

5th SHE Summer School

Kuopio, Finland, 10–13 June 2015

State of the art of
school-based health promotion in Europe



Organized by
the Department of Nursing Science, University of Eastern Finland, Kuopio
in collaboration with CBO SHE Network, the Netherlands and SHE Research
Group, Department of Education, Aarhus University, Denmark

Abstracts



Organizing institutions

- Department of Nursing Science, University of Eastern Finland, Kuopio, Finland, www.uef.fi
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- SHE Research Group, Department of Education, Aarhus University, Denmark.

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Programme

University of Eastern Finland, Kuopio Campus, Yliopistonranta 1 C,
 Canthia building, 3rd floor, Kuopio, Finland, Auditorium CA301 / CA300
 10-13 June 2015

Wednesday, 10th June 2015:	
Introduction to health promoting school approach	
9.00 – 9.30	Arrival and registration (Tea / coffee)
9.30 – 9.40	<i>Opening of the Summer School: Greeting from the Faculty of Health Sciences</i> Dean Hilikka Soininen
9.40 – 10.00	<i>Welcome and practical information</i> Kerttu Tossavainen, Hannele Turunen
10.00 – 10.30	<i>Get to know each other activity</i> Marjorita Sormunen
10.30 – 10.45	Coffee-break / refreshments
10.45 – 11.30	<i>Schools for Health in Europe (SHE)</i> Goof Buijs (Buijs 2009; Simovska et al. 2012)
11.30 – 12.30	<i>Schools for Health (SHE) in Finland: research and practice</i> Kerttu Tossavainen, Hannele Turunen, Päivi Nykyri
12.30 – 13.30	Lunch together and interpersonal interaction
13.30 – 14.45	<i>Researching stakeholders perspectives on school-based health education and health promotion: between policy intentions and reality of practice</i> Venka Simovska (Madsen et al. 2015; Simovska & Carlsson 2012; Simovska et al. 2015)
14.45 – 15.00	Coffee-break / refreshments
15.00 – 16.00	<i>Reflections on using research for further development of (a) research and (b) practice</i> Venka Simovska (Buijs et al. 2014; Carlsson & Simovska 2012; Simovska 2012)
16.00 – 16.30	<i>Summing up, preparing the field visits / assignment</i> Kerttu Tossavainen, Hannele Turunen, Marjorita Sormunen

Thursday, 11th June 2015:		
Aspects in health promotion: school and community approach		
9.00 – 10.30	<i>Aspects on methodology and evaluation of school health research</i> Marjorita Sormunen (Sormunen et al. 2012; Sormunen et al. 2013)	
10.30 – 10.45	Coffee-break / refreshments	
10.45 – 12.30	<i>Diversity and equality in different settings for health – need for cultural competences and multidisciplinary approach</i> Paula McGee (Auditorium CA300)	
12.30 – 13.30	Lunch together and interpersonal interaction	
13.30 – 14.15	Previous topics continue; reflection and discussion in groups	
	<table border="0"> <tr> <td style="vertical-align: top;"><i>a) Overview of the SHE online school manual and implementation in practice; examples from different countries</i> Goof Buijs</td> <td style="vertical-align: top;"><i>b) Writing for publishing in academic journals</i> Venka Simovska</td> </tr> </table>	<i>a) Overview of the SHE online school manual and implementation in practice; examples from different countries</i> Goof Buijs
<i>a) Overview of the SHE online school manual and implementation in practice; examples from different countries</i> Goof Buijs	<i>b) Writing for publishing in academic journals</i> Venka Simovska	
14.15 - 14.45	Key points from both groups	
14.45 – 15.00	Coffee-break / refreshments	

15.00 – 17.00	<i>PhD students present their work and get feedback / theoretical and methodological aspects</i> Venka Simovska, Kerttu Tossavainen	<i>Non-PhD students (participants) present a case from practice and get feedback</i> Goof Buijs, Marjorita Sormunen
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Friday, 12th June 2015:

Educational structure and renewed school curriculum in basic education in Finland

9.00 – 10.00	<i>Educational structure in Finland</i> Marjorita Sormunen
10.00 – 11.00	<i>Health promotion in schools and health education in the renewed curriculum.</i> <i>Case: Oral health as a part of health education in comprehensive schools</i> Hanna Miettinen, Marjorita Sormunen, Kerttu Tossavainen
11.00	Departure from the UEF by bus
11.15	Study visit 1: Lunch at the Steiner School Virkkula - Healthy school meal Tiina Halinen, Via Gourmet
12.00	Study visit 2: Kuopio Classical High School - Teaching and learning technology Headmaster Jukka Sormunen
13.00	Study visit 3: Aurinkorinne Comprehensive School – Sports activities by an NGO Manager Téa Knuutila
13.30	Study visit 4: Martti Ahtisaari Comprehensive School – Tolerance/peace education (tbc) Headmaster Titta Kaukonen
14.30	Study visit 5: Lehtoniemi Nursery School - Environment, physical activity and play Director Tiina Kerman
15.30	Visit to the Observation Tower at Puijo
16 -	Nature Trail “Konttilan kierto” (2,3 km) at Puijo Picnic snack on the go
-18	Arrival to the centre
	Free time
19.30 – 21.00	Cruise on the Lake Kallavesi on M/S Queen R + dinner on board

Saturday, 13th June 2015:

Collective contributions to school health promotion

9.00 – 9.30	<i>Finalizing the assignments from the study visits</i> Marjorita Sormunen	
9.30 – 10.30	<i>Discussing the assignments & conclusions</i> Marjorita Sormunen	
10.30 – 10.45	Coffee-break / refreshments	
10.45 – 12.30	<i>Latest news from the HBSC</i> Raili Välimaa (Haapasalo et al. 2012; also Aira et al. 2014; Kronholm et al. 2015; Paakkari & Välimaa 2013)	
12.30 – 13.30	Lunch together and interpersonal interaction	
13.30 – 14.45	<i>PhD students present their work and get feedback / theoretical and methodological aspects</i> Kerttu Tossavainen, Marjorita Sormunen	<i>Non-PhD students (participants) present a case from practice and get feedback</i> Hannele Turunen
14.45 – 15.00	Coffee-break / refreshments	
15.00 – 16.00	General wrap-up & feedback, closing of the summer school	

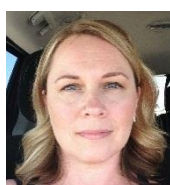
Lecturers



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Health, Helsinki, Finland



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Raili Välimaa, Lecturer, Docent/Adjunct Professor of the University of
Eastern Finland, University of Jyväskylä
Jyväskylä, Finland

Abstracts

Aura Annamari, MSc, PhD-student,
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CHANGES IN DAILY SMOKING AND SMOKING ON SCHOOL AREA AMONG
15 - YEAR OLD PUPILS IN THE REPUBLIC OF KARELIA, RUSSIA AND
NORTH-KARELIA, FINLAND FROM 1995 TO 2013

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Key words: Adolescent, health inequality, smoking, school

Introduction

Smoking rate has traditionally been high in Russia (1) as well as in former Soviet Union countries (2). Among 15 years old adolescents the smoking rates are for boys and girls 15 and 9 percent, respectively (3). After transition of Soviet Union, smoking prevalence of woman has strongly increased and the smoking has become more common among young women (2, 4). However, Russia is geographically widely spread and heterogenic area where the prevalence of smoking varied strongly between areas and only part of the areas has up-to-date information available, particularly among adolescents (5, 6). Adolescents in Eastern Europe smoke more than their counterparts in Finland (1). However, in Finland adolescents smoking rates are reasonably high despite the fact that adolescents smoking has decreased in Finland among girls since 2000`s and among boys since 1990`s and this trend seems to continue (7).

Previous studies have indicated that smoking behaviors begin to develop in early adolescence (8). It has been pointed out that the younger the smoking starts, the greater is the risk for habitual smoking for later life (9), leading to serious dependence on nicotine and extensive health problems and has far-reaching consequences to later life and health (10). Therefore it is important to prevent the smoking experiment and initiation to smoke in early state of adolescence and prevent the inequalities in later health.

The study is a part of a more extensive project "Addressing challenging health inequalities of children and youth between two Karelias (AHIC)", which is administered by the University of Eastern Finland and received funding from the Karelia ENPI CBC program. The aim of this study was to compare and find out how smoking prevalence have changed during the time, between the years 1995-2013 in North Karelia, Finland and the Pitkäranta district, Republic of Karelia, Russia and between the genders. Moreover, study aim was to find out how easy it is to smoke on school area during the school day. These results provide new valuable

information for the current smoking situation among pupils in local schools in North-Karelia, Finland and Republic of Karelia, Russia.

The following study questions were formulated:

1. How the adolescents' smoking tendency has been changed in North Karelia, Finland and Republic of Karelia, Russia from 1995 to 2013?
2. How easy it is to smoke on school area during the school day?

Methodology

The whole data consisted of 4 separate cross-sectional survey studies from years 1995 (11-14) and 2013. The target group was 15 years old pupils. Samples consisted of all pupils in all schools in Pitkäranta region (1995: n=385, response rate 95 %; 2013: n=182, response rate 98 %) and in selected schools in North Karelia (1995: n=2098, response rate 93 %; 2013: 635 response rate 93 %). The latest data were collected in April 2013 in local schools by means of the standardized self-administrative questionnaire concerning health behavior. The adolescents fulfilled the questionnaire anonymously in classrooms according to standard instructions by a researcher. Schools represent both urban and rural schools in both areas. The results were expressed by using descriptive statistic (percentages and chi square test) and general linear model (GLM) was used to analyze the statistical significance of the relationships between factors and joint effects of the changes in smoking prevalence between countries, genders and research years.

Results

In both countries, the daily smoking prevalence has not changed either among girls or boys from 1995 to 2013. Smoking prevalence among Russian boys are 28 % and among girls 7 % in 2013. In Finland the proportion of daily smokers are for boys and girls 19 % and 18 %, respectively. However, results revealed significant differences between countries among both genders. Among the Finnish boys the prevalence of daily smoking was lower comparing the Russian boys in 1995 ($p=0.001$) as well as in 2013 ($p=0.021$). Finnish girls daily smoking were significantly higher in both years ($p=0.001$) comparing their counterparts in Russia. The joint effect of gender, research year and country pointed out significant differences. Statistically very significant differences were found by country ($p<0.001$) as the Finnish adolescents smoke more than Russians. Gender differences revealed also that boys in general smoke more than girls ($p<0.001$).

We asked how easy it is to smoke on school area during the school day. In Russia among adolescents who smoked on daily basis more than half thought it was easy to smoke on school area. The prevalence has not been changed during from 1995 to 2013. In Finland, smoking on school area seemed to be more difficult in 2013 than it was in 1995. In 1995, 70 % of daily smokers thought it was at least quite easy to smoke on school area. The proportion was 53 % in 2013.

Conclusions

Our results indicate that smoking prevalence among fifteen years old 9th grade adolescents has not changed either in North Karelia, Finland or the Republic of Karelia, Russia from 1995 to 2013. However, there were some noteworthy results and points to notice concerning the gender differences in Russia whereas the boys smoke a lot and girls do not. In fact, the smoking among boys was higher and girls lower compared to the general prevalence in Russian Federation (1). In Finland, the equality of smoking behavior by genders is typical for western

European countries (15). However, the daily smoking among adolescents are still reasonable high except the Russian girls. In addition, over a half of the daily smokers thought it was at least quite easy to smoking on the school area in 2013.

To increase equity in health, it is important to influence structural inequalities, school policies, school culture, and adolescents' attitudes. Our results suggest that the differences between genders and cultural aspects should be noted more carefully when implementing and promoting health strategies and health promotion programs in cross-border area in local schools. Furthermore, the overall anti-smoking climate of these neighboring societies should be discussed in close collaboration. These results suggest evaluating the strategies in used and to develop more effective actions to obtain decreasing trend in smoking among adolescents.

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FEATURES OF PROVIDING HEALTH-EDUCATIONAL TECHNOLOGY IN SECONDARY SCHOOLS OF DIFFERENT TYPES

Abstract

The objective of this research was to evaluate effectiveness of introduction of the program Health Basics lessons in Kharkov different types general-education institutions (public school and gymnasium). It is based on quantitative (anonymous questionnaire) and qualitative (personal interviews and focus groups) analysis among children 14-16 years. During evaluation we used a questionnaire. The questionnaire included both alternative and ranged by level of demonstration questions related to studies, leisure and relations in students' families and nature of the spread of harmful habits (smoking, alcohol and drug abuse). One of the principally important factors of non-formation of healthy lifestyle skills is the spread of harmful habits.

Introduction

The problem of healthy lifestyle is one of the principally important problems for ensuring the health of growing generation and harmonious development of individuals. Unsatisfactory level of health of children and teenagers, low level of hygienic skills and the spread of harmful habits are very crucial for many countries.

Traditional children's and teenager's health care system focused firstly on curing the ill and prevention of diseases is not able to stop worsening of health of growing generation. The program Health Basics lessons are very important for further sustainable development of the system of disease prevention, formation of healthy lifestyle skills among youth. We must take into consideration that in today's Ukrainian social and economic situation only the school together with family can systematically and systemically influence physical and psychological development of a child over long period of time and to a certain extent correct its relations with environment. According to the WHO European regional bureau the school is an influential environment that can form and sustain the health. Understanding of health issues by youth can be substantially improved by certain contents in official curriculum [Петручук

О. Е., Щепин В. О., 2007; Шевченко И.О., 2007; Абдылдаева А.А., 2009; Ashiabi G.S., O'Neal K.K., 2007].

Theoretical framework

Main priorities of the Health Basics lessons are: to preserve and strengthen physical, psychological and moral health of studying youth, promotion of conscious attentive attitude towards health among pupils and students, keeping with principles of healthy lifestyle.

It is recognized education program itself without a favorable school environment, without the cooperation of the parents cannot provide a global goal - a healthy lifestyle of school children and adolescents, and in fact, it is only one of many factors to achieve [Шабалов Н.П., 2004; Рахманин Ю. А., Новиков С. М., 2005; Михалкина М. И. 2005].

To provide for the effective cooperation between medical, psychological and pedagogical school workers the health must be perceived as everyday life requirement, as a positive concept underscoring social and personal resources as well as physical abilities (as defined by WHO).

At the same time, a modern and effective school can become a reality only with a rational use of funds and time to provide for harmonious development of a student. Evaluation, as a feedback system, is an integral part of every process envisaging influence on behavior or health of a young person.

