medical) model

The most influential definition of health over the last two centuries has been the medical model. The scientific, biomedical accounts of health emerged in Western Europe at the time of the Enlightenment, along with rationality, individualism, technology and science as main forms of knowledge. The medical approach focuses on determining why people become ill, what the risk factors are, and how these factors can be avoided, ameliorated or treated. In this approach, students are often viewed as risk-carriers whose health should be protected to reduce the risk of becoming ill later in life. The concept of health is determined as pathogenic (disease causing) in nature. Naidoo and Wills (2016) have suggested the following terms:

**biomedical** - health is a property of biological beings.

**reductionist** - health is determined through summing up its smaller constitutive components.

**mechanistic** - the body is like a machine and can be "fixed" if broken.

**allopathic** - if something is wrong with the body it should be treated by applying an opposite force, for example, medication.

Despite incredible improvements in public health brought about by the medical approach during the

enlightenment, this model also has its limitations. The approach is underpinned by a certain set of values and power relations between "health experts" and "lay people", in which the individual is viewed as (more or less) a passive recipient of expert (health) services. Individual's subjective experiences about health are not the focus. In schools, this model is used, for example, to learn about different illnesses, their links with individual behaviour, and about prevention of diseases through changes in the lifestyle of students.

In his classic criticism of the medical discourse, Crawford (1977; 1980) used the term "healthism" to highlight the predominant preoccupation of the discourse with individual health, and the links between individual lifestyle and illness, and "blaming the victim". He is critical of the premise directed against vulnerable individuals whose illness is attributed to their lifestyle, while ignoring important issues such as inequality and the social causation of disease.

This critique generated the foundation for the launch of the health promotion agenda by international organisations and set in motion the Ottawa Charter (WHO, 1986) which played a critical and influential role in the development of the framework of Health Promoting School (WHO, 1998).

## The World Health Organization (WHO) model

The most influential and instrumental definition of the concept of health for the development of a health promoting schools framework comes from the World Health Organization. The WHO definition determines health as a positive state of wellbeing, viewing it as both a fundamental human right and as an investment in a democratic and just society:

*...the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources as well as physical capabilities.*  
(WHO, 1984)

This definition also underlines that health is embedded in individual everyday lives. It is intertwined with living conditions and socio-political and cultural factors as well as with individual resources.

It is closely linked to the issues of equity and social justice. Furthermore, health is perceived as encompassing different dimensions that are mutually interconnected. When WHO introduced the concept for the first time in 1946, health was divided into three dimensions: physical, mental and social. Physical health can be understood as concerning the body, and it includes various propositions: from the absence of disease or illness, to being fit and being able to perform daily tasks. Mental health involves: a realisation of one's worth and potential; being able to cope with normal type of stress, and to feel good; to work productively and to participate in contributing to the collective good. Social health relates to: being able to create and sustain social relationships; having a bond to family and friends; and having the sense of being supported and being involved in activities with other people. However, several other dimensions such as spiritual and sexual have been suggested afterwards to highlight the complex and comprehensive nature of health.

## The salutogenic model

Salutogenesis is a term coined by Antonovsky (1987) to underline the distinction from "pathogenesis". It is composed of two terms: *salus*, Latin for wellbeing and happiness, and *genese*, Greek for origin. In contrast to the medical model and aligned to the World Health Organization (WHO) model, this understanding of health emphasises wellbeing and positive aspects of health, focusing on the dynamics that produce or keep people healthy, rather than on those that produce illness. Health itself, within the positive domain, is understood as being on a dynamic continuum rather than in a static condition. The focus is on the way(s) in which individuals cope with adverse health-related living conditions. In consideration of the complexities and uncertainties of the world in which we live, and taking into account the fundamental human need to understand and bring order to these complexities, Antonovsky introduced the notion of a "sense of coherence" as a key quality characterising a healthy person.

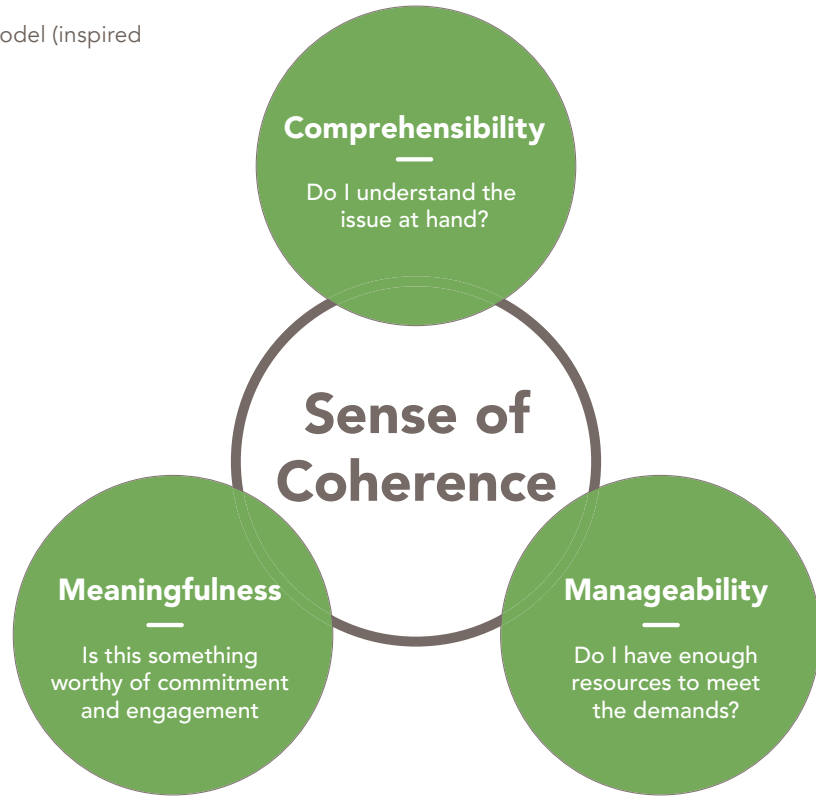
He suggested that a 'sense of coherence' consists of three components - comprehensibility, manageability and meaningfulness (Figure 2). Antonovsky 1987, states:

*a sense of coherence is...a global orientation that expresses the extent to which one has a pervasive, enduring and dynamic feeling of confidence that:*

- a) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable;*
- b) the resources are available to one to meet the demands passed by these stimuli; and*
- c) these demands are challenges worthy of investment and engagement.*

**Figure 2.**

The salutogenetic health model (inspired by Antonovsky, 1987)



Evidently, a ‘sense of coherence’ draws attention to the dynamic interaction between individuals and their habitats including material resources, social environments as well as the factors that influence individual coping capacities. It emphasises that these factors do not simply consist of an individual’s internal resources but also include the quality of interpersonal relationships, the level and quality of social con-

nectedness, and the existence of supportive environments. In schools, this model is emphasised when learning in, through and about health and health promotion practices. Where this works well, students are involved in defining what health means to them, and in identifying important social relations and other circumstances in their immediate environment which influences health.