MATERIALS AND METHODS

Research aim, focus and questions

The objective of this research was to evaluate effectiveness of introduction of the program Health Basics lessons in Kharkov different types general-education institutions (public school and gymnasium). Seeing that school administration and parents play an important role in program implementation and ensuring the healthy and safe behavior of students of this age, they were also considered target groups for this program.

The long-term outcome objectives were defined for each target group accordingly. For students these were: successfully adopt the Health Basics lessons materials; for teachers – successfully introduce the Health Basics lessons materials; for administration – create an atmosphere favorable for promotion, preservation and strengthening of students' health; for parents – study the Health Basics lessons materials and disseminate the important health concepts from school to their families and community.

Object and Scope of Research

To achieve this goal the main target groups were secondary (252 students) and high (156 students) school-age pupils in the secondary schools of two types - gymnasiums (three establishments) and public schools (3 institutions).

Gymnasium-is a new-type educational establishment. Gymnasium students are distinguished by a high motivation for studies since the acceptance to the gymnasium is based upon successful passing of entrance exams. Usually the students come from families without serious financial and economic problems and being at quite high social level. The gymnasium has a stable pedagogical collective who base their activity, according to principal, on «orientation towards acquiring the knowledge in possibly optimal conditions of school environment».

The gymnasium maintains and cultivates a positive image of a healthy lifestyle.

The public school has children from neighboring micro-districts who do not have to pass entrance exams. Some of the children come from families with financial and economic difficulties, some parents do not have stable jobs and are worried about possible dismissal from existing jobs and facing the need to find new ones.

The evaluation program had to provide for: analysis of changes in health and behavior of students and their environment; identifying the level of acquiring the healthy lifestyle skills; developing the decision-making process with regard to overcoming obstacles to change students' behavior; identification of unfavorable environment (physical and social) and dynamics of changes in internal school environment; coordination of actions of all levels of management inside the educational institution; evaluation of efficiency of student's community activity; development of professional level of teachers; creating a stable motivation of all participants of the students' health promotion process and acquiring necessary information to provide for positive changes.

During evaluation we used a questionnaire. The questionnaire included both alternative and ranged by level of demonstration questions related to studies, leisure and relations in students' families and nature of the spread of harmful habits (smoking, alcohol and drug abuse). The interviews were carried out anonymously, however, the questionnaires included information about the date of birth and gender. Before we started the survey we received consent of students and their parents.

To provide for the higher level of openness of students the qualitative analysis of course impact on students' behavior was carried out only by sociologist specialists from the Institute in focus-groups (4 – with students and 3 – with parents, individual interviews with pupils(12) and teachers(6). Focus groups and individual interviews were conducted in specially-prepared classrooms during the normal school hours.

The database was built in Microsoft Excel software and the statistical analysis (ANOVA, correlation and regression ones) was done with the help of SPSS

Results of the survey

One of the principally important factors of non-formation of healthy lifestyle skills is the spread of harmful habits. According to interviews with 11th grade students of both schools the most intensive involvement in smoking and drinking alcohol was between 13-14 years. The smoking was more spread in the public school.

Analysis of specifics of formation of harmful habits among the teenagers was studied at example of 9th grade students. This age is the one when the problems of spreading of harmful habits among students are becoming most acute. According to results of multi-factor graded regression analysis the attempts to smoke among 9th grade boys were influenced by problems of communication with mother and adults, amount of pocket money, self-evaluation of studies, satisfaction with conditions of study and family situation, self-evaluation of attitude towards harmful habits.

Refusal of smoking was observed among boys who in most cases did not have problems of communication with mother and adults; they had almost no pocket money and were satisfied with conditions of study and their status in family.

The problem of spread of smoking among 9th girls was generally caused by different factors. Smoking attempts of girls were primarily caused by self-evaluation of studies and importance of a good mark. Satisfaction with own status in family and problems of communication with

adults were also important. The number of cigarettes smoked by 9th grade girls depended on realization of the possible negative influence of smoking, desire to get a good mark and self-evaluation of health (disease kept them back), satisfaction with own clothes and going for sports.

The type of drinking of alcoholic drinks by 8th grade students depended on alcohol content of the drink. Thus, beer drinking among boys was stimulated by the lack of satisfaction with study conditions and own clothes, over-care and went in line with frequent conflicts with adults. Understanding of harm of alcoholic drinks kept them back. Among girls beer drinking was typical for those who realized their own failures in studies and did not feel comfortable in gymnasium. Such girls were coming home very late and frequently used swearing words.

Family is the first and principally important environment in which children's healthy skills are forming. Families in our society remain that primary unit where the basics of a certain lifestyle of a person are laid down. The family chooses the school for its child and can significantly influence his or her behavior, level of needs formation and certain activity.

Family relations, according to questionnaires are equally important both for gymnasium and public school students with some gender specifics. Among girls the family factor was primarily conditioned upon authority of the mother, for boys, especially from the public school, the relations between mother and father were very important.

For gymnasium students it was very important to be confident in the help from parents backed by high educational level of father and active communication with mother. On conditions of normal relation in the family, the gymnasium students were more ready to keep with socially-acceptable behavior. Dissatisfaction with own status in family and relationships with parents is demonstrated through high conflict potential with them and outwardly brutal behavior; they are emotionally sensitive to punishments. Problems of communication with father are often connected with the lack of pocket money and are compensated by relations with brother/sister. At the same time limited communication with parents is worsened by problems in relations with brother/sister.

For gymnasium students the relationships are first of all associated with the high level of conflict potential with parents and developed system of punishments. In unfavorable material conditions the emotional state of teenagers is worse due to insufficient communication with mother. The father more often becomes a factor of outward stability of the family. Lack of understanding with mother in family is compensated by pocket money, but demonstrated through outwardly brutal behavior of teenagers.

Educational level of gymnasium students' parents was considerably higher than that of the school children parents. At the same time public school had just a little bit less incomplete families than gymnasium.

Family relationships also had some gender and age specifics. Punishments in students' families of both institutions were identical, however, the parents of public school girls were punishing them until 11th grade, whereas in gymnasium – only until 9th grade. Conflicts caused by bad studies more often appeared among boys. Most problems caused by friends were observed among school girls. Unwillingness to help at home was the biggest among 11-grade boys and girls, with exception of gymnasium girls, for which this problem at a higher school age is substantially decreasing.

Conflicts between teenagers and parents caused by smoking, alcohol or drugs were starting predominantly in 9th grade, and among gymnasium students, especially among boys, in 11th grade. Problem of disrespectful attitude towards adults was more typical for girls of both institutions and 9-grade boys of gymnasium. Lack of understanding with school parents aggravated in the 9th grade, and in gymnasium, especially among boys – in the 11th grade.

Therefore, the stereotype of socially-acceptable behavior and relations with parents (in family) is forming faster among gymnasium students, but they are more egoistic. If one of the leading factors of public school students' adaptation in family is conflict potential and dissatisfaction with own status, among gymnasium students it is assurance in the help from family members. Irrespective of the type of educational institution, girls had more problems in family.

The level of school adaptation of public school and gymnasium students did not differ too much but the type of adaptation processes had certain specifics in each educational institution. On the basis of acquired data we can assume that the mechanisms of adaptation of students to studies is identical, irrespective of the type of educational establishment, however, the public school environment was less favorable. Public school students are also more passive in the processes of social adaptation to school environment; their studying activity, as a part of general life process, is less structured

Consequently, during introduction of the Bathes of Health lessons in schools we must keep in mind that the public school students are more focused on the studying process, while gymnasium students strive for getting certain result from their studies.

Conclusion

Whereas parents have the most significant effect on children in the early school years is expected to investigate the effect of the relationship on the formation of healthy lifestyle primary school pupils with regard to quality of life and subjective evaluation make available health.

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THE HEALTHY ELEMENTARY SCHOOL OF THE FUTURE

Background

People living in regions that are characterized with a low average socio-economic status are often living with an unhealthier lifestyle like physical inactivity and unhealthy dietary behaviour. This can result in overweight and obesity, which can lead to health problems, such as type 2 diabetes, hypertension, dyslipidemia, cardiovascular diseases, and metabolic syndrome (Ogden et al, 2003). Worldwide, overweight and obesity has increased dramatically in recent decades among both adults and youth (Rocchini, 2002). Globally, approximately 180 million children (< 18 years) are overweight (WHO, 2013). In The Netherlands, 13–15% of children (ages 2–21 years) are overweight; a 2- to 3-fold increase compared to the 1980 prevalence rates (Schonbeck et al., 2011). The Parkstad region, a former mining area in the south of the Netherlands is characterized by its low average socioeconomic status, as compared to the rest of the Netherlands. The prevalence of overweight in 10 year old children

living in this region is 16.1 to 27.7% compared to 15% in the Netherlands. The prevalence of obesity in this region is 2.5 to 5.0% (3% nationally). Besides that, relatively few children from this region achieve an adequate start qualification for the labour market; they have more often no school certificate and school dropout rates are relatively high. This is a persistent problem from generation to generation (Jungbluth, 2011; Schils, 2011).

Promoting a healthy lifestyle at school and innovations in learning and the school environment may help to reverse these negative trends. However, in the Netherlands a regular school environment is not optimally equipped for this. Children in a regular school attend from 08:30 until approximately 15:15. There is no attention to the moments when the child's cognitive performance is optimal. No nutrition is provided to children. Children have the option to consume their lunch at home during the 1-hour lunch break, or eat their self-brought lunch at school. Children usually have one physical education lesson per week, and spend the majority of the day in sedentary position. Education about a healthy lifestyle (e.g. nutrition, physical activity) is limited, and is not incorporated in the school curriculum.

In response to all of this, the so-called 'Healthy Elementary School of the Future' is developed, which aimed to create an optimal environment to compensate shortcomings in the development of a healthy lifestyle and to fully develop talents of children with lower socioeconomic backgrounds.

The Healthy Elementary School of the Future

The complete concept

The Healthy Elementary School of the Future consists of the regular compulsory educational curriculum and an integrated sport, play and creativity program for 2 hours/day for 5 days/week, including healthy meal facilities. To incorporate all activities in the school-day, school hours will be extended. Children will attend school from 08:30 until 16:00. This change in school-hours allows educational activities to be more in line with the bio-rhythm of children (Driessen et al, 2010). The Healthy Elementary School of the Future is not just a regular intervention, but a complete concept for a new way to arrange a school day. The focus will be on many different aspects in the school, such as policy, playground, education, parental participation etc. Many different stakeholders, such as the school team, parents (and children), MOVARE school board, Maastricht University, child care organisations, SODEXO (food services and facilities corporation), sport and leisure organisation, public health services, and province Limburg, are cooperating to design and implement the new concept together with the school.

The overall goal of The Healthy Elementary School of the Future is to promote a healthy lifestyle and talent development of the children. The Healthy Elementary School of the Future will be evaluated. The general aim of the research is to study the effects of the integrated education, physical activity, health and nutritional program in day-schools, on the (mental and physical) health, (non-)cognitive, and academic outcomes of young children, the cost-effectiveness of such a program and the legal aspects of day-schools. When positive effects are found, the concept will be enrolled in other Dutch elementary schools.

Two aspects of the concept: nutrition and physical activity

Two main aspects to promote a healthy lifestyle and talent development in children are healthy nutrition and physical activity. Therefore, part of The Healthy Elementary School of the Future will be a healthy morning-snack and an integrated sport and play program for 2

hours/day for 5 days/week, including a healthy lunch. However, there are many more activities the school can implement to improve physical activity and dietary behaviour. With the use of the Intervention Mapping steps, a systematic search is done to select evidence-based activities which could be implemented in the school. It depends on the possibilities and goals of each school which of these evidence-based activities will be chosen.

Step 2 of Intervention Mapping results in many different determinants that effect children's physical activity and dietary behaviour. One of these determinants that are important to the child's behaviour is 'linking of'. As this determinant is also relatively easy to investigate, we will include this determinant in the study to investigate it more in depth.

Besides the activities for children in the school environment, also activities specifically for parents and teachers will be implemented, as it is known that they have a great influence on children's behaviour by their physical activity and food practices (for example: do parents and teachers have rules about physical activity and nutrition; do parents and teachers encourage children to be active and eat healthy). The aim of this study is to investigate the effect of The Healthy Elementary School of the Future on children's dietary and physical activity behaviour. The study is split into two parts: 1) effect study and 2) implementation study.

Research questions for the effect study are:

1. What is the effect of The Healthy Elementary School of the Future on children's dietary and physical activity behaviour?
2. What is the effect of changes on 'liking of' physical activities and food products on children's dietary and physical activity behaviour?
3. What is the effect of changes on parents' and teachers' physical activity and food practices on children's dietary and physical activity behaviour?

The implementation study will be executed to be able to explain the effects that were found in the effect study. Besides this, the implementation study is also used to monitor physical activity and nutrition aspects of The Healthy Elementary School of the Future. This creates the opportunity to change aspects that do not work properly. For this, several research questions are formulated:

1. Which activities did the school choose?
2. Which activities did the school implement?
3. How was the implementation fidelity of the activities that were chosen?
4. What were perceived barriers and facilitators of implementation of the activities?
5. Which strategies are used to optimize implementation of the activities?
6. How was the implementation fidelity of the strategies that were chosen?
7. What were perceived barriers and facilitators of the used strategies?

The effect study

Design

The effect study has a longitudinal quasi-experimental design, with two intervention schools, two physical activity schools (with no nutrition activities) and four control schools. Aspects of dietary behaviour that will be evaluated are intake at breakfast and lunch, fruit and vegetable intake, soda, sport- and energy drink intake and snack consumption. Aspects of physical activity behaviour that will be evaluated are active transport, sport participation, and physical activity behaviour during breaks at school, after school and in the weekend.

Participants

All children and their parents will be invited to participate in the effect study. Approximately 1200 children will be included in the intervention and physical activity schools, and 1200 children in control schools. However, the exact amount of participants depends on the amount of children and their parents who fill in the informed consent. Also all teachers of the intervention and control schools will be asked to participate in the effect study (n=±70).

Measurements

Measurements of the effect study will take place every year in September and October from 2015 till 2018. All data will be gathered during a 'research week' in the school. All researchers will be trained according to a strict protocol to prevent differences in procedures. As this study is part of a greater study to evaluate The Healthy Elementary School of the Future on all different aspects, this study will have access to several baseline variables, such as age and gender of child and parent, parents' income, parents' education and child's and parents' ethnicity.

Anthropometry

Measurements of body composition will be integrated in the school hours that are allocated to physical activity education. Body composition will be assessed by height, weight and waist circumference using a standardized protocol. Age- and gender-specific BMI cut-off points will be used to define overweight and obesity (Cole et al, 2000).

Accelerometer

At the beginning of the 'research' week participants will receive an accelerometer, the Actigraph activity monitor, to assess objectively for seven days children's physical activity levels and sedentary time. The monitor is attached to the hip with an elastic band. The monitor should be worn all day except during sleeping hours and activities in which water is involved (e.g. swimming, bathing and showering).

Questionnaire

Children, parents and teachers will all receive a questionnaire which needs to be filled in. The questionnaire for children is to assess (liking of) physical activity and dietary behaviour. Physical activity behaviour measures include active transport, sport participation, and physical activity behaviour during breaks at school, after school and in the weekend. Dietary behaviour will be assessed by a food frequency questionnaire (FFQ). The FFQ will measure intake at breakfast and lunch, fruit and vegetable intake, soda, sport- and energy drink intake and snack consumption. Liking of activities and food products is measured by pictures of the different activities and food products to which children can indicate whether they like it or not. This questionnaire will be filled in by writing during class hours, in presence of a member of the research team. The estimated time to complete the questionnaire is 40 minutes. Three sets of questionnaires will be used, according to the school class of children (e.g.: questionnaires for group 2, group 3-4, and group 5-8). Every questionnaire is adjusted to the level and age of the children.

The questionnaire for parents is a digital questionnaire about their child's physical activity and dietary behaviour, which is similar to the child's questionnaire. Besides this, parenting food practices will be assessed by 9 items based on the questionnaire of Gevers et al (2015), which is evaluated on psychometric properties. Parenting physical activity practices will be assessed by 14 items based on the Preschooler Physical Activity Parenting Practices instrument of

O'Connor et al (2014) and the questionnaire of Gevers et al (2015). Parents are asked to fill in this questionnaire during the 'research' week.

The questionnaire for teachers is a written questionnaire assessing food and physical activity practices. Food practices of the teacher will be assessed by 13 items based on the questionnaire of Gevers et al (2015). Physical activity practices of the teacher will be assessed by 15 items based on the Preschooler Physical Activity Parenting Practices instrument of O'Connor et al (2014) and the questionnaire of Gevers et al (2015).

The implementation study

Theoretical framework

To investigate implementation fidelity of the physical activity and nutritional activities, Dusenbury et al. (2003) will be used as theoretical background. This theory uses five aspects to describe implementation fidelity: adherence, dose/exposure, quality, participation and unique aspects. To investigate the perceived facilitators and barriers, relevant determinants described in Bessems et al. (2014), Bartholomew et al. (2011) and the CFIR framework of Damschroder et al. (2009) are used. The many different relevant determinants are aggregate to 1) user-related determinants, 2) activities-related determinants, 3) context-related determinants and 4) implementation strategy-related determinants.

Design

The implementation study will be executed on the two intervention schools and the two physical activity schools. Due to the fact that results of the implementation study will also be used for monitoring and improving the activities, measurements will take place throughout the years.

Participants

To investigate implementation fidelity employees of The Healthy Elementary School of the Future will be included in the implementation study. Besides the employees also some randomly selected parents and children will be asked to participate. To investigate implementation strategies the implementers and the receivers of the strategies will be included.

Measurements

To investigate implementation fidelity observations will be used and the implementers will be asked to fill in a logbook of the activities. To investigate implementation strategies semi-structured interviews will be held with the implementers and the receivers of the strategies. Perceived barriers and facilitators of both implementation and implementation strategies will be investigated by semi-structured interviews, which will be held with the implementers of the activities and the implementers of the used strategies.

Planning

When	What
2014/2015	<i>Preparation year: selection of activities</i>
September/October 2015	<i>T0, Baseline measurement of effect study</i>
November 2015	<i>Start 'The Healthy Elementary school of the Future'</i>
September/October 2016	<i>T1 measurement of effect study</i>
September/October 2017	<i>T2 measurement of effect study</i>
September/October 2018	<i>T3 measurement of effect study</i>

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According to Paul Schilder's¹ definition, the body image is the image that we create in our minds, as well as the way in which our body looks for ourselves. In other words, it is an idea that a person has on his/her body, formed under the influence of interpersonal, environmental and temporal factors. The image of the body is made up of three components: cognitive, emotional and behavioural. Cognitive component includes thoughts and beliefs about the body, the emotional component includes the feelings associated with the body, and the behavioural component contains behaviours towards the body as a whole and its individual parts. These factors play a significant role in shaping the assessment of body image, which may include a wide spectrum of attitudes, from the satisfaction to the dissatisfaction, or even distortion in the perception of one's own appearance (body dysmorphic disorder). Meanwhile, both the distortion in the perception of the body, as well as a negative attitude to it can lower self-esteem, negatively affect interpersonal relationships and induce a series of more or less dangerous health problems (e.g. self-harm, eating disorders and others.). This happens when an individual accepts the cultural scheme, in which physicality and physical attractiveness are necessary to achieve happiness and success in life, and thus the assessment of one's value is synonymous to assessment of one's physicality. In this way, appearance becomes the basis for building self-esteem and a value of a person is dependent on the socio – cultural ideals.²

Issues related to body image are particularly important in a group of people entering a period of adolescence, because this developmental stage is characterized by increasing concentration on the appearance, which is often associated with the intensifying dissatisfaction with own physicality. It seems that this problem affects girls more because social and media messages glorifying thinness and an attractive appearance are mainly addressed to them. Whereas, dissatisfaction with self-appearance can push the person to undertake various types of risky and dangerous behaviours such as excessive reduction of the caloric value of meals or a drastic reduction in the number of meals consumed during the day. In addition, it has been indicated that dissatisfaction with the self- appearance is often associated with substance abuse, risky sexual behaviours and mental health problems.³ In turn, the factors that protect against

¹ P. Schilder: *The image and appearance of human body*. International University Press, New York 1950; A. Brytek–Matera: *Obraz ciała – obraz siebie. Wizerunek własnego ciała w ujęciu psychospołecznym*. Warszawa, Difin, 2008, p.11

² A. Brytek – Matera: *Obraz ciała – obraz siebie. Wizerunek własnego ciała w ujęciu psychospołecznym*. Difin, Warszawa 2008, p.12-20

³A.R. Kaufman, E.M. Augustson: *Predictors of regular cigarette smoking among adolescent females: does body image matter?* "Nicotine & Tobacco Research", nr 10(8), 2008, s.1301–1309; I.L. Kvalem et al.: *Body evaluation and coital onset: a population-based longitudinal study*. "Body Image", nr 8(2), 2011, s.110–118; B. Verplanken, R. Velsvik: *Habitual negative body image thinking as psychological risk factor in adolescents*. "Body Image" nr 5(2), 2008, p.133–140; C. Currie et al. (eds.): *Social determinants of health and well-being among young people. Health behavior in school-aged children (HBSC) study: international report from the 2009/2010 survey*. WHO Regional Office for Europe, Copenhagen 2012, p. 89

excessive anxiety associated with physical attractiveness include regular physical activity, as well as the experience of acceptance from peers and families and good social relations.⁴

For the mentioned reasons, issues concerning body image and risky behaviours undertaken to change the self-appearance has become the subject of surveys conducted in 2015 in a population of 160 girls aged 13 and 16, attending lower secondary school and higher secondary school in the region of Upper Silesia (Poland).⁵ A specially designed questionnaire including 30 items, as well as the Figure Rating Scale - FRS created by A.J. Stunkard⁶, were used to carry out the research. The research was primarily aimed to determine how respondents assess their appearance, what methods of weight reduction are applied by them and what preventive/educational actions are undertaken in their environment.

The most important data that were obtained during the research are presented below:

- 88.7% of the girls says that appearance is important (51.8%) or very important (36.8%) in their lives - there were no significant differences in the responses of older and younger age group. Gained data are consistent with the results of the studies described in the literature.⁷ 62.5% of respondents declare a lack of satisfaction with their silhouettes - 40.7% of them think that they must lose weight, and 21.8% present the opinion that they need a lot of physical activity to achieve the look they desire. In addition, during the research a big part of the girls responded positively to the following statements about themselves: "I feel fat" (41.2%), "I'm afraid to put on weight" (39.3%), "when I eat too much I feel terrible" (34.3%) and "I feel I'm constantly getting fatter" (20.6%). It should be noted that 82.5% of questioned girls had normal BMI, 9.3% were underweight and 7.5% were overweight. Questionnaire data were confirmed by the Figure Rating Scale findings, in which the majority of respondents (72.8%) pointed the figure slimmer than that they actually have (in their subjective opinion) as the most attractive (divergence ratio 1 - 48.7% of respondents, divergence ratio 2 - 20% of respondents, divergence ratio 3 - 4.1% of respondents)⁸. There were no significant differences between age groups, however it was found that the higher BMI, the bigger discrepancy between the real and ideal body image.
- The majority of respondents intensively control their body weight - 30% of them admit that they weight themselves daily, 25.6% - twice a week, and 10% after each meal. In addition, 61.1% of respondents declare that they are currently using or has used a slimming diet⁹. Among the effective methods of weight reduction the questioned girls indicated: fasting (14.3%), the use of weight loss medicines (48.7%), use of laxatives and

⁴ M. Monteiro Gaspar et al.: *Protective effect of physical activity on dissatisfaction with body image in children – a cross-sectional study*. "Psychology of Sport and Exercise", nr 12(5), 2011, p.563–569

⁵ G. Thomas: *How to do your research project*. Sage, London 2013

⁶ Stunkard, A., Sorenson, T., & Schulsinger, F. (1983). Use of Danish adoption register for the study of obesity and thinness. In S. Kety, L.P. Rowland, R.L. Sidman, & S.W. Matthysse (Eds.), *The genetics of neurological and psychiatric disorders*. Raven, New York 1983, p. 115-120.

⁷ A. Owsiejczyk: *Determinanty kulturowe zaburzeń odżywiania*. „Rocznik Socjologii Rodziny” nr XVIII, 2007, s.210; M. Godała, E. Karasińska, E. Trafalska, A. Kolmaga, F. Szatk: *Wiedza na temat zaburzeń odżywiania*. „Problemy Higieny i Epidemiologii” nr 93(1), 2012, s.84

⁸ Por. A. Głębocka, J. Kulba: *Być albo nie być szczupłą. Dylematy autoprezentacyjne młodych kobiet*. Monografie Centrum Studiów Niemieckich i Europejskich im. Willy Brandta, Opole 2003, s. 25-26

⁹ Por. J. Joško, J. Kamecka – Krupa: *Czynniki kulturowe i społeczne predysponujące do zaburzeń odżywiania u młodzieży szkolnej w wybranych miastach województwa śląskiego*. „Problemy Higieny i Epidemiologii” nr 88(3), 2007, s.324

diuretics (5%) and the return of food through vomiting (3.7%), nevertheless they also indicated physical activity (55.6%) and the rational nutrition (50%)¹⁰. It is worth noting that the use of fasting was more frequently mentioned in the younger age group. The respondents also acknowledged that in order to avoid putting on weight, they undertake such behaviours as: not eating breakfast (76.8%), drinking water between meals (57.5%), counting calories (55%), using their own diet (53, 7%), smoking while feeling hungry (28.1%) and drinking alcohol (16.8%).

- Only 36.8% of respondents report that the classes on body image disorders prevention were carried out in their school, the rest of them doesn't know (21.8%) or declares that such activities were not undertaken. In the group of respondents that confirmed the implementation of preventive activities in their schools 77.9% (46 persons) admitted that they took part in them, the remaining part (22.1% -13 persons) did not participate in the workshops. Additionally, 64.4% of respondents said they would participate in such activities, if they had the opportunity, 13.1% are not interested in participating, and 22.5% have no opinion on the subject. The subject of body image and eating disorders is also rarely discussed in the families of respondents - 67.5% of them report that they don't talk with their parents on this issue, and only 32.5% take such a conversation.

The research findings characterized above point to insufficiency of educational activities concerning a positive body image. Such activities can be implemented both in the individual and institutional levels. The impact made by the family is the most significant on the individual level, because parents largely affect the body image of their children by modeling their behaviours and shaping their opinions. Nevertheless parents don't always have the adequate knowledge and skills to do that properly, so it is advisable to provide them education on that issue through educators'/health promoters' environmental actions and/or social campaigns developed for this purpose.

In spite of the family impact, initiatives related to the positive body image creation and the prevention of its distortions should be undertaken on the institutional level. The most important institution for carrying out this type of activity is school, due to its long-term and systematic influence on children and adolescents, however the fact that every school operates in a specific environmental context shouldn't be underestimated. For this reason, an effective preventive system located in the area of school health promotion¹¹ should take into account the systemic perspective, in which the following levels of actions can be distinguished¹²:

1. **The inter-institutional level** (school, counselling center, police, dormitory, medical clinic, etc.) - within this level it is necessary to develop the principles of effective communication and cooperation between the core institutions in order to offer care/aid to specific individuals and realize the educational programmes for workers and pupils as well as exchange actual experience.

¹⁰ Por. W. Chytra – Gędek, A. Kobierecka: *Gotowość anorektyczna u dziewcząt i młodych kobiet*. „Psychiatria” tom 5, nr 1, 2008, s.11; A. Wojtyła, P. Bliński, I. Bojar, C. Wojtyła: *Zaburzenia odżywiania u polskich gimnazjalistów*. „Problemy Higieny i Epidemiologii” nr 92(2), 2011, s.346

¹¹ Por. I. Young, L. S. Leger, G. Buijs: *School health promotion: evidence for effective action. Background paper SHE Factsheet 2*. CBO, Utrecht 2013

¹² J. Wycisk, B. Ziółkowska: *Młodość przeciwko sobie. Zaburzenia odżywiania i samouszkodzenia – jak pomóc nastolatkom w szkole*. Warszawa, Difin, 2010, s.135-138

2. **The institutional level** (school administrators, teachers, psychologist, educator, supporting staff, etc.) – within the school the education concerning disorders that may be a consequence of inadequate body image is required. This education should be provided to all members of the school community. Furthermore, it is recommended to provide the social skills training to all teachers and educators as well as the pupils. It is essential for trainings addressed to teachers to take into account the skills that are particularly useful in contact with pupils manifesting adapting difficulties. Selecting from the school staff the individuals that will make up the "crisis team", involved in contacts with the pupils manifesting destructive behaviours might also be useful. Moreover, clear rules of safety and proceeding in case of occurrence of alarming symptoms among pupils should be defined. It is also advisable to engage pupils in art projects and sport activities as well as the actions for environment and the local community to enable them expressing emotions and their attitudes towards others and themselves.
3. **The level of relationship educator - pupil** - under the direct relationship with the pupil it is primarily useful to improve communication skills and provide the necessary emotional support and information.
4. **The personal level of educator** – it is important to increase the insight into the educator's own emotions triggered by pupils' non-adaptive behaviours and improve his/her competencies related to providing assistance to pupils, as well as developing the ability to effectively cope with stress and benefit from the support of colleagues¹³.