## The quality of life model

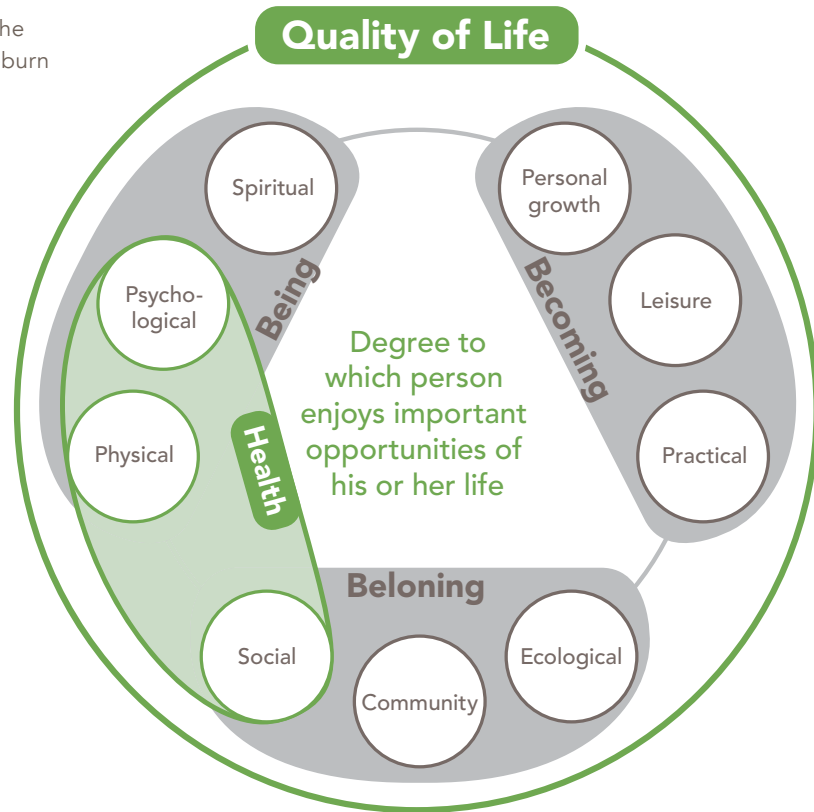
The quality of life model understands health as fundamental to the quality of life. Quality of life can be defined through three main categories: being, becoming and belonging (Woodill et al., 1994; see also Raeburn & Rootman 1998).

Each category encompasses different areas of individual’s everyday life and lived experience. The being category involves the areas that are related to the physical, psychological and spiritual dimensions of individual’s lives.

The becoming category contains aspects related to work, learning, leisure and personal development. The belonging category involves the social, relational and working environment, as well as living conditions in the broader sense. Health is identified as a subfield of the quality of life, and the three areas - psychological, physical and social - corresponds with the dimension of and WHO health model (Raeburn & Rootman, 1998) (Figure 3).

**Figure 3.**

Health as a component of the quality of life (Adapted Raeburn & Rootman, 1998)



Each of the domains holds a range of opportunities and challenges to an individual's health and wellbeing. The degree to which an individual can exercise agency over the determinants (at both macro and micro level ) in these areas of life, and the degree to which change is brought about as a result of agency in these domains to amplify the range of opportunities, determines their health and wellbeing.

Teachers with students can plan and co-construct their health education and health promoting activities using the different domains of this model; for example, promoting and embedding positive social relations (belonging); and/or through school achievement where students know and feel success (becoming); and/or guiding and working with students to initiate positive changes in the school environment (being).

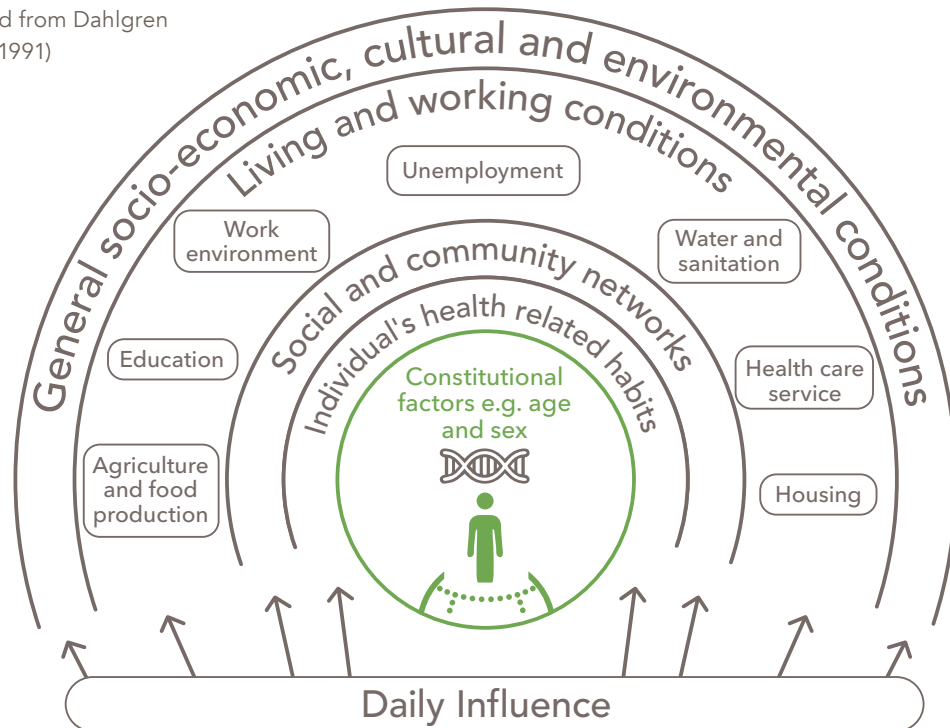
### The socio-ecological model

The concept of salutogenesis signified a shift from the medical discourse to what has been called a socio-ecological or eco-holistic concept of health. This model interprets health as multifaceted and influenced by a number of symbiotic forces ranging from individual level factors to interpersonal and community, as well as societal level factors. One of the most popular diagrams illustrating the various factors promoting, protecting and challenging health is that of Dahlgren and Whitehead (1991) (Figure 4).