All kinds of preventive activities described in Table 1 are recommended to be carried out in the context of the individual elements of described system in order to provide its effectiveness. It is worth considering if the creation of such systems adjusted to different social and cultural factors could be a subject of international project.

Table 1 Types and levels of body image distortion prevention

Level of prevention	Characteristic
1st degree prevention	The actions directed to people who do not yet present non-adaptive behaviours - preventing the occurrence of harmful and unhealthy behaviours by diagnosing the risk factors and neutralizing them as well as promoting positive body image.
2nd degree prevention	The actions addressed to people who present a single non-adaptive behaviour, i.e. a restrictive diet - stopping the development of a disorder at the onset of the first symptoms.
3rd degree prevention	Preventing the escalation or recurrence of non-adaptive behaviours and mitigating their negative effects, i.e. stigmatization, the consequences of hospitalization, etc.

Źródło: J. Wycisk, B. Ziółkowska: *Młodzież przeciwko sobie. Zaburzenia odżywiania i samouszkodzenia – jak pomóc nastolatkom w szkole*. Difin, Warszawa 2010, s.135

¹³ Por. J. Wycisk: *Samouszkodzenia umiarkowane u młodzieży. Podstawy prewencji na terenie szkoły*. „Ruch Pedagogiczny”, nr 3-4, 2009, s.5-20

de Boer Thilly, Rutgers Netherlands
HOW CAN THE WHOLE SCHOOL APPROACH SUPPORT SCALING UP CSE
IN LOW RESOURCE SETTINGS?

1. Introduction

Rutgers is an expert centre on sexuality and sexual and reproductive rights in the Netherlands¹⁴, that combines expertise on research, advocacy and material development for professionals in the educational and health sector. Its working area are both the Netherlands and some selected developing countries¹⁵, where comprehensive sexuality education is one of the important areas of work. In 2004 WPF, later becoming part of Rutgers¹⁶, developed a comprehensive, rights based and evidence based sexuality education lesson package for secondary schools, named *The World Starts With Me*¹⁷. The package is computer based, with the intention to offer students also computer skills for the job market and to facilitate and support the role of CSE teachers. Meanwhile, also a printed version is available. The lesson package was first developed in Uganda and then adjusted to the specific context of a number of countries¹⁸, through a participatory process with partner organisations, experts and young people. The introduction of the lesson package in a new country comes with the training of master trainers for capacitating teachers in schools in the lesson package. Rutgers always cooperates with country based partner organisations and the specific implementation process and practices differ per country.

Evaluations and reporting by partner organisations have shown that the WSWM is highly appreciated by teachers and students, though the quality and fidelity of implementation are not satisfactory, which has two main consequences:

- The outcomes at student level are more modest¹⁹, than expected.
- The number of students reached per school is limited and hence costs per student are high²⁰

Fidelity and implementation depend on several factors.

- The design of the lesson package (number of lessons, relevance and acceptability of content, user friendliness, cd rom applicability at school, etc),
- Individual teachers (motivation²¹, time availability, capacity on teaching CSE)

¹⁴ www.rutgers.nl

¹⁵ Uganda, Kenya, Malawi, Tanzania, Burundi, Pakistan, Indonesia. Our materials are also used by other organisations in among others Ghana, Ethiopia, South Africa.

¹⁶ Rutgers came into being after a merger in 2011 between two SRHR organizations, Rutgers Nisso Group and World Population Foundation (WPF).

¹⁷. In 2010 WSWM was recognized in UNESCO's 'International Guidance for Sexuality Education' as a model program for comprehensive sexuality education programs (UNESCO, 2009), complying with the 17 UNESCO criteria for quality CSE.

¹⁸ Kenya, , South Africa, Malawi, Pakistan, Indonesia, Vietman

¹⁹ Leerlooijer, 2013; Leerlooijer et al., submitted; Rijdsdijk, 2013; Rijdsdijk et al, 2011, 2014; Rutgers WPF, 2011

²⁰ School-based Sexuality Education Programmes: A Cost and Cost-Effectiveness Analysis in Six Countries , UNESCO 2011: this report describes the WSWM in Kenya, as one of the more expensive programmes.

²¹ Haas, B de, Hutter, I & Timmerman, G. Ambivalent cultural schemas: why teachers feel uncomfortable teaching comprehensive school-based sexuality education in Uganda. Draft: 2014 Unpublished observations.

- The school environment (a.o. management support, timetabling, facilities, parents support and support from other (health) experts).

Over the years, design of the lesson package as well as teacher training have received due attention in terms of updates and adjustments. Guidance on implementation at the level of the schools got much less attention. Sensitization of the school management to guarantee access and support was done, though we know that for a sustainable implementation at school level, the involvement of more stakeholders is needed.

Scaling up

Rutgers has the ambition to scale up its interventions, in order to contribute to the high unmet need for CSE and the sexual and reproductive health and rights of young people. This asks for a sustainable, replicable and scalable implementation model for its WSWM lesson package and other quality materials. The experiences in Uganda and Kenya concerning the implementation of the WSWM were reviewed²² to assess till what level programme implementation complied with the criteria and conditions for scaling up²³. This has led to a research project, implemented in Uganda and in Kenya to develop a sustainable, replicable and scalable implementation model.

2. Problem statement

The above situation has led to the following problem statement. *How does a sustainable, replicable and scalable implementation model for the WSWM (and possible other CSE packages) look in low resources contexts? Specifically considering the tension between the need for quality implementation and a whole school approach on the one hand and keeping the model simplified and cost effective for scalability on the other hand? What are decisive indicators that combine quality implementation and sustainable implementation? Does the Whole School Approach provide an effective and efficient approach to reach this? Is scaling up of CSE using the Whole School Approach possible?*

The theoretical frameworks

Several theoretical frameworks sustain the design of this project, as illustrated in the graphic below:

- Scaling Up framework²⁴:
- Comprehensive Sexuality Education²⁵:
- Whole School Approach²⁶:
- Operational Research²⁷:

²² Boer, T. de. Possibilities for Scaling up Comprehensive Sexuality Education: The case of the WSWM programme in Uganda. 2012.

²³ Scaling Up – From Vision to Large-Scale Change. A management Framework for Practitioners. Management Systems International, Washington, Second edition 2012

²⁴ Idem

²⁵ UNESCO 2009, International Technical Guidance on Sexuality Education: an evidence-informed approach for schools, teachers and health educators, Volume 1&2 Paris: UNESCO Published in partnership with UNAIDS, UNICEF, WHO,

²⁶ Promoting Health in School From Evidence to Action, IUHPE

²⁷ Guide to Operational Research in Programs supported by the Global Fund, WHO and The Global Fund.

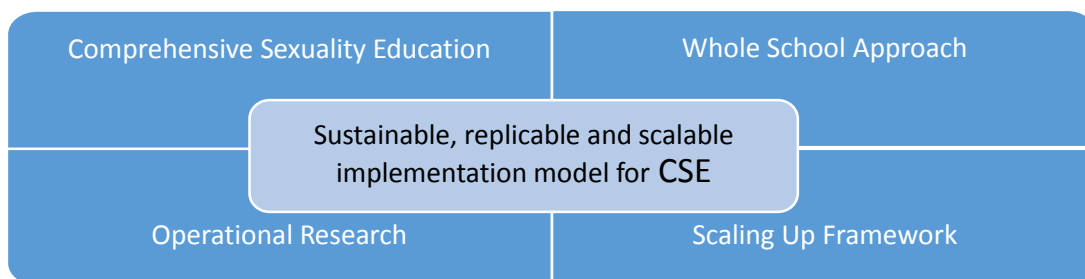


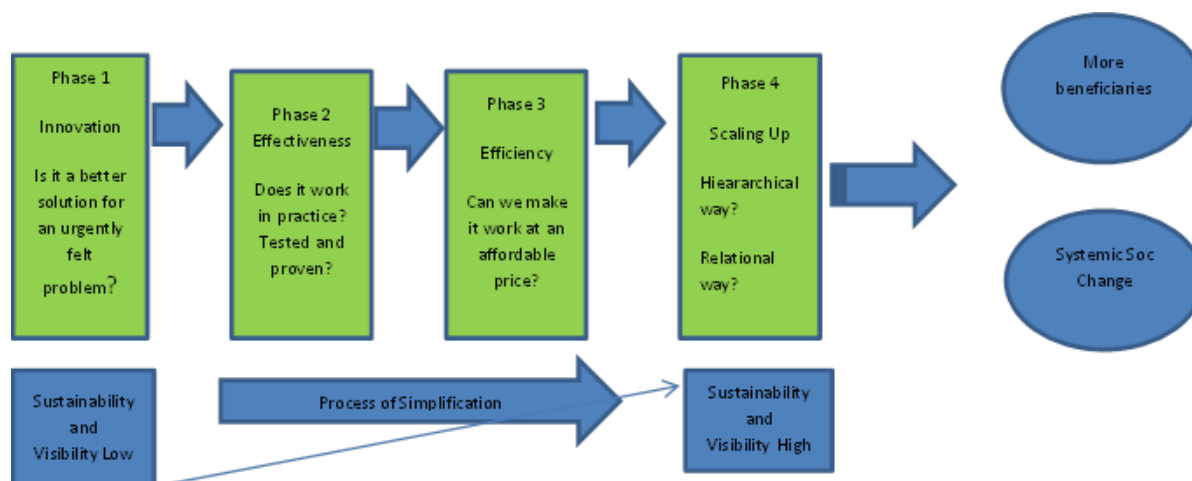
Figure 1: The four pillars to develop a sustainable, replicable and scalable implementation model for CSE

3. Scaling Up framework and Whole School Approach

The WHO defines ²⁸ scaling up as: *“deliberate efforts to increase the impact of (health service) innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis”*.

“Innovations” have two aspects. A practice (technology, service, lesson package) that is new to a specific setting and offers a better solution than other and previous practices. Secondly, *“a set of interventions, including the process necessary to build sustainable implementation capacities”*. This set of interventions is crucial, as a practice in itself is rarely the sole solution. With regards to the WSWM programme, this means that a quality CSE package is not enough. To be able to scale up and reach more beneficiaries, we need a sustainable implementation model at schools.

A sustainable model has passed through several phases as shown in the graphic 2. The innovation has proven to be effective, though also efficient. Pilot projects are relatively expensive, and it is needed to ‘simplify’ the design, without losing its effectiveness. This makes it necessary to focus on the crucial indicators and reduce the number of interventions and involved stakeholders as much as possible.



Graphic 2: Phases in the Scaling Up process

In line with this simplification process, some key conditions for success are the following:

- Embeddedness in the socio-political-juridical context (eg the School Health policy, Education policies, etc)

²⁸ Practical guidance for scaling up health service innovations WHO 2009, EXPANDNET, page 1.

- Use of locally available resources (eg the available school budget, parents contributions, or local/district funds)
- Ownership based on a participatory approach and motivation of the involved stakeholders.: *the implementing organisation is always right (WHO),*
- A longer term processes, as introducing innovations takes time. Magic bullets are not available and *“successful scaling up is not fully under the control of the donor or innovator, but rather grows organically out of a deep understanding of and engagement with user groups and their environmental context”²⁹.*

SHE defines the Whole School Approach to health promotion³⁰ as an “approach that focuses on achieving both health and educational outcomes through a systematic, participatory and action-oriented approach”. A Whole School Approach for health promotion goes beyond class room teaching on specific isolated health topics. It addresses the whole school, involves the community and consists of a set of coherent interventions that support a positive health promoting setting for young people’s health and hence their learning performance. While a Scaling Up approach pursues simplification, the Whole School Approach goes for more interventions and more stakeholders involved. How can these two be combined, or even more, strengthen each other?

Sustaining the Whole School Approach

Some factors have been demonstrated to be conditional for sustaining the implementation of health promoting programmes in schools³¹. These factors show a high resemblance with success factors for scaling up processes.

Nevertheless, good practices of the Whole School Approach are not abundant:” the practice is complex, dynamic and dependant on the context in which it is embedded”³² Most studies show that implementation is only partial, due to factors like teachers’ workload, and lack of structural school policies. Data on successful implementation in the African context are even more scarce. A n evaluation of 17 programmes on schools aiming at diabetes prevention³³, found that none of the programmes applied a whole school approach, due to several setbacks (lack of premises for sports, high costs for healthy food, classroom focus, and the like).

4. Design of the Research project to develop a sustainable implementation model of CSE

The design of the research project is based on all four theoretical frameworks:

The WSWM is a lesson package that complies with the criteria for comprehensive sexuality education and comes with a training to capacitate teachers in using the package.

²⁹ AIDED model in Dissemination, Diffusion, and Scale Up of Family Health Innovations in Low Income Countries”, Yale Global Health Leadership Institute, E.H. Bradley and L.A. Curry, Nov 2011.

³⁰ SHE Online School Manual – 5 steps to a health promoting school, CBO, December 2013 page 8.

³¹ Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools version 2, IUHPE

³² Better schools for health: Learning from practice. Case studies of practice presented during the third European Conference on Health Promoting Schools 15-17 June 2014 Vilnius page 7.

³³ Skar, M., Kerstein E., Kapur, A. Lessons learned from school-based health promotion projects in low – and middle income countries. December 2014, Pubmed, University of Copenhagen and World Diabetes Foundation.. Countries reviewed were Tanzania, Kenya, South Africa, India, Sri Lanka, Cambodia, Brazil.

Based on the Scaling Up framework, the research focuses on collecting evidence that the innovation is effective, efficient and feasible, with a focus on the innovation component that consists of “a set of interventions, including the process necessary to build the capacities for intervention”.

The Whole School Approach is taken as the approach to develop this set of interventions and to address all stakeholders and the necessary related interventions to support the CSE implementation at school.

Finally, this evidence is collected making use of operational research methods, during implementation data are collected, reflected upon and interventions adjusted to improve outcomes and numbers further.

Objectives of the Research project

At school level the following objectives are pursued:

- All students are addressed with CSE
- Students are reached at the right age (as much as possible as young adolescents)
- Ownership of the school
- Improved outcomes of CSE
- Continued implementation of CSE at school.

Positive experiences will inspire new schools to participate, considering the high needs of young people and the fact that most schools and staff are motivated to respond to these needs.

Altogether this will lead to increasing the reach of CSE for young people and contribute to the final impact: Youth making informed and healthy decisions concerning their sexual and reproductive health and rights.

5 The five Outcome areas

The five outcome areas further defined as follows:

- Outcome area 1: Management actively supports ASRHR education in the school**
timetabling, budget allocated, moral and practical support, involved in PME system, statistics
- Outcome area 2: Access to youth friendly health services and evidence based, comprehensive and rights based ASRHR information**
relation with health services, condom info and demo, youth corner
- Outcome area 3: Parent/ community involvement**
parents are informed, communication between student and parent, parents as advocates
- Outcome area 4: Adequate ASRHR teaching capacity (quantity and quality)**
teachers address sensitive issues, peer training for staff, use of interactive methods, etc
- Outcome area 5: Safe and healthy school environment**
Code of conduct, counsellors, referral system, lockable clean toilets, etc

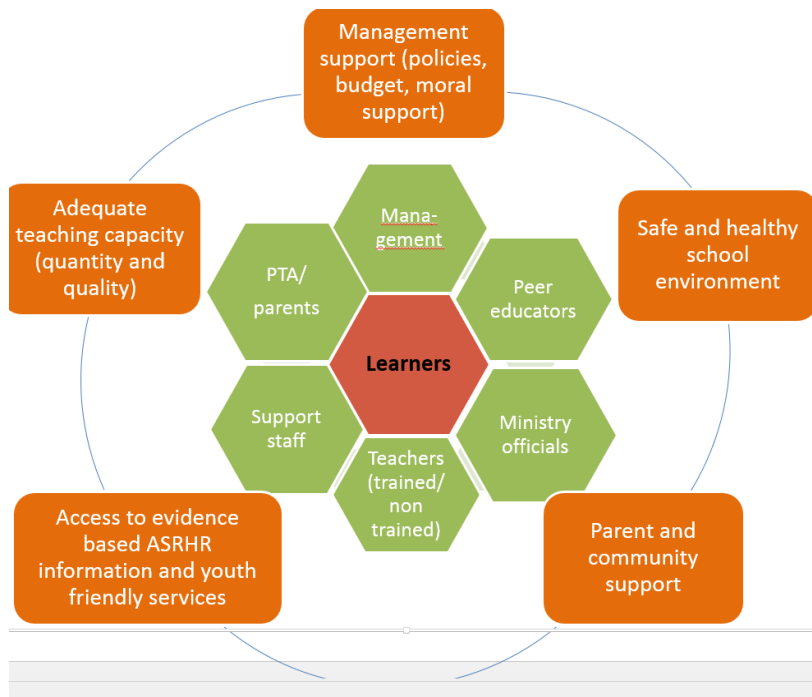
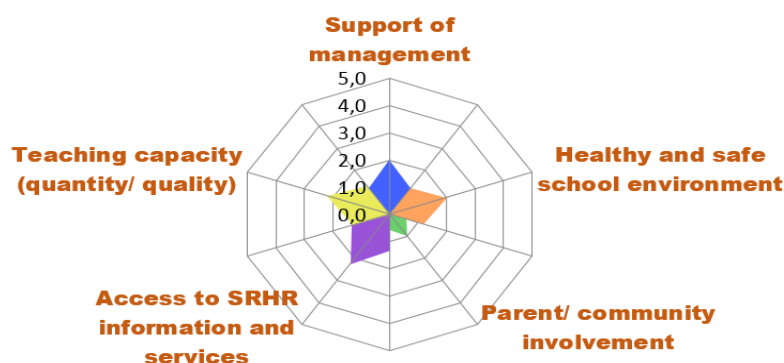


Figure 4: The five Outcome Areas and Stakeholders involved

A school based self assessment resulted in a graphic per school that shows at a glance how the school is performing and where the areas for improvement are. During the project, new data deliver new graphics, showing the gradual progress. The visualization works very motivating for schools, especially when the progress clearly shows.

Figure 5: The performance in the five Outcome areas visualized



5. Action research questions

Four Action research questions have been formulated concerning some specific critical issues that need further thinking and new interventions to build up experience.

Outcome area 2: Access to youth friendly health services and evidence based, comprehensive and rights based ASRHR information.

If we involve other professionals (health staff, school nurse, matron) in providing information and condom demonstration for students, does this lead to :

- *Enhanced access to condom information and demonstration?*
- *A solution that all parties feel comfortable with (Ministry of Education, teachers, management, students, board, parents and religious leaders)?*
- *Change in knowledge and intentional behaviour with regards to condom use?*

Justification: Condoms are forbidden at schools and having one in pocket can lead to school expulsion. This complicates organizing condom information and demonstration within the school compound, while it is known that a demonstration using real condoms has a higher impact on knowledge and attitude towards its use. Condoms are the most widely used contraceptive by young people and protect against both pregnancies and STI and HIV, but are connected to a wide variety of myths and misconceptions on presumed negative effects (such as that condoms can disappear in the woman's body and cause infertility). Cooperating with health services might solve this problem, as health providers act from a health perspective and are more tended to refer to evidence based information.

6. First results on applying the Whole School Approach for a sustainable, replicable and scalable implementation model

The project description shows that schools participating in the project now need to pay attention to a much longer list of supporting interventions in all five Outcome areas, than before. Also, many more stakeholders in and outside school are involved. This seems contradictory to the objective of scalability, as the scalability of an innovation reduces the more interventions and the more stakeholders are involved.

The role that Rutgers' partner organisation needs to perform towards the schools has also changed. Before, it mainly focused on sensitization of the management to secure access into the schools, training for teachers and exchange workshops for WSWM (head) teachers. Now, a more coaching and facilitating role is requested from the partner organisation. For sure the exchanges resulted in worthwhile reflections and new ideas for more effective interventions: during the years more attention was paid to informing parents, involving matrons and school nurses in the teacher training and adjusting the teacher training to pay more attention to learner centred activities.

All these learning experiences did however not contribute to more sustainable implementation at the school level: a change of head teacher causes serious setbacks, if not a total halt to the CSE lessons. Also, the number of students reached per school remained limited and fluctuating.

Positive results

Working according to the Whole School Approach has delivered various interesting results.

- All stakeholders of a school were brought together for the first time. This yielded positive energy and willingness to take up some quick win interventions, such as timetabling the lessons (instead of programming them in the after school hours- clubs), informing the parents in the regular assembly meeting, painting a classroom to become a restroom. Schools are much more in the driver seat than before.

- Some persons take up an outstanding advocate role (head teacher, chair of the parent association, the WSWM teacher) and know to inspire and motivate others.
- As it is a joint process, WSWM teachers experience more support and mandate for their work. In several schools workshops for all staff were organized by the WSWM teachers.
- All schools show a modest, though steady progress in performance on the five Outcome areas. This indicates that all schools are working on the implementation of the School workplan and the Action research questions. Though, it takes longer than planned, among others due to the packed timetables of schools. This pleads for a prolonged project duration: two years are at least needed to deal with all the outcome areas. Also, some new interventions (eg on access to condom information and demonstration) most probably need several rounds of implementation, reflection, adjustment, implementation, etc before it will become part of the school practices in a satisfactory way.
- Fastest results have been achieved on the physical school environment (toilets, changing rooms, allocating a youth corner), with modest financial support from the project. Though not enough, it contributes to a certain pride and care for the school environment.
- Most dramatic effect so far is shown by the intervention on designing a new Code of Conduct based on a participatory process with students and after a sensitization workshop for school staff³⁴. The Code of Conduct was completely revised and disciplinary measures redefined into pedagogical measures that are now experienced as justified and fair. Corporal punishment has been abolished fully, which seems to relieve not only the students but also the teachers, some of whom were fierce supporters before. It has led to a sharp reduction of violence cases and disciplinary offenses in the class room and the school compound, hence greatly contributing to the Outcome area on a safe and healthy school environment.
- Gradually, the ownership of the project by the Partner organisations is growing as well. Initially, especially the relatively heavy operational research component caused some hesitation. So far, it is a selected group of staff that has been involved and that increasingly appreciates the approach and their new coaching role. Full acceptance by the partner organisation needs to be fuelled further by the experiences and estimation of the involved schools.

This overview of results is far from complete, though intends to indicate the trends and processes initiated. How now, does this relate to the scaling up potential of this model?

Scaling Up potential

One of the main conditions for a scaling up process is the ownership of the implementing organisation (here both the partner organisation and the schools): without intrinsic motivation, based on perceived benefits and a feeling of belonging to the process, no sustainability will occur. At school level the set of interventions for sure has become more

³⁴ Facilitated by Raising Voices, an Ugandan NGO that developed the “Good School” approach, to stimulate a positive, violence and corporal punishment free, paedagogical climate at schools. www.raisingvoices.ug

complex, as well as the number of involved stakeholders. However, they are fully part of the school system and can integrate relatively easily in existing procedures, responsibilities and budgetting. For sure, it demands for new initiatives to be taken up, and to score on some indicators, the school management, teachers and/or parents have to step over their own shadows. This does not occur overnight: schools need time to live through their own process, and to find their own specific solutions. The role of the partner organisation is to guide schools and to motivate them to push limits for more comprehensive sexuality education.

Cost efficiency

Once this research project has been finalized and new schools will participate, the budgetary picture needs to be drawn again, compared to the budget of the previous way of working. Partially it is a matter of shifting budget lines to other activities, partially it will also ask for more staffing to guide and coach the schools. At school level, costs are not supposed to create hindrances, as the school will make use of available budget, parents contributions, local sources, and some modest support from the project for necessary investments. The reduction in costs will show through the increased number of students addressed in one school. Even after the project duration, the school is presumed to be much better prepared to continue the whole school approach and hence continue with CSE as part of its school policies and practices: slightly higher investments in the beginning will pay back in the longer term.

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THE HEALTHY ELEMENTARY SCHOOL OF THE FUTURE: THE
FUNDAMENTAL RIGHT OF THE CHILD TO HEALTH AND THE LEGAL ROLE
OF PRIMARY SCHOOLS AND OTHER ACTORS IN REALIZING THE RIGHT TO
HEALTH IN THE NETHERLANDS.

Introduction:

Several conferences have taken place in Europe on healthy school programs since 1997. Healthy school programs are high on the international and national political agenda nowadays in Europe, and also in The Netherlands.³⁵ Research indicates that a healthy start in life can contribute to better academic achievements³⁶ and even a better adult life. Moreover, this may even have an effect on the future economical and social status of the child.³⁷ Hence, this can contribute to a better economical status of an entire group of people, and even an entire country.

The Healthy elementary school of the future (Dutch: De Gezonde Basisschool van de Toekomst³⁸. further: HESF) is a new health school concept in South-Limburg, The Netherlands.

³⁵ See G.J. Buijs, Better Schools through Health: Networking for health promoting schools in Europe, *European Journal of Education*, vol. 44, no. 4, 2009 part I.

³⁶ See Suhrcke, M. en C. De Paz Nieves (2011). The impact of health and health behaviours on educational outcomes in high-income countries: a review of the evidence. World Health Organization.

³⁷ *SHE Schools for Health in Europe; School Health Promotiion: Evidence for effective action*. SHE Factsheet 2, p. 3.

³⁸ www.degezondebasisschoolvandetoekomst.nl

The concept is aimed at improving the health of children at primary schools by applying a complete concept of health promotion: improving physical activity and exercise, change of diet by providing school meals, such as healthy lunches, breakfasts and snacks and longer schooldays due to a variety of active and compulsory courses in which healthy activities play a central role. Moreover, the HESF aims at learning and promoting children about health, healthy food, and physical activity en recreation. Furthermore, another aim of the HESF is to contribute to the healthy development of children, hence, talent development of children. The project provides children with a structured daily program with compulsory educational courses and diverse healthy elements such as sports and playing, in which health plays a central role. The question is whether the children provided with this structured daily program, will experience a better intellectual and emotional development and less stress in their early lives. The HESF schools are included with facilities in providing children with healthy breakfasts between 7.30 and 8.30 and there is a healthy after school program. Research indicates that many children leave for school without having breakfast. By providing healthy breakfasts in the early morning, children will not have to skip breakfast, which can have a positive effect on their academic achievements. Moreover, due to the after school program, parents can decide to work on a full-time basis and pick up their children later in the afternoon when it is more convenient. However, the healthy concept is also applied to the after school program. The HESF is the main inducement of this *legal* research project, however, a wide variety of programs and concepts of health promotion in schools already exist in The Netherlands and in the world.³⁹

The legal aspects of healthy school programs: this PhD project

There is a close link between health and education. The unification of these two concepts can create better schools, with better academic results, which is beneficial to a whole community or country. However, healthy (school) programs are closely related to the fundamental right to health of the child of article 24 CRC. Projects such as the HESF, and other healthy school concepts, consequently have legal implications. Changing a school into a healthy school, and thus changing the daily school program, implies a changing daily routine, for children, parents and teachers. Thus, the fundamental rights of children and parents may conflict with the objectives of a particular healthy concept in schools. Moreover, the fundamental rights of parents can even conflict with the fundamental rights of children. Therefore, this research project focuses on the conflicts of these fundamental rights, such as the right to self-determination of the child and the right of the parents to raise their children according to their own standards and values and the implied consequences for these rights in a healthy school concept. Thus, the project focuses on the right to health of the child and the legal responsibilities and obligations of different actors, such as parents, primary schools, the State, children, and primary school teachers. Moreover, the project focuses on the different legal consequences in Dutch educational law. The pitfalls of a healthy primary school project such as the HESF are described and studied. Moreover, another aim of this research project is to serve as a 'guideline' for the HESF in The Netherlands. The projects' focus is on The Netherlands, and therefore, the dissertation will be published in the Dutch language.

The HESF is focused on improving children's health, and eventually, improving children's cognitive skills, economic and social position and life. The concept of children's health and

³⁹ In The Netherlands, the concept of healthy schools is very important. A school can receive a healthy school vignette when the school focuses on healthy projects. See www.gezondeschool.nl.

education is involved with many different factors. First, the parents and caregivers are responsible for their children.⁴⁰ Therefore, it is important to consider the rights and obligations of the parents in discussing a new healthy school concept. Which responsibilities do parents have in educating their children on healthy foods and lifestyles? What is the extent of their authority on healthy lifestyles? Moreover, what legal consequences are implied with a healthy primary school concept in relation to the right of the parents in bringing up their children? In other words: to what extent can parents decide on (healthy) lifestyles of their children and to what extent can schools or the Dutch State decide?⁴¹ What is the maximum extent of influence of the schools on the lifestyle of children and how does this conflict with the concept of family life and the right of parents to raise their children? Furthermore the healthy school concept can imply a conflict of fundamental aspects of academic freedom and of primary schools and the right of parents to raise their children according to their own standards. A new concept of promoting healthy lifestyles can also affect teachers and the school's employees. A small part of this research project focuses on the possible consequences for teachers and other employees and the issues related to academic freedom.