Here, health is influenced by the broader societal and environmental contexts, various material and social conditions, mutual support from family, friends and neighborhood, as well as various individual level factors (for example, health behaviour, age and sex). This approach using the determinants of health indicates that health is not only an individual, but also a social as well as a societal issue.

**Figure 4.**

The main determinants of health (adapted from Dahlgren & Whitehead, 1991)



This model emphasises that health involves the complexity of the whole person as well as the environment. Health is created in places where people live, love, learn, work and play (World Health Organization, 1986), and consequently, actions to improve and sustain health should consider these places or settings such as schools, workplaces, hospitals and cities. This conceptualisation shaped the “setting approach” to health promotion, of which the ‘Health Promoting Schools’ initiative is one example. The

school policies and practices prioritising this model addresses not only individual students’ knowledge and understanding related to health, but also addresses structural determinants of health at school and/or local community level. It creates opportunities for students to be agents of change at school and/or community level.



## PART II

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# PARTICIPATORY PROCESSES AND LEARNING OUTCOMES

## Participation as a key pillar of school health promotion

In this section, we emphasise that schools should ensure the right of every student to participate in deciding on the actions that affect their health and wellbeing, is secured. We define the concept of participation and describe the benefits of participation for students and schools. We present five modalities of participation in schools that can be used to reflect on current school practices, and plan future activities to improve, increase and/or secure student participation.

### What is participation and why is it important?

In democratic societies, participation is an important value and a critical component in the life of a school as a community. It is closely linked to the United Nations' Convention on the Rights of the Child, which emphasises that children's best interest should be the key priority in making decisions that affect their lives. Children should be heard and involved in a manner that is appropriate to their age and development. Children have unique understanding of their own experiences, wishes and preferences, and through participatory approaches, children's voices can be heard, communicated and followed through.

According to Save the Children and United Nations International Children's Emergency Fund (UNICEF) (Lansdown, 2011), participation can be defined as an ongoing process of children's expression and active involvement in decision-making at different levels in matters that concern them. It requires information-sharing and dialogue between children and adults based on mutual respect, and requires that full consideration of their views be given, taking into account the child's age and maturity.

**“**Decisions that are fully informed by children's own perspectives will be more relevant, more effective and more sustainable”  
(Lansdown, 2011)



School is an important setting in students' lives. It is a place where they spend a lot of time, creating and sustaining important relationships, and having space and time for learning the many valuable competencies that they need now and in the future. Also, it is recognised as a setting which affects students' health and wellbeing. Hence, the school is an appropriate environment where students can learn to identify the factors that promote or impair their health and wellbeing, as well as a place to set goals, plan and decide activities with a view of taking actions for further self-development and improvement of their school.

According to several reviews (for example, Greibler et al., 2012, Mager & Nowak, 2017), fostering student participation in school-based health education and promotion benefits not only individual students, but also schools' social relationships and schools as organisations. Participation promotes learning in, through and about health-related competencies, in-

cluding citizenship skills, motivation, agency, a sense of ownership, self-esteem and self-efficacy. Doing things together improves student-staff and student peer-to-peer relationships through improved communication, cooperation and an understanding of the perspectives of others. In addition, participation in promoting health and wellbeing in school contributes to the positive development of school culture; including the ethos and life of the school as a community.

**“** Participation offers opportunities for children from diverse backgrounds to build a sense of belonging, solidarity, justice, responsibility, caring and sensitivity.”  
(Landsdown, 2011)



## | How to enable participation?

Supporting student participation varies across all schools. To be able to respond to the rights of a child, students should be able to take responsibility and to have opportunities to exert influence. For instance, they could be involved in identifying problems related to school wellbeing and discussing different ways of addressing these problems. Younger students are capable of describing school wellbeing in a broad manner and can give concrete examples on how to organise school in ways that are more conducive to thriving in school. In order to do this, school policies and practices must encourage and support student participation. Where this is not in place, students may feel that they do not know how to participate, that much has been decided already or that there is no space for expression of their views (Välivaara et al., 2018).

It is important to be aware of various ways of defining student participation to be able to assess the school's approach to it and to develop practices that are more supportive to active participation. Participation can be characterised in many ways.

One useful categorisation is modified from Hart, 1998; Simovska, 2005 below:

- 1) Lack of participation:** students are not allowed to express their wishes and views, and school practices are decided and implemented by the adults.
- 2) Symbolic participation:** students may be asked to express their opinions, but these are not necessarily followed through, since adults make the decisions and carry out the practices.
- 3) Consultation:** students' opinions are taken seriously in identifying relevant factors to be addressed, setting goals and deciding corresponding actions, but adults make the decisions.
- 4) Influence:** students' have a genuine and active role in discussions and in decision-making, but, the final decisions are made by the adults.
- 5) Shared power:** students' share power with adults over decisions, and the decisions are made in a democratic way. Also, students take responsibility for their decisions in a way that is appropriate to their age and development.

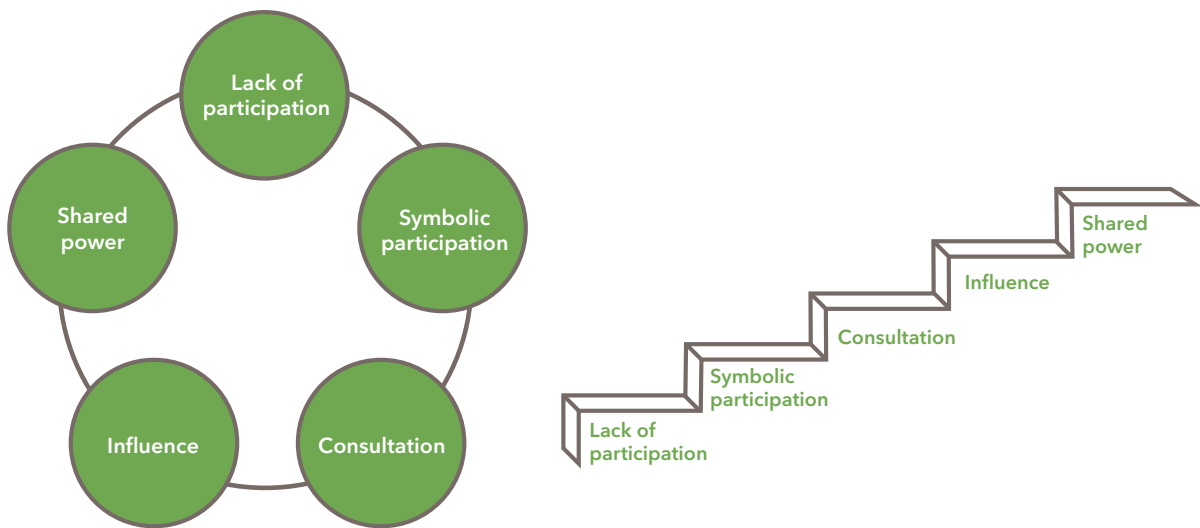


The five modalities of participation can be organised in many ways. Presenting various types of participation in a circular layout demonstrates that each type has equal importance, and when selecting one over another, a decision is often made based on the appropriateness of the type in a given context. Whereas presenting participation using the ladder or pathway, visually suggests that participation is hierar-

chical: those lower in the hierarchy (on lower steps/ at the beginning of the pathway) represent less advanced or more simple way of approaching participation; whereas those higher in the hierarchy (on higher steps/at the end of the pathway) represent more advanced or a more complex way of approaching participation.

**Figure 5.**

Circular and ladder layout for presenting participation (modified from Hart, 1998; Simovska, 2005)



Schools may approach participation in different ways. What is important is that throughout students' school years, all students should have genuine opportunities for active participation offered in an age appropriate manner. Even the youngest students should be provided with opportunities to be seen, heard

and appreciated as co-constructors in decision-making when age appropriate.

## Teaching of health literacy and action competence

In this section, we define health literacy as a learning outcome of health education and describe its five core components. Examples for learning objectives with a view of developing health literacy are offered for grades 1-2, 3-6 and 7-9 to help teachers plan. Through such planned activities, teachers can facilitate learning of comprehensive health literacy throughout basic education. In addition, we discuss action competence as a way to engage with health issues at various levels. We describe a particular pedagogical model to develop action competence among students called IVAC:

I stands for investigation; V for visions; A for action and C for change (Jensen, 1997).

## Health literacy as an outcome of learning in, through and about health

Health literacy according to Nutbeam (2000) is a key outcome of health education linked to the health promotion action area 'development of personal skills'. Health literacy has been linked to positive health outcomes including better self-rated health. Hence, the development of health literacy helps in a reduction in differences in health among children. Health literacy is asset-based, supporting the development of students' autonomy, empowerment and abilities to participate in promoting the collective good, and action competence related to health. Learning in, through and about health literacy is a right of every child. When health literacy is embedded in school policies and practices, the school ensures that all students have opportunities to practice and attain a broad range of health-related competencies throughout their schooling.

Health literacy, which has many similarities to the concept 'life skills', can be defined as an ability to understand oneself and others, and the world in a way that enables one to make meaningful decisions related to health. This also includes the ability to identify and address the factors that constitute one's own and others' conditions for health and wellbeing. According to Paakkari and Paakkari (2012), to achieve this, students should be able to develop a broad range of health literacy competencies, including:

### Theoretical knowledge

related to health and wellbeing. This involves an ability to name, describe and memorise the health-related issues, principles, concepts and models. They are communicated through, for example, teacher-led and peer-led discussions in the classroom, and mak-

ing use of real life stories and scenarios. Health is seen as multidimensional (as illustrated in Figure 4) and multidisciplinary.

### Practical knowledge

and skills, including intuitive knowledge which is partly rooted in the student's experiences. The practical skills require that students can apply the theoretical knowledge in practice. This is developed through continuous, progressive and coherent experiential learning in the classroom and beyond. Skills may be specific health skills, such as an ability in taking care of personal hygiene. Alternatively, they may be more general skills important in other context as well such as an ability to search for (health-related) information.

### Critical thinking

Individual critical thinking assumes the ability to treat knowledge as dynamic and uncertain, and adopting an explorative attitude towards the world. Students should be supported to investigate health topics from various perspectives, as critical citizens as well as critical consumers. In doing so, they search for logical connections, solve problems, argue for/or against current issues, and evaluate the validity of health information, using strategies such as mind-mapping, problem-solving, interactive pairs/ group work and collaboration.

### Self-awareness

Self-awareness is the ability to reflect on oneself; allowing personal contextualisation of health issues and insight into one's own wishes, preferences, strengths, weaknesses, values and attitudes. It also includes an ability to reflect on oneself as a learner.

Self-awareness can be developed through creating learning experiences where students reflect on the content from the perspective of their personal lives and critically examine one's own way of thinking and behaving. It also supports students to understand others, how they perceived you, your attitude and your responses to others, in the moment. It is crucial for self-management and self-efficacy.

### Citizenship

Citizenship refers to an ability to act in an ethically responsible way. This involves participating in the promotion of the collective good and democracy and engaging in dialogue involving different perspectives in relation to a topic. The development of health-related citizenship in school calls for learning situations where students are supported to think beyond their personal perspective, and to consider the probable consequences of their actions on themselves, on others, and/or on society as a whole. For the development of health-related citizenship competences, students also need to experience participation in actions

that develop students' ability to work with others, to respect varying views, and to identify and address the opportunities and/or challenges to achieve and maintain good health.

Health literacy can and should be developed in all grades, in an age-appropriate way. The examples given below show how various components of health literacy can be introduced through the various grades of basic education.

**During grades 1-2** (approximate age 7-8), the focus is often on the factors related to personal daily life and immediate surroundings, to practice basic health-related skills (Table 1). The students come with curiosity towards the world and some elements of citizenship skills are already advanced. Using participatory approaches, young students can and should be encouraged and involved in developing health and wellbeing of their school environment. Also, simple questions around rights and responsibilities can be discussed.

Table 1

Examples of the curriculum objectives for the grades 1-2 (approximate ages 7-8; applied from Finnish National Core Curriculum, 2014).