Another aspect that will be researched in this project is the right of children themselves in deciding on their (healthy) lifestyles. Again, the right of the child to self-determination and self-decision can conflict with the rights of the parents to take responsible decisions for their children, and the healthy concept of the school the child is attending. Thus, the question is how to balance these conflicting rights. It is therefore important to research the extent of the right of the child to health and to involve the concept of education. Moreover, in light of the above, arises the question whether parts of the healthy school projects should be made compulsory.⁴² Furthermore, an important question in this matter is whether the concept of the HESF and other healthy school programs contribute to the fundamental right of the child to health. The question is whether one implies the other: in other words: does the right to health implies an obligation for the state to create healthy school programs?

The previous shows that there are many legal questions related to the right to health of children and the role of the state and, indirectly, schools and parents and even teachers, in realizing the right to health. Therefore the research project will focus firstly on the extent of the right to health of the child. The main focus of the project is the promotion of health in schools, and therefore the project will not focus on other aspects related to health of children such as the right to health care. The previous leads to the main question of this legal research project:

What is the extent of the right to health of the child and what are the legal responsibilities and obligations of primary schools, teachers and the Dutch State, in realizing the right to health of the child in relation to the interests of parents and children themselves?

In order to answer this main research question, other sub questions are answered.

⁴⁰ H. van Crombrugge, W. vandenhole, J.C.M. Willems, *Shared Pedagogical Responsibility*, Antwerpen-Oxford: Insertia 2008.

⁴¹ See the case of ECHR Kjeldsen, Busk Madsen and Pedersen (Danish Sex Education case) Judgement of 7 december 1976, *Appl. no. 5095/71; 5920/72; 5926/72*. The parents of school children objected to sex education in the curriculum and asked their children to be exempted from this course.

⁴² This is an important question in the HESF project. Children are expected to stay over in in the afternoon between classes and have a healthy lunch. One can ask the question whether this can be made compulsory and whether this conflicts with the right of parents to decide on lunch breaks of their children.

1. *What is the current extent of the right to health of the child in relation to other fundamental rights?*

The first question relates to the extent of the right to health of the child. Moreover, the question is related to other fundamental rights of children, such as the right to self-determination, family life, best interests of the child, autonomy and bodily integrity. The research project will only focus on the rights of children to health in school and family-contexts. Thus, the project will not focus on, for instance, the right to health care.

2. *What rights, obligations and responsibilities do related parties have to realize the right to health of the child?*

This part of the research is an examination of the rights, responsibilities and obligations of parties involved with the right to health of the child. In this part of the research, the focus will be on the parents and caregivers, children themselves and the Dutch State. The aim of this part of the research is to describe the current obligations and rights of these actors to realize, direct (state) or indirect (for instance parents) the right to health of the child. In the third chapter of the research, the focus will be on the legal role of primary schools in realizing the right to health of the child. This chapter is linked to the previous two chapters.

3. *How should conflicting interests, fundamental rights and perspectives be dealt with in realizing the right to health of the child?*

In the fourth chapter of the research an overview of the conflicting interests related to the right to health and the role of primary schools will be provided. In this chapter the focus will be on the parties as mentioned above and their fundamental rights and obligations. The fifth part of the research describes the pitfalls of the healthy elementary schools in The Netherlands. Here, the focus will again be on the right to health, the right to healthy education, the conflicting interests and the application of the project in The Netherlands. In this chapter, the previous described theory on the right to health of the child will be applied to education. It thus becomes clear that the link between education and health is certainly present.⁴³ This is also stated in the WHO report of 1997 'Promoting Health Through Schools'.⁴⁴ This is also the concluding part of the research project.

Methodological approach

The research project is mainly placed within the theoretical human rights framework and thus this implies an international character of the research project. However, the research is focused on application in The Netherlands.

To answer the research questions, a legal dogmatic approach will be used. The first part of the research is focus on the extent of the right to health. The research will focus on previous dissertations and literature on the right to health of the child. Moreover, international and national laws and case-law will be studied. Furthermore, the research method consists of studying and applying general comments and documents of several international organizations (WHO, UN, UNICEF, UNESCO).

Due to the broad range of legal questions linked to the HESF project, these questions will be derived from different questionnaires and interviews with teachers, children and parents. In

⁴³ *SHE Schools for Health in Europe; School Health Promotiion: Evidence for effective action*. SHE Factsheet 2, p. 3.

⁴⁴ WHO, 'Promoting Health Through Schools' Report of a WHO Committttee on Comprehensive School Health Education and Promotion' 1997, p. 2.

other words: this project focuses on the right to health of the child. However, the main inducement of this project is the HESF project. Parents can either choose to join or not to join the HESF project, and the research of HESF. Therefore, they have to sign an informed consent form. In the interviews the parents and teachers are asked to elaborate on their decision, which will lead to new legal sub-questions.

Moreover, legal experts, professionals in healthy school programs and health care will be interviewed. The main aim of these interviews is to gain more information on the right to health of the child, and to gain more information on the different health promoting programs in The Netherlands and other countries in Europe. The results of these interviews will be included in the research project. At last, in the second or third year, an expert meeting will be organized.

Another methodological approach in this project is the comparative law method. Due to the international character of the project and the relation to education, other 'healthy school approaches' are studied. To draw conclusions for the Dutch legal system, the legal frameworks of these other healthy school concepts are elaborated upon and applied in this research project. The HESF can learn from the legal pitfalls of other healthy school programs in other similar European countries. The countries are being selected on the basis of a lengthy history in healthy school concepts. Because of the fact that some European countries have a long history in improving children's health with the use of healthy school programs, these countries may have overcome the same legal pitfalls and obstacles the HESF is facing.

The HESF project is an interdisciplinary project. The results of other dissertations of other PhD candidates of this project will be reflected upon and, if possible, used in this legal research project.

Huuhka Helena, Kuopion klassillinen lukio, Upper secondary school HEALTH EDUCATION IN UPPER SECONDARY SCHOOL HEALTH AND RESEARCH COURSE. TEACHER'S EXPERIENCES AND PERSPECTIVES

Three health education courses

- Foundations of health (compulsory)
- Young people, health and everyday life (specialisation)
- Health and research (specilisation)
- Preparation for matriculation examination (optional)

Multidisciplinary nature - CROSS – CURRICULAR THEMES

- ▶ Biology
- ▶ Psychology
- ▶ Geography
- ▶ Social studies
- ▶ And also: chemistry, sport sciences, language skills etc.

HEALTH and RESEARCH course contains three main parts:

- a. History

- b. Health service
- c. Research
 - Acquire, assess and interpret health research
 - small survey in practice

History

- ▶ Trends
- ▶ Various health issues
- ▶ Finland / global



The School Health Promotion study

The **purpose of the survey** is to gather information about pupils' and students' experiences of school, their health and their lifestyles. The findings will be used in the planning and development of services intended for young people.

The survey is **anonymous and confidential**. Participation is voluntary. After the survey session, the questionnaire forms will be sealed in an envelope and sent to the recording centre. Once the responses have been entered in the system, the forms will be destroyed.

The results of the survey will be available...

Interpretation of research results

- ▶ Media competence
- ▶ Medicalization

Small survey

- ▶ Students perform a small empirical survey of their own
- ▶ Choosing the right research method
- ▶ Planning the timetable
- ▶ Equipments, permissions etc.
- ▶ 6-7 lessons

Subjects

- ▶ *Independent training among football and hockey players*
- ▶ *Fast food consumption*
- ▶ *Daily activity levels for athletes versus nonathletes*
- ▶ *Teenage boys sports habits*
- ▶ *Burnout experiences among teenagers*
- ▶ *Music listening habits among teenage girls and boys*
- ▶ *The relationship between eating bananas and the speed of falling asleep*

Collecting data

MEASUREMENT

- ▶ Sit & reach test
- ▶ 50 meter sprint with and without warming -up
- ▶ Amount of daily steps: comparison between school caretaker, P.E. teacher and police officer

OBSERVATION

- ▶ Eating salad for school lunch, comparison between girls and boys

QUESTIONNAIRE

- ▶ Psychological pressure in secondary school

INTERVIEW

- ▶ Description of the successful dance lesson - boys experiences

EARLIER COLLECTED MATERIAL

- ▶ Cooper test results with 16 year of boys – comparison during last 3 years

Examples

- ▶ Hypothesis
- ▶ Literary survey
- ▶ Methods
- ▶ **Results**
- ▶ Conclusions
- ▶ Sources

Utilization of the surveys

Usefulness – students' perspectives

- ▶ Students use critical thinking with increased amount of health information available
- ▶ Comprehensive ja extensive knowledge – benefits in the Matriculation examination
- ▶ Students are aware of the research process (reliability, validity, confounder, dose-response relation, prevalence, incidence, mortality etc.)
- vocational or university studies in the future

Teacher's perspectives

- ▶ In school setting, the results have been utilised in the planning and evaluating of health education
- ▶ Reports give an opportunity to monitor students' interests and challenges (sport injuries, problems in communication skills, emotional pressure during school years etc.)
- ▶ Co-operation between different professionals and students (ex. school nurse, teachers, parents)

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TEACHER AS HEALTH EDUCATOR AND PROMOTOR

Despite the variety of ways how health education (HE) is introduced in schools in different countries, this subject is part of general education across the world. So HE meters are addressed not only to SHE network but to all schools. Health education is getting to be a question of pedagogy and teacher training, and SHE experience would be useful for developing these areas. Therefore, my tasks in the Course are following.

- **Best evidence-based experiences from schools participating in SHE network in Europe have to be taken during the Course and transferred to initial teacher training institution, Lithuanian University of Educational sciences (LUES).**

Almost all study programs in LUES have 3 ECTS Health Education course during their studies and also small part of HE during their pedagogical practices in schools. All schools in Lithuania have to implement *General Health Education Program (2012)* independently if it participates or not in SHE network. Numerous studies show that work of schools implementing HE in Lithuania is not sufficiently theoretically and methodically grounded, shows low effect, insufficient teacher's HE competences and motivation. Activities of Lithuanian schools, participating in SHE network, lack theoretical approach. They are conducted mostly by practitioners, implementing preventive health measures (Centre of Health Education and disease prevention, Health Bureaus). Despite "We have a strong network of health promoting schools in Lithuania, and these schools do a lot of different activities related to health and wellbeing" (*Zeromskiene et al, 2014*), despite many schools make great input promoting their children's health and are really satisfied with the results they achieved, positive results can hardly be measured in scientific approach, they are fragmentary and not visible enough to monitor their progress.

- **SHE network experience on teachers' competences would be very useful. Directions for future scientific studies and, possibly, for international collaboration, most willingly would be discussed during the Course. Future research would probably be related teachers' competences, their health values, approaches and behaviour, their health literacy, health potential and quality of life. This would increase awareness that may promote developing pre- and in-service teachers' training programs and increase the understanding what kind of measures should be taken in both in teacher's preparation, and in the ways HE tasks is implemented in schools.**

As different studies show, that even in the beginning of the studies in the university students from the teacher training programs already have variety of unhealthy habits, attitudes, stereotypes (e.g. differences in physical activity between different study programs illustrate that). Teachers who work in schools often show low health literacy, have unhealthy lifestyle, lot of health disorders, critically evaluate their competence to implement HE, and not necessarily serve a role model to their students. There is also great need to change the stand of HE in school from "incidental" delivery of health messages to a theoretically and methodically grounded subject. To achieve effective shifts in school HE teacher' training programs have to develop contemporary approach using evidence based data of education effect.

The level and quality of the preparation of teachers to implement health promotion is a crucial factor. Both initial and/or pre-service teacher education are central for school health education and health promotion. Teacher attitudes and knowledge are key factors in their intention to work with health-related content. Teacher education helps to shape teachers' identities as educators of the whole person as well as their role as subject experts (*Health education: theoretical concepts, effective strategies and core competencies, WHO, 2012*). In Health education, pedagogies are concerned with processes of knowledge (re)production and also the (re)production of values, attitudes, dispositions, subjectivities and identities in regard to health (*Timming, 2014*). Experiences in Slovenia, as example of good practice from networking for health promoting schools in Europe demonstrated that among other factors the most successful methods were in-service training for teachers in health promotion, and having a school team in each school (*Buijs, G., 2009*).

To achieve effective shifts in school health education pre- and in-service teacher' training programs have to develop contemporary approach using evidence based data of education effect. E.g. student's participation is a key component of health promotion. As was shown in the study (*Griebler et al., 2014*), students participation has been discussed as a value, but different schools understand this in different ways. Authors conclude that student's participation should be taken seriously and utilized as more than rhetoric. This example evidently how teacher understands is important.

HE in contemporary school

Schools are increasingly involved in a range of health work (*Tinning, 2014*). They prosecute health policies in regard to vaccinations and the spread of contagious diseases, they teach about food, nutrition and exercise. They monitor hygiene, they have a responsibility for maintaining a safe environment and they have an eye for the mental health of their charges. In many ways, the health-work that schools do is a manifestation of the idea that schools should be a "frontline" technology of health promotion.

Health education in schools reflects wider notions of health and, indeed, the wider politics of health in our societies (*Tinning, 2014*). Health education is a response to societal health concerns. These begin with epidemiological evidence of physical and mental health trends and invariability distil into the recommendation of particular behaviours to enhance health. Concurrently, schools are increasingly expected to be responsible for the health and wellbeing of students and notions of "safety" and "risk" continue to dominate educational discourse (*Evans and Davies, 2004, Leahy and Harrison, 2004, Tinning, 2014*). Schools are also charged with responsibility for addressing particular perceived health problems as teenage pregnancy rates, alcohol use and obesity. Health promotion sites overlap with health education in other health related extracurricular interventions and initiatives (e.g., surveillance of kids' lunch boxes; sun-smart playgrounds). Schools and classrooms become sites of micro-politics and that they are spaces where particular forms of knowledge and ways of understanding health are formally legitimated. Health is a result of complex assemblages, of health knowledge, practices and representations (*Leahy, 2012, Tinning, 2014*).

Health education in Lithuania

In the Lithuania HE is integrated to the curriculum of all primary and secondary education. General Health Education Program was developed (*General Health Education Program, 2012*). It sets compulsory goals and objectives of health education, scope, education guidelines, curriculum extend and student's achievements for the school implementing general education programs. In the General Programs HE is seen as an integral part (*Kalesnikienė, 2015*). The General Programs are composed and oriented to the goals of key competencies, therefore the goals of health education as integral part of competencies should cover all key and special competencies as, *Learning to learn, Communication, Cognitive, Social, Initiative and creativity, Personal*. Integrated health education program has to be implemented during the lessons of all subjects, activities of school community and informal education.