HEALTH LITERACY COMPONENT	TO SUPPORT AND ENCOURAGE STUDENTS...
Theoretical knowledge	In naming and describing factors that support health and well-being, and the basic necessities of life
Practical knowledge	To practice using (i) simple everyday self-care skills. (ii) seeking help and (iii) team-working skills
Critical thinking	To ponder about, and ask questions and justify their opinions related to simple health topics related to simple health topics
Self-awareness	To ponder what brings happiness, joy, sadness and anger to themselves
Citizenship	To participate in experiential learning with peers and work with school staff to promote school health and wellbeing to strengthen self-respect and respect of others

**In the grades 3-6**, (approximate age 9-12), students' progress to more in-depth and challenging issues. Health literacy covers students' abilities to reflect on their own growth and development. More complex thinking skills should be developed and more attention should be put on critical thinking skills as well as ethical responsibility such as the ability to promote

sustainable decisions and actions. Similarly, students should be encouraged to reflect on how their own decisions and actions influence others and the surrounding environment. Table 2 gives some examples on the objectives for health literacy learning and teaching in grades 3-6.

**Table 2**

Examples of the curriculum objectives for the grades 3-6 (approx ages 9-12; applied from Finnish National Core Curriculum, Finnish National Board of Education, 2014)

HEALTH LITERACY COMPONENT	TO SUPPORT AND ENCOURAGE STUDENTS...
Theoretical knowledge	In understanding aspects of health, including self-development, and the importance of everyday health habits over the life course. Students will learn about individual growth and development in children and teenagers
Practical knowledge	To practice role play in pairs/groups using a range of real life stories and scenarios to inspire students to express themselves and to listen to others. Students will be supported to practice and apply their health literacy knowledge and skills in daily life, including the practice of recognising, expressing, and regulating their emotions
Critical thinking	In obtaining reliable health information, expressing and justifying different views, and interpreting and critically evaluating health information sources and viewpoints
Self-awareness	To set personal study goals and make continuous efforts to achieve them. Also, as a learner, reflect on their own competencies and identify strengths and next steps in learning in relation to the current topic
Citizenship	Environmental awareness and to guide students to act and become involved with their surroundings and community, with the aim of promoting sustainable development and appreciating the importance of sustainable development for themselves, at school, at community level and on the global stage

**In grades 7-9** (approximate age 13-15), consolidation and progression will build on prior learning during grades 1-6. Learning will be expanded, deepened and applied using more advanced competencies (for example, higher order thinking skills), as well as learning new health-related competencies (Table 3). Students should be supported to broaden their perspective explicitly towards the wider community and society while still developing their competencies around personal growth. Ethical and criti-

cal questions related to various health phenomena should be discussed, with sustainability continuing as a central theme. More opportunities to participate in identifying, planning, organising and enacting health promoting activities, with a focus on school policies, practices and structures to improve the learning environment, should be offered at this level.

**Table 3**

Examples of the objectives for instruction for grades 7-9 to support the development of health literacy (approx 13-15 years old; adapted from Finnish National Core Curriculum, Finnish National Board of Education, 2014)

HEALTH LITERACY COMPONENT	TO SUPPORT AND ENCOURAGE STUDENTS...
Theoretical knowledge	To describe what health promotion and the various aspects of health means as well as its interdisciplinary nature, using examples. Students learn about an assets-based approach to health and wellbeing and its significance as a resource for life
Practical knowledge	To identify various emotions and explain how these interact and impact on behaviour, and the importance of self-regulation To be solution-focused in negotiating conflict; finding ways to understand and apply stress and crisis-management strategies To explore the concepts of boundaries and privacy and how to protect them
Critical thinking	To evaluate the reliability of health-related information, on the basis of multiple factors affecting the reliability of information To analyse factors affecting the adoption of healthy habits, and to explain the formation of phenomena related to health habits
Self-awareness	To recognise and evaluate their habits and choices related to health and safety To reflect on the resources that are important for their health and how to access them To self-reflect as a learner; understanding personalisation and choice, and how to learn by setting goals and targets to make progress in learning
Citizenship	To analyse the consequences of healthy and unhealthy lifestyles on self, on others and the environment To give examples of measures affecting health in their immediate and local context To describe different methods of protecting, developing and influencing their surroundings and communities and enacting these methods jointly with others To evaluate impact or improvement in school and/or the community

When learning is developed at this level to promote health literacy, the components described above could be used to plan. Please note that the various components will be developed throughout the school year, but not necessarily within one learning activity.

In these materials, in relation to the examples of 'Activity' and related objectives for learning and teaching, explicit reference will be made to the identified components of health literacy.

## From action experiences to action competence

The development of health literacy, in particular citizenship skills, is reinforced and consolidated through experiential learning and action-oriented approaches to develop and improve students' action competence. Action competence refers to abilities to engage with health issues at individual, organisational and societal level (Jensen, 1997; Jensen & Simovska, 2005). An important characteristic of action competence is the ability to engage in planning, initiating, delivering and evaluating actions aimed at improving the conditions of health and wellbeing in "real life". In schools, this implies actions at classroom level, school level, local community level or societal level more broadly. These actions can be direct or indirect, smaller or larger in scope, but they will always address some of the causes, or conditions for health and wellbeing, rather than solely individual behaviour.

Action competence is grounded on visions of an ideal community (for example, school, classroom, the local community or society as a whole), which is conducive to the health and wellbeing of all. Furthermore, action competence is characterised with a high level of commitment, motivation and/or engagement to work alone or with others, to bring reality closer to the ideals (visions), and to persist with the efforts when faced with challenges.

In other words, the following dimensions constitute action competence: *commitment*, *knowledge* (related to the health domain, but also interpersonal and intrapersonal knowledge), *visions*, *action experiences*, and resilience when faced with barriers (Jensen, 1997; Jensen & Simovska, 2005). Students should be supported to become involved and motivated to identify and work on authentic health-related issues, and to acquire a broad range of knowledge of the selected problem or situation (for example, what is it, how did it develop, and what are the possible solutions?). Furthermore, they should be supported to create a vision of how the situation should be and the possibilities and means available to fulfill the vision. Finally, the students with staff co-construct action experiences to bring about health-promoting changes, and then reflect and evaluate both the process and the outcomes to identify next steps.

The Investigation, Vision, Action and Change (IVAC) (Jensen, 1997) model has been suggested as a peda-

gogical tool to develop action competence. The four key phases share many similarities with problem-based, enquiry-based learning, and other comparable approaches to learning. They all support students' natural curiosity and investigative approach to learning, knowledge, planning of action, responsibility, independence and working with real-life problems. However, in the IVAC approach, carrying out actions and change-making in real-life contexts are made explicit. Hence, this model does not focus on developing competencies to be used only in theoretical or hypothetical situations, but on competencies relevant for students in their everyday life, for instance, bringing about improvements and changes in their school environment.

Participation is critical to developing action competence. Table 4 illustrates various phases of the planned process to support learning in, through and about action competence in order to carry out health promotion changes in schools. Using the table, students, teachers and non-teaching staff can assess previous or current practices on how participation is approached during the various phases of each project. Also, the table can be used in planning school practices to ensure genuine participation, an important requirement if the aim is the development of action competence.

Table 4

Modalities of participation in various phases of the project (adapted from Jensen & Simovska, 2005)

PHASE OF THE PROJECT	A	B	C	D	E	F
MODALITY OF PARTICIPATION	Involved in the project	Selecting the problem/ theme	Investigation	Vision/Goals	Actions	Evaluation /Follow-up
Lack of participation						
Symbolic participation						
Consultation						
Influence						
Shared power						

## Health literacy and action competence supportive schools

Schools can be considered being more or less supportive of the development of health literacy and action competence depending on the level of commitment to promote learning and the practice of these competencies. To support this process, the following questions (inspired by Brach et al., 2012; UNESCO, 2005) can be used as part of a school’s self-evaluation on health literacy and action competence:

- 1) Are health literacy and action competence an integral part of the school’s policies: mission, structure and actions?
- 2) Is health literacy of the school staff promoted? Is staff’s ability to promote health literacy and action competence among the pupils supported and developed?
- 3) Is health literacy and action competence promoted among all pupils, and with a special input on those in greatest need? Is health literacy curriculum offered with a particular emphasis on action competence?

- 4) Does the school communicate health messages in a way that is understandable to pupils?
- 5) Does the school offer access to valid and age appropriate health information?
- 6) Does the school offer access to information technology and lifelong learning?

These challenge questions are intended to be used by staff at all levels to evaluate whether health literacy and action competence are embedded into a whole school approach and not restricted to classroom-based learning and teaching.



## PART III

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# EXAMPLES OF TEACHING ACTIVITIES



## Examples of learning and teaching activities

In this section, we give examples of learning and teaching activities that support learning of competencies and aspects of health literacy mentioned in the two first sections. The examples provide opportunities for students to participate in developing the school environment through health promotion. It is important to emphasise that the examples are designed to help the teacher and students plan lessons and choose the didactic and pedagogical approach. The examples must be adapted to students' age, levels and competences as well as to the teaching aims and content. For example, many of the activities involve writing skills, but when working with younger students or students with learning difficulties, drawings or photographs can replace written notes.

The teaching activities are aimed at: students' perspective of health (Activity 1, 2 and 3); the whole-school approach (Activity 3, 4, 5 and 6); and students' action for health (Activity 3, 5, 7, 8 and 9).

### Activity 1. Categorising different perspectives of health

Objectives:

To promote students' ability to describe the concept of health and to categorise different perspectives based on similarities and differences (to increase theoretical knowledge and to develop critical thinking).

- Draw a child in the center of a flipchart.
- Give students post-it notes. Ask them to work individually and finish the sentence: "A child is healthy when... ". Each student should write one sentence per post-it note and produce at least three different sentences.
- Divide students into groups of five. Ask them to read all the sentences they have written and to group similar definitions together onto a flip-chart paper. Each group should be given a theme/topic (for example, physical health, mental health, social health, sexual health etc).
- Each group presents their flipchart to the class.
- Discuss with the whole class the different aspects of health, and the similarities and differences between them. Include cultural differences in the discussion.

NOTE:

The exercise could also be conducted by using photos. Students would be asked to pick a photo from a selection of photos, describe to others what kind of health is represented on the photo, group together the photos based on similarities and differences, and then name each category.

## Activity 2. Health Alias

Objectives:

To promote students' abilities to describe and explain various health-related concepts (to increase theoretical knowledge).

Prepare sets of words/concepts related to the health phenomenon at hand that you wish students to be able to describe and explain to others (e.g. physical health, mental health, school nurse, participation, health promotion). Divide the class into smaller groups (2-3 students in each). Give each group one set of words which they divide equally between the members in that group without watching the words. Give each member same time (e.g. 30-60 seconds depending on the amount of words) to explain one word at a time to other members, without showing or using that one particular word. When the time is out, the words that were identified and answered right brings one point to the group. After all the members have explained their words, the group with most points will win.

## Activity 3. Mapping exercise: the concept of health and wellbeing

Objectives:

To promote students' understanding of the concept of health and wellbeing (to increase theoretical knowledge); and their ability to assess existing practices, develop new ideas (to develop critical thinking and citizenship); and advocate for possible improvements (to develop citizenship).

- Give the students an assignment to read the school's homepage. They then map out and assess school policies, vision and value statements, the health education curriculum, or specific health and wellbeing services provided. Divide the class into four groups, and give each group one main aspect of a health promoting school to focus on, for example,
  - School policies
  - Curricula
  - Vision and values
  - Health and wellbeing services
- Ask the groups (i) to assess how health and wellbeing is presented in a given area (for example, curriculum) and what is missing, and (ii) how that area could be developed to be more supportive in promoting and improving further aspects of health and wellbeing.
- Groups present to the class.
- Discuss and summarise with the class:
  - According to the website, in which ways does our school address health and wellbeing?
  - What is missing?
  - What can be done better?
  - Appoint a team of students to summarise good, practical ideas for improvement and submit to the school leader/leadership

## Activity 4. Photo stories: a safe and happy school

Objectives:

To support students to name the factors contributing to safety at school (to increase theoretical knowledge); identify the most important factors (to develop critical thinking); and develop specific plans to make changes, carry out actions and evaluate impact of any changes (to develop citizenship and action competence).

- Ask students to walk around the school environment and take photos of places which they consider to be safe and happy for most of the students. They should create a photo story with these places. Then, they should reflect about the school environment and write down three practices that would make it safer and happier for everyone.
- Create small groups to share the photo stories and ideas about the practices. The group task is to discuss and prioritise the most important ones.
- Decide at a class level - which practices are the most important and why? How can the observation of these practices at the school be improved?
- Make suggestions to be presented to the school leadership with a plan and timeline for a follow-up discussion to enact selected practices.