The *General Health Education Program* was influenced by both the initiatives of the World Health Organization, as well as political priorities provided in "Health 2020", which are oriented towards an important goal – to significantly improve health and well-being of the population, reduce health inequalities and to ensure person-oriented health system activities.

The objective of health education set in the *General Health Education Program* is helping pupils acquire holistic health concept, developing abilities, habits and attitudes that are beneficial for

health, understanding responsibility for the health of their own and others, encouragement to choose a healthy lifestyle. Four areas of health education, which include important physical, mental and social health education areas, as well as general concept of health and healthy lifestyle, are provided in the *General Health Education Program*.

Successful implementation of the *General Health Education Program* requires not only the creation of healthy and safe school environment, but also teachers' preparation, inclusion of other school specialists, parents and other members of society, their support. European and global dimensions help to understand the purpose and meaning of health education with the projection to the future and the approval of five main values of the European network of health promoting schools "Schools for Health in Europe": justice, support, empowerment, operational competence and democracy.

Readiness of Lithuanian physical education (PE) teachers to apply new physical Education ideas

One specific focus of much of health work is on the body. In addition to range of formal curriculum activities such as those of health education (HE) and physical education (PE), most schools also include sport as an extra-curriculum activity (Tinning, 2014).

The survey was designed to investigate the attitude of Lithuanian PE teachers towards their readiness to apply new schoolchildren's physical education ideas (Poteliūnienė et al., 2012). Novelty of PE ideas is related to implementation of new education paradigm: renewed secondary school curriculum, new education technologies. Professional and special competences PE teachers were analyzed. Professional competences are composed altogether of psychological, pedagogical, methodical, ethical, cultural, social, sport knowledge and skills and the ability to apply them implementing concrete PE tasks. Special, or subject-related competences combine planning and realization of the PE content, applying appropriate technologies, managing teaching process (individualization, differentiation, creation of learning surroundings).

One of the objectives of the survey was to determine HE competences of Lithuanian PE teachers that allows promoting schoolchildren's health (Juškelienė et al., 2010). PE teacher together with other school staff among other objectives also has to implement HE goals. Results of the study showed that 26,0% of study population reported insufficient competences to integrate HE topics into PE lessons. No significant differences by sex, work experience, and qualification category were found (there were some demographic differences). PE teachers reported difficulties creating healthy surroundings (36,3%) during the lessons, methodically directing students to harden off (32,6 %), conducting lessons outdoors in winter (33,7%), working with the students of impaired health (26,6%), communicating and collaborating with parents (21,7%); explaining to students the links between exercising and nutrition (19,4%); conducting sportive games outdoors (11,5%), explaining benefits of exercising to students (7,4%).

Teacher's HE abilities extracted by the factorial analysis showed that special abilities of the physical education subject and general abilities (communication, collaboration) are less important compared to special health education abilities for successful implementation of HE tasks. The study results suggest that projecting the prevention points of schoolchildren's health it is important to extend, adjust and implement more single-minded theoretical and practical content of HE for present and coming teachers of physical education.

Health Potential in First-Year Students of Full-Time Studies at the Lithuanian University of Educational Sciences and its association with exercising behaviour

Little is known about health and its determinants specific to student's population subgroups, like students, future teachers. Students from teacher's training programs are future leaders and decision makers concerning not only subject they teach in school Their responsibility also is related to implementation of HE creation of health potential, and setting the standards of healthy lifestyle for their schoolchildren.

Research aim was to estimate the health status of first year students at the LUES using self-reported measures, and to determine its relation with exercising behaviour (*Juškelienė, 2014*). Study population consisted of full-time students from 20 teachers' training study programs. The study results revealed high prevalence ill-health indicators. Acute morbidity was characteristic to one fifth part of the students, frequent psychosomatic symptoms to one third parts. Headaches, tiredness in the morning, fast fatigue, nervousness, irritability, sleeplessness were the most prevalent symptoms. Analysing prevalence of frequent psychosomatic symptoms between the study programs differences were found. Students from the Faculties of Sport and Health Education showed the lower prevalence, compared to those from the Faculties of Science and Technology, History and Philology (they also used pain-killing and sedatives more often).

In the all study population 22,3% (9,2% men and 30,4% women) were insufficiently active as reported exercising one time or less per week. Other respondents exercise at least 2 times a week. There were zero cases with low physical activity among students coming from the study programs named Physical Education and Health Education, despite no entrance physical tests are performed in the university. Highest part of insufficiently active students was found in the study programs related to science, technology history philology social sciences. Among the students, who were insufficiently physically active relative risk of acute diseases is 2,4 times higher compared to those whom exercising frequency was one and more times per week. It is seen the tendency, that relative risk of frequent psychosomatic symptoms is 1,4 times for inactive students.

While the university students increased control over their lifestyles, they may not necessarily develop behaviour like regular physical activity and achieve best results for their health (*Sallis et al., 1990*). The transition into the university environment can potentially offer new 'cues to action' and different social norms that can influence an individual's readiness for behaviour change. It was found that multiple healths' related risk behaviours are highly prevalent among German university students. Studies have shown that large number of them start using alcohol (*Borsari et al., 2007*), do not eat enough fruits and vegetables (*Unüsan, 2004*) and do not exercise enough (*Haase et al., 2004*).

In the practical approach it is important to provide the evidence and to offer the progressive developments for the beneficial impact of health education, physical education to the universities to achieve best possible health potential of the students. During the last decade physical education and sport activities in Lithuanian universities experienced major changes (*Žilinskienė R., 2014*). This process is related to the adjustments to the EU standards and legal regulations of studies, also other processes going in the universities. Ten years ago Physical Education was the obligatory subject in all universities, however now, despite universities offer variety of sport possibilities, but mostly not as the subject for credit points and student's motivation to participate in organized sport activities decreased. The study showed that

student's health, physical fitness, knowledge and abilities to exercise independently are not sufficient. Other study demonstrated beneficial impact of health educators on college campuses and suggests that the health education may be showing beneficial impacts on college student health status (Zullig et al., 2012).

Health of present teachers

Three-year project (2012-2015) on health promotion for teachers and non-teaching staff within the framework of the health promoting school programme in Poland with the support of WHO Regional Office for Europe showed the need to take into account health and wellbeing of teachers and non-teaching staff, as the school staff act as role models for students (*Equity, education and health: learning from practice, 2013*). Furthermore, the wellbeing of staff has an indirect influence on pupils' health and learning (Saaranen et al, 2006). The results of Polish the project demonstrated health promotion of school staff is not easy to implement and needs to take some time (Woynarowska, 2015).

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DIAGNOSING LIFE SKILLS AMONG 15-YEAR-OLDS ATTENDING HEALTH-
PROMOTING SCHOOLS AND SCHOOLS THAT DO NOT BELONG TO THE
NETWORK. PROPOSAL OF INTERNATIONAL COMPARATIVE STUDIES.

In the contemporary world, children and youth are exposed to a number of temptations from their peers, adults or the mass media. An important action to be taken by the family and school is to neutralise the impact of factors causing potential threat to biological, psychological, social and cultural development of young people and shaping the skills which will protect them from threatening situations. Such skills certainly include the so-called life skills. This notion encompasses certain abilities to adapt and behave positively, which allows individuals to cope efficiently with daily life challenges. Life skills comprise psychological and social competences as well as interpersonal skills, which facilitate:

- taking right decisions,
- solving problems in a constructive manner,
- thinking critically and creatively,
- communicating effectively,
- building healthy relationships with others,
- coping and managing one's own life in a healthy and effective manner.

A special role in shaping life skills is played by the school. In Poland, owing to the obligation imposed on the schools in 1999, it is possible to develop school prevention programs, where life skills are an important component, and to introduce health education to the core curriculum of the Polish school. Despite many years' attempts, health education was

introduced as late as in 1997, but it was not included in the school timetable. Two years later, *i.e.* in 1999, 'health promoting education' educational path in primary school and middle school, and in 2002, 'health promoting education' educational path was introduced in all types of schools. In 2008, a decision was taken to incorporate the 'health promoting education' module in the core curriculum of physical education in middle schools and secondary schools⁴⁵. The policy makers assume that it should be followed by the school at specific education stages within the scope of many subjects, but mainly during physical education classes⁴⁶.

The current curriculum contents related with life skills envisaged for including in health education are defined by the core curriculum of the pre-school education and general education in specific types of schools⁴⁷. At the level of middle school (13- 15 year-olds), it provides for following the discussed curriculum contents under such subjects as Polish language, foreign language, social studies, biology, preparation for family life. Detailed requirements for the students in this scope are described in table no. 1.

Tab.1 Detailed requirements concerning life skills included in core curriculum under various subjects at level III of education (middle school)

Subject	Requirements for the students. A student:
Polish language	<ul style="list-style-type: none"> • recognises emotional and persuasive expressions • recognises intentions of the expression (approval, disapproval, negation) • perceives aggressive and manipulative expressions • participates in the discussion, justifies his/her opinion, accepts others' views, enters into polemics
Modern foreign language	<ul style="list-style-type: none"> • asks for advice and gives advice to others • works in a group (project works)
Social studies	<ul style="list-style-type: none"> • enumerates and applies rules of communication and cooperation in a small group • enumerates and applies basic methods of taking joint decisions • presents and applies in practice methods of solving conflicts in group and between groups • explains, using examples, how to keep the distance towards unapproved behaviours of the group and how to oppose them
Biology	<ul style="list-style-type: none"> • enumerates factors causing stress and gives examples of positive and negative effect of stress • presents methods of coping with stress

⁴⁵ Regulation of the Ministry of Education (23 December 2008) on Core Curricula for Pre-school and General Education in particular types of schools. Official Journal of Laws of 15 January 2009.

⁴⁶ B. Wolny: *Edukacja zdrowotna integralnym elementem oceny z wychowania fizycznego*. Warszawa, Ośrodek Rozwoju Edukacji 2014, p.4.

⁴⁷ Regulation of the Ministry of Education (27 August 2012) on Core Curricula for Pre-school and General Education in particular types of schools. Official Journal of Laws of 2012, item 977. In: <http://isap.sejm.gov.pl/DetailsServlet?id=WDU20120000977> (21.08.2014).

Preparation for family life	<ul style="list-style-type: none"> • builds correct relations with the parents • explains reasons and discusses manners of solving the generation gap- related conflict • discusses interpersonal relations and explains their meaning • practices assertive behaviour
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Source: B. WOYNAROWSKA: *Edukacja zdrowotna w podstawie programowej kształcenia ogólnego, jako fundament szkolnego programu profilaktyki*. Ośrodek Rozwoju Edukacji, Warszawa 2012, p. 9. http://www.ore.edu.pl/index.php?option=com_phocadownload&view=category&id=65:materiay-dot-programu-edukacja-zdrowotna&Itemid=1105 (18.05.2015).

Within the scope of physical education classes, the middle school students also face requirements regarding life skills. A specific scope of such requirements is presented in table no. 2.

Tab.2 Specific requirements regarding life skills included in the core curriculum of physical education at education stage III (middle school)

Subject	Requirements for the students. A student:
Physical education	<ul style="list-style-type: none"> • identifies his/her strengths and plans manners of developing them • identifies his/her weaknesses and is aware of working on them • discusses constructive manners of coping with negative emotions • discusses manners of reducing high level of stress and coping with stress constructively • discusses the meaning of good relationships with other people, including parents and peers of the same and opposite sex for psychological and social health • explains how he/she can give and receive society's support • explains what assertive behaviour is and can give some examples of such behaviour • explains how and why pressures, persuasions to use psychoactive substances and other risky behaviour should be opposed

Source: B. WOYNAROWSKA: *Edukacja zdrowotna w podstawie programowej kształcenia ogólnego, jako fundament szkolnego programu profilaktyki*. Ośrodek Rozwoju Edukacji, Warsaw 2012, p. 9-10. http://www.ore.edu.pl/index.php?option=com_phocadownload&view=category&id=65:materiay-dot-programu-edukacja-zdrowotna&Itemid=1105 (18.05.2015).

A special place where life skills can be acquired successfully by students is a health promoting school. Schools being part of SHE (Schools for Health in Europe) network are taking actions based on the concept of positive health and good well-being, at the same time using the provisions of the UN Convention on the Children's Rights and European Convention on Exercising the Children's Rights. A superior objective of a health promoting

school is a healthy lifestyle of the entire school community, under which acquiring life skills is a priority action.

Polish schools more and more frequently apply for joining the SHE networks, increasing their standards and following the health ethics in school. The network comprises over 2,000 Polish schools⁴⁸, of which a certificate of National Network of Health-Promoting Schools in Europe is currently held by 142 schools in Poland⁴⁹.

Taking into consideration the above assumptions, it seems plausible to carry out a diagnosis of life skills among students in the period of adolescence, attending public schools that do not belong to the network and compare them with the results of students from health promoting schools. To this end, a Life Skills Questionnaire was prepared by Katarzyna Borzucka-Sitkiewicz and Katarzyna Kowalczywska-Grabowska. The tool consists of 25 questions which tackle the following issues:

- communication and interpersonal skills (questions from 1 to 15),
- decision-making and critical thinking skills (questions from 16 to 19),
- life-coping and self-management skills (20 – 25).

The questionnaire questions are closed, semi-open and open, and their contents match the requirements for the middle school students in terms of acquiring life skills. It is proposed to examine 15-year old students, attending grade 3 of middle schools that are not part of the network, and schools holding the SHE certificate.

Additionally, international comparative studies may be considered in the selected EU member states, which would allow a full diagnosis of the discussed life skills among 15-year olds, but first and foremost it would contribute to recognition of differences or similarities in the scope of acquiring and using the life skills by the young generation. Such studies at international scale would contribute to exchange of experiences in the area of the applied regulations and practiced solutions in the specific states.

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⁴⁸ *Procedura nadawania Krajowego Certyfikatu Szkoła Promująca Zdrowie*, p. 2. in: http://www.ore.edu.pl/strona-ore/index.php?option=com_phocadownload&view=category&id=66:materiy-dot-programu-szkoa-promujca-zdrowie&Itemid=1105, dated 29.08.2012.

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HEALTH BEHAVIOURS OF FINNISH 14-15 YEAR OLD ADOLESCENTS WHO USE SCREEN-BASED MEDIA FOR SOCIAL AND ENTERTAINMENT PURPOSES.