## Activity 5. Assessment of the school environment: If I were a Minister...

Objectives:

To promote students' understanding of school wellbeing (to increase theoretical knowledge); their ability to identify the factors that promote health and wellbeing in their school (to develop citizenship); assess existing practices and develop new ideas (to develop critical thinking and citizenship); advocate for possible improvements (to develop citizenship); and participation to carry out changes in their school (to develop citizenship and action competence).

Ask students to work individually on the following task: Imagine that you are the Minister of Education. You are visiting schools and deciding if they are (i) very healthy and happy, (ii) fairly healthy and happy, (iii) and not healthy and happy. Make a plan for your visit to the school and for the follow up, by answering the following questions:

- Which parts of the school would you go to?
- What would you look for in order to make the assessment?
- What changes would you recommend if your assessment is that the school is 'not healthy and happy'?
- How would you go about initiating and bringing about the changes?

Discuss the ideas with the class.

## Activity 6: The whole-school environment: how does our school promote or hinder health and wellbeing?

Objectives:

To support students' abilities to describe various aspects of a health promoting school (to increase theoretical knowledge); to analyse the influence of the current school environment on health, and to create a vision of change to match a more positive health promoting school environment that leads to improved outcomes for the students (to develop citizenship and action competence).

This activity can be organised into single lessons in one curriculum/subject area delivered over a period of time and/or as an interdisciplinary learning project across subject areas delivered over a period of time, and/or as an extracurricular project.

- Demonstrate and explain the health promoting school model to students (use Figure 1). Ask students to reflect on each aspect. Broaden their understanding with theory if needed, and encourage questions and discussion.
- Divide students into groups of three. Each group gets a task to create a poster illustrating the positive and negative effects on health of one of selected aspects from the model. The composition of the poster can be the students' own choice; they can use photographs, drawings, text, videos (if the poster is electronic). The idea is to portray how the selected aspect/s in their own school, promotes or hinders health and wellbeing. Also, ask students to envision how they would like their school to be in relation to one particular aspect, and then present the key similarities and differences between the current situation and their vision for the school.
- Organise an exhibition of the group work. Set up forums for students, staff, parents and partners to debate and discuss how to move this forward to improve the school learning environment, and how this vision can contribute to improved outcomes for the school community.

## Activity 7: Action for health

Objectives:

To support students in scenario planning and be solution focused when handling given situations (to increase practical knowledge).

- Prepare sheets of paper to be handed out to the students (see the example)
- Hand out two different sheets to each student to fill out
- Divide students into groups of three. Share their ideas and add new ideas to each sheet
- Discuss the ideas and possibilities for action with the class

## Example of a sheet:

**1.** Veronica has broken her leg and was absent from school for three weeks. Now she is back in school. How can she keep herself healthy and happy during interval in the school playground?

Veronica could \_\_\_\_\_

I could help her by \_\_\_\_\_

The teacher could \_\_\_\_\_

The school could \_\_\_\_\_

**2.** Pedro's mother died recently. He sometimes seems sad while in school. How can he be supported?

The class could \_\_\_\_\_

I could \_\_\_\_\_

The teacher could \_\_\_\_\_

The school could \_\_\_\_\_

**3.** Fatimah and John are often teased by the other students. What can be done?

I could \_\_\_\_\_

The class teacher could \_\_\_\_\_

The school principal could \_\_\_\_\_

The students in my class could \_\_\_\_\_

**4.** Here is a list of people who can help you be healthy and happy. Complete the sentences, and add others on the list:

My teacher can help me by \_\_\_\_\_

My class can help me by \_\_\_\_\_

The school principal can help me by \_\_\_\_\_

My friends can help me by \_\_\_\_\_

My family can help me by \_\_\_\_\_

## Activity 8. 'Voices for Health'

Objectives:

To involve students in developing the school environment to be more conducive to school-wellbeing (to develop citizenship), and to develop a broad range of health literacy competencies and action competence.

'Voices for Health' is a broader project to involve students in developing the school environment to be more conducive to school-wellbeing, and to develop their citizenship skills (Boberova et al., 2017). An adapted description of the project and its phases plus teaching objectives can be seen in Table 5 below. A broad range of activities are mentioned in the right hand column.

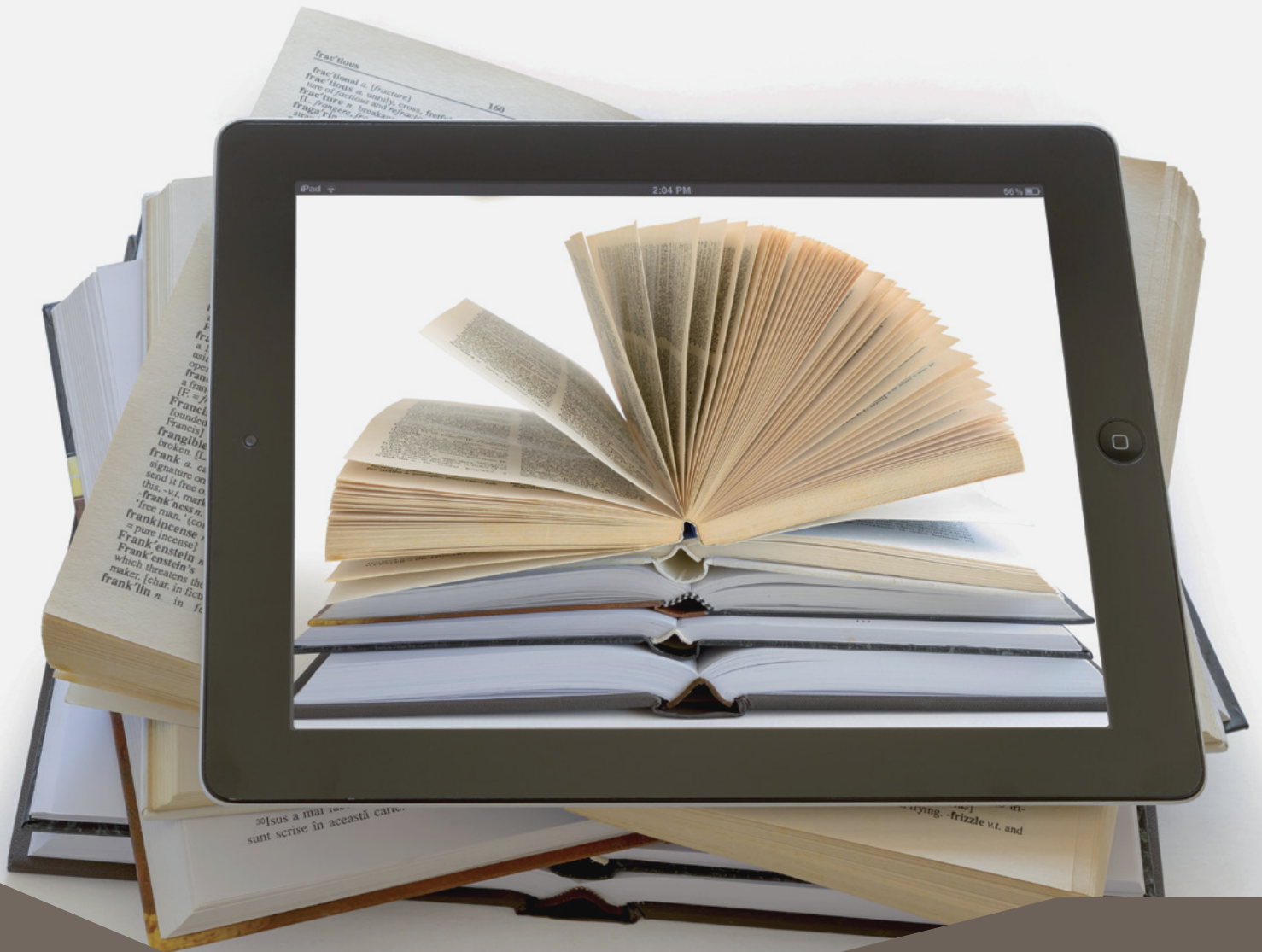
IVAC phase	Teaching objectives	Questions to students and to whole class	Educational activity
Investigation	<ul style="list-style-type: none"> <li>- To support peer learning as they explore and describe their perspective of health and the factors affecting their health (self-awareness)</li> <li>- To support students compare their perspective on health (theoretical knowledge);</li> <li>- To support students to evaluate the consequences of their perspective on health on others (citizenship)</li> </ul>	<ul style="list-style-type: none"> <li>- How would I describe my health by using different adjective? What does health feel like and look like? In what ways/s do my daily habits and activities affect my health?</li> <li>- How does my understanding of health affect others?</li> <li>- In what way/s is my perspective on health similar/different to my peers?</li> </ul>	Diary "My Daily Health"; Classroom-based discussions; Photo voice; Health mapping.
Investigation / Vision	<ul style="list-style-type: none"> <li>- To support students to explore, identify, name and evaluate the factors in their school environment that influence their health;</li> <li>- To support students to create a vision with proposals of the kind of school they would like to have (citizenship, critical thinking, theoretical knowledge);</li> <li>- To support students to evaluate the various proposals to school improvement from personal and collective perspectives;</li> <li>- To discern what is good for 'me' and what is good for 'us'.</li> </ul>	<ul style="list-style-type: none"> <li>- How does the school environment affect our health?</li> <li>- What is significant to me/us/others, now and/or in the future?</li> <li>- What would be an ideal health promoting school for us?</li> <li>- How could we change the school environment according to our vision?</li> <li>- Which proposal/s are possible for us, what shall we prioritise, and what are we basing our decisions on?</li> </ul>	Health mapping using a school map; Participatory dialogue process; Action-oriented school project; Debate, school elections and shared decision making with students, staff, parents, partners, senior leaders and the school principal.
Action and Change	<ul style="list-style-type: none"> <li>- To support students to participate and co-construct the planning process.</li> <li>- This will include conducting ethically-responsible actions in their school surroundings (citizenship)</li> </ul>	<ul style="list-style-type: none"> <li>- Which changes would lead to desirable outcomes?</li> <li>- What consequences will the proposed changes have?</li> <li>- What kind of action do we need to undertake to achieve the changes?</li> <li>- Which barriers might prevent us carrying out these actions and preventing the desired outcomes?</li> <li>- Which actions will we initiate?</li> <li>- Was our decision-making collective?</li> <li>- Is everyone involved into the action, and in what way?</li> </ul>	Planning, deciding on and carrying out the action-oriented project with the school staff and where appropriate, parents and local community partners.
Evaluation	To support students to evaluate the project (critical thinking, citizenship)	<ul style="list-style-type: none"> <li>- Which changes did we achieve?</li> <li>- Were they expected or unexpected?</li> <li>- In what way/s did these changes affect our everyday life?</li> <li>- What are the reasons for success/failure?</li> <li>- What can we do different in future?</li> <li>- What did we learn?</li> <li>- What are our next steps?</li> </ul>	Group and class-level critical discussions about the various phases of the project

## Activity 9. The New Story Dialogue Evaluation

Objectives:

To increase students' ability to assess existing practices and develop new ideas (to increase critical thinking and develop citizenship); and advocate for possible improvements (to develop citizenship).

- As preparation, choose the topic for evaluation in partnership with the students.
- Give students time to individually prepare a story about their experiences on this topic.
- Decorate the room with group tables covered with coloured paper to use during the process. Ensure there is enough space for moving around both inside and outside the room.
- Divide students into groups of five-ten, with one adult facilitator in each group, for a two-hour workshop.
- The students share their stories, and through questioning and dialogue the group reflects on the stories, finding similarities and differences. Students create reflective cards by writing key words and sentences and/or by drawing pictures on pieces of paper to be hung on the wall.
- To facilitate the process, an empathetic and appreciative attitude towards all contributions from the students is essential, as are the use of questions to guide students' reflection upon the health promoting possibilities. Make sure that teachers and students use all the following type of questions:
  - "What?"-questions (describe)
  - "Why?"-questions (explain)
  - "So what?"-questions (synthesise)
  - "Now what?"-questions (act)
- If the process slows down or lacks focus, give short power breaks with physical activity, for example, team building tasks or games.
- When the wall is covered with paper, the students categorise and discuss the most important elements in each category. This is achieved through dialogue, choosing headlines, and placing a range of reflective cards under each headline.
- At the end of the workshop, the students' conclusions and reflections are written down as notes. The notes can be compiled either by one student who has volunteered, or two students working together, or by the teacher acting as a scribe noting what the students dictate. An alternative is to record the conclusions.
- The conclusions/formulation of notes should lead to agreements about desired actions.



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# MATERIALS FOR TEACHERS (version 1.2.)

## Learning about health and health promotion in schools

Key concepts and activities

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