Data from school health registers combined with
the views of adolescents and their parents

My thesis is still at an early stage. In this summary I will present the rationale and aims of the study and preliminary research objectives alongside methodological approach.

SUMMARY

In the past few years international research on adolescents' health has shown more interest on examining how screen-based media use affects health behaviours. Data emerging from studies suggests that spending more than two hours a day using screen-based media in sedentary position is associated with unfavorable health behaviour problems around overweight and obesity, decrease of physical activity, encouragement of the consumption of energy-dense foods, problems around sleep and lowered scores for self-esteem. This usage has also been associated to decrease the academic achievement among school-aged children. (Iannotti et al. 2009, Russ et al. 2009, Rideout 2010, Strasburger et. al. 2010, Calamaro et al. 2011, Jolin & Weller 2011, Racine et al. 2011, Calamaro et al. 2012, Sandercock & Ogunleye 2012, Garmy et al., 2013, Nuutinen et al. 2013, Yang et al. 2013, Straker et al. 2013, Wethington et.al 2013, Herrick et al. 2014, Taehtinen et al. 2014). These behaviours compromise adolescent's health and therefore many fail to achieve the full health potential they need during growth and development towards young adulthood.

As a result of this current dilemma, national health authorities and specialists especially in the "west" (America) and in the "north" (Europe) have noticed this complexity. Common to these parts of the world is that these concerns are associated with the region's economic, modern political, cultural or spiritual status. Because of this adolescent's media use is stigmatized as "a problem of welfare countries", where adolescents can afford, are allowed or are guided to use screen-based media on a daily basis. (UNICEF 2013.) For this reason, national authorities

in these regions, such in the United States of America (USA) and in Finland, have made recommendations for children's and adolescent's entertainment media use. In USA and in Finland national guidelines suggest that screen time in children (over 2 year old) and adolescents (up to 18 year old) should be limited to no more than 2 hours per day (The United States Department of Health and Human Services 2015, the Finnish Ministry of Education and Culture 2015). However despite the recommendation's broad age range, no specific guidelines targeting children over 2 year old, preteens or teenagers do not still exist. Neither there are no existing guidelines on media use focusing on media's educational use.

Schools in the USA and in Finland are in a central position in securing adolescent's health and well-being in childhood (CSH 2015, SHE 2015, Sormunen et al. 2011). The World Health Organization (WHO) established the international Health Promoting Schools -initiative in the 1990s that emphasizes the view of promoting health to all who learn in schools and guide schools to understand how health problems affect school performance (WHO 1996). Today this initiative has spread and developed in to wider meanings at schools in areas of health education, physical education, healthy and safe school environment, health promoting staff, family / community involvement and also to school health services (CSH 2015, SHE 2015). In welfare countries, adolescent's media use has been taken in to account in all of these presented areas in school health promotion (Valimaa et al. 2007, Chenchob 2013).

School health services in Finland gather various health related information about children's health and health behaviours to administrative and municipal registers in regulated health examinations at 1st, 5th and 8th grade that are obligated under the Finnish pupil health care law (Ministry of Social Affairs and Health 2013). In these examinations school health services carry out also health promotion to children and there is a current need in promotion development strategies to get information about the effects of media use in sedentary behavior to health (Ministry of Social Affairs and Health, 2014, Finnish Report Card 2014). In the USA, school health services share the same need of getting information on this current adolescent health problem associated to media use (Rey-Lopez 2011).

Parental monitoring and guidance are also essential and have a significant meaning to adolescent's media use (Gentile et al. 2014). Parental media monitoring includes understanding the media, talking about the diversity of media and its content with adolescents and also making rules for using it (Cain & Gradisar 2010). Adolescent's media use need parental made rules about the appropriate amount of media exploitation because they cannot regulate the media use themselves (Gentile et al. 2014). Previous international and national studies have mainly focused on studying parents visions about children's media use, the impact of having a television in the bedroom and the meaning of having enough of sleep while securing the quality of sleep (Vandewater & Huang 2006, Steffen et al. 2009, Cain & Gradisar 2010, El-Sheikh et al. 2012, Coyne et al. 2012, Goldfield 2012, Nuutinen et al. 2013). Study findings indicate that media based screen time use higher than 1-2 hours per day exposes children to bedtime resistance, short sleep duration and anxiety around sleep (Calamaro et al. 2011, El-Sheikh et al. 2012).

This study aims to tackle this research area in the USA and in Finland based on previous addressed evidence. It will produce knowledge on how adolescents' screen-based media use effects on their health behaviours and how school health service identifies this issue as a part of health promotion and health examinations. Study will include components from the whole-school approach (Hargreaves 2008) and the SHE (Schools for Health in Europe) health promoting school approach (International Union for Health Promotion and Education 2008,

SHE 2015). This addressed study will involve 14-15 year old Finnish and American adolescents; their parents and also Finnish municipal administrative health information registers. This research is going to be carried out in an international research group, involving participants from the University of Eastern Finland and from the East Carolina University, from the USA.

The preliminary research objectives

1. To examine how administrative and municipal school health registers in Finland store information about children's health behaviours in wide health examinations at the 5th and 8th grade
 - a) Is there any health behaviour differences to be found among pupils between 5th and 8th grade examinations?
 - b) Is there any information stored about pupils screen-based media use in 5th and 8th grade examinations?
2. To compare what kind of amount a 14-15 year old adolescent uses screen-based media for social and entertainment purposes on a daily basis in Finland and in the USA
 - a) Evaluated by adolescent's themselves
 - b) Evaluated by adolescent's parents
3. To compare how do parents monitor and guide their 14-15 year old adolescent's screen-based media use in Finland and in the USA
4. To examine is there a relationship between health behaviour factors together with screen based media use among 14-15 year old Finnish adolescents

Methodological approach

Study will be a cross-sectional study. Study will include a quantitative approach as a research method (Burns & Grove 2009, Polit & Beck 2012, Grove et al. 2013). In Finland, adolescent's health behaviour information will be retrieved from school health registers (as register data) from wide health examinations at 8th grade (in 2015-2016) and also retrieved retrospectively from the examinations from 5th grade (in 2012-2013). Information on adolescents screen-based media use will be gathered through web-based questionnaires (as survey data) from adolescents and their parents. After this the register data will be matched with the survey data at the person level and be used to validate information collected in the survey. In the USA, the methodological approaches are under consideration.

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PUBLIC HEALTH CARE SPECIALISTS AT SCHOOL:
CHALLENGES AND PERSPECTIVES OF PRACTICE

Student health care in Lithuania has had the tradition of almost a century and for many a year was linked to school nurses that took care of primary child health care and prophylaxis for diseases, provided a timely medical assistance, taught and consulted students, their parents

or guardians and teachers how to strengthen health resources of a concrete student or their groups, contributed to the betterment of educational conditions of students and their academic results. The nurses working in the communities of Lithuanian towns and villages were subordinated to the institutions of primary children's health care (a health centre, family doctors) that provided the services of children's health care and implemented the tasks of public health care devoted to the development of the school community that strengthens health [5; 6;7]. During the latter decade after the service of a public health care specialist at school was established [1; 2; 3; 9] the practice development of nurses that remained in the communities of Lithuanian schools is being directed from professional care after children encompassing the targeted satisfaction of needs for children's primary personal health care and the ones connected to health (self-) education towards the implementation of universal preventive goals for public health strengthening. The Law on Education of the Republic of Lithuania laid down that health care at school has to be performed by healthcare specialists that have a higher education degree in public healthcare. Correspondingly, health care at school is no longer attributed functions which had consumed the majority of work time (annual health monitoring of pupils, vaccination).

There appears to be the tendency in Lithuania to force out the assistance of community nurses and person's health care services that are oriented towards student(s) from Lithuanian schools.

At the present time, in general education schools of Lithuania, only those specialists of person's health care practice who, according to the order laid down in legal documents [3; 10], have acquired a right to perform the functions of public healthcare oriented towards the children's health care and the interpretation of data; the assessment of student nutrition, the educational environment and the educational process; the application of health strengthening models for separate age groups of children and the dissemination of information. These specialists are entrusted with a wide range of preventive work when solving psychological and social problems of students [3].

The Description of Qualification Requirements of the Public Health Care Specialist (2007) notes that while leading his practice the specialist has to prepare health promotion programmes (projects), implement the policy of public health bureaus, teach his community to lead a healthy lifestyle and reduce illness rate of the population independently and engaging his school community and specialists of institutions and interested persons [3].

There is a lack of publications by Lithuanian scientists oriented towards the role of the public health care specialist of schools when implementing health promotion activities (programs, projects) and satisfying the needs of students and their parents (guardians). The performed scientific researches, in which the needs of public health care specialists for knowledge and perfection of skills are assessed, are connected with the information dissemination on the topics of health preservation and strengthening and the application of health strengthening models. It is thought that the implementation of health strengthening models, on which the implementation of the activities of student health promotion is based, is a complicated complex process encompassing the processes of student health education and socio-educational assistance and person's health care, the coordination of the activity and additional resources, the development of the partnership of specialists and pedagogues and parents (guardians) of students and the dissemination of good experience [5].

When performing the analysis of the data of the qualitative research A. Petrauskienė, S. Ustilaitė (2013) perceived that the teachers that took part in the research tend to assign public health care specialists not the role of the coordinator of health promotion activity (projects),

but that of an informal health educator which is realized when cooperating with teachers and creating extracurricular learning environment for targeted groups of students. It has been noticed that the cooperation between teachers and public health care specialists working at schools undergo difficulties when they endeavor to perform such activity of health promotion as health education in the classes without linking it with the individualized satisfaction of the needs of students and/or their parents and teachers, and the development of the interaction of assistance.

A public health care specialist working at school faces the following challenges:

Health care specialists working at school belong to Public Health Bureaus which create their own plans for the implementation of health promotion activities at schools. Each school also creates its own plans of action and a challenge arises to a specialist of public health care to harmonise different approaches, interests, needs and objectives of the activity of the authorities (a Health Bureau and a school) oriented towards health education of pupils. Public health care specialists experience vagueness of their activity when there is no clear-cut line of their activity in the environments of pupils' health education and personal and collective responsibility.

Health promotion lessons are not compulsory at Lithuanian schools of general education (only schools that belong to the network of health promoting schools choose health promotion as a compulsory lesson or as an optional lesson) and most often the model of its integration into the content of other subjects is implemented. In such a case, a public health care specialist does not have opportunities to pursue health promotion at a school systematically and consistently, but is forced to coordinate the time and place of the lectures of his, outside lecturers with specialist subject teachers and homeroom teachers, "thrust oneself upon" and insert health topics planned by him into the lessons of specialist subject teachers. When implementing these activities he faces a challenge related to the resistance of teachers and the unwillingness of pupils to take part in these activities. He also experiences doubts due to fragmented, inconsistent participation of his pupils in the process of health education. Fragmented health education of pupils when thrusting himself upon or inserting into the lessons of specialist subject teachers causes the experiences of frustration and disappointment when there are no visible results, sense and perspective. Pedagogues assess health care specialists and the specialists invited by them as "disturbing" the process of pupils' health education, as lacking the experience in education, whereas their fragmented teaching of pupils is treated as amateurish and auxiliary [5].

The formal obligation to conduct lessons also poses a challenge to public health care specialists (that is one of the functions of a specialist defined in their description of qualification requirements due to the fact that they do not have professional competences of a pedagogue). Pupils' health education, while giving informative lectures on the topics of hygiene, the prevention of infectious diseases, alcohol and narcotics use, cast doubts for a specialist regarding the necessity of such lectures for pupils, because then pupils are not active participants of an education process and lectures do not create an interest in pupils. It may also be observed that the work especially with senior pupils on sensitive topics of sexuality education and the prevention of addictions are not a strong area of these specialists.

Health education of pupils ought to be related to assessment of achievements that would shape pupils' abilities to react, identify and provide feedback in self-evaluation of positive experiences related to health-favourable behaviour. Therefore, assessment and evaluation of health education achievements is expected to embrace not only traditional assessment of

pupils' knowledge, skills and abilities in points, but also involvement of the pupil himself or herself in systematic and consistent process of self-evaluating own experiences in behavioural changes. Pupils' achievements are also a challenge to public health care specialists [8].

Despite the fact that a public health care specialist, who works at a school, faces various challenges, there can also be seen the perspectives of their activity.

Teachers are inclined to attribute to public health care specialists the role of an informal health educator and collaborate with them and support them when implementing health promotion activities outside their classroom or premises of their school for targeted groups of pupils. Teachers are inclined to seek consensus together with public health care specialists while assessing the needs, competence, responsibility and time of the educational activities of these specialists focused on the health promotion of pupils. The need for public health care specialists at schools is shown by their competence to contribute when organizing sports events at school, consulting teachers individually, acting freely and creatively at informal summer camps together with teachers.

The need for direct assistance linked to the personal health care of a pupil (or their groups) (to contact a public health care specialist regarding somatic disorders of a person's health) and health education are topical at school. It is thought that this process of educational help must exhibit interactiveness, be based on confidentiality, the interaction of the public health care specialist and the student(s) and correspond to his (their) experience of health changes [5]. Thus, at school, medics, who, firstly, have to satisfy the needs of children's personal health care, and especially of those children who due to some or another reason have difficulty accessing such services, should work at schools.

The perspectives of the practice of public health care specialists at school are linked to interprofessional cooperation and the creation of support relationships with the administration of schools; non-formal participation, which responds to the needs of pupils and teachers, in the process of health education of pupils in the environments of a school or the community outside the school; the satisfaction of a targeted individualized assistance for a student (and/or their groups) and the development of long-term interaction and cooperation abilities.

When organizing health care at a school health care specialist that work at a school have to work not only with children, but also with their parents and teachers. It is necessary to apply the principles of teamwork and to think regarding measures promoting the engagement of the community of a school (parents, teachers) in the activities of health education. New teaching methods have to be applied (e.g., a problematic teaching, simulations and the like) the purpose of which is the training in social skills and resilience.

The role of the modern health care specialist of pupils must be complex, covering numerous functions and duties. They have to administer not only first aid, but also to have theoretical knowledge and practical skills related to disease prevention, health safety, health promotion and teaching, the provision of methodological counselling for an individual and a group, programming planning, epidemiology, care for sufferers from chronic disorders and complicated medical conditions, crisis management, work with the 'at risk' group of pupils, communal and occupational health, communicable disease control, pharmacology, health care policies, health law, the preparation of information publications, documentation, the assessment of environmental factors and the provision of recommendations to avoid harmful impact of those factors [4].

